ADVANCE DIRECTIVES AND EUTHANASIA IN FRAIL CARE AND THE TERMINALLY ILL

ALICIA CHETRAM
Student Number: 210511478

This Research Project is submitted in partial fulfilment of the regulations for the LLM Degree at the University of KwaZulu-Natal

College of Law and Management Studies
School of Law

Supervisor: Mr. MAROPENG NORMAN MPYA

DECLARATION

I declare that this project is an original piece of work, unless specifically indicated to the contrary in the text, which is made available for photocopying and inter-library loan.

_____

ALICIA CHETRAM

DECEMBER 2015

ACKNOWLEDGMENTS

I wish to express my appreciation to my supervisor, Mr MN Mpya, for the advice and guidance with regards to the completion of this piece of work. I am grateful to have a supervisor who is so understanding and willing to take the time to ensure that this would be a good piece of work.

I wish to thank my family as I would not be where I am if it were not for you all. I am appreciative for the patience and sacrifices that have been made to get me where I am.

I also wish to thank all my friends and work colleagues for the daily support and encouragement. It has truly meant a lot and kept me going.

TABLE OF CONTENTS

CHAPTER 1 – INTRODUCTION AND BACKGROUND TO ADVANCE DIRECTIVES AND EUTHANASIA

1.1 Introduction

She looked at me and then at my mum with big old eyes that told a story of all her emotions. She then spoke with what energy she had left and said:

> "I just want all of this to end. I am tired of the suffering. The doctors said that the cancer is spreading…and to my head! Anyone will be able to tell you that this will not end well. I do not want my family to be burdened with things I should be doing by myself every day."[1]

To end one's own life can be seen to many as a dignified death. It is submitted that there are many plays by Shakespeare which depict that there is honour where one kills him/herself such as 'Romeo and Juliet' and 'Antony and Cleopatra' to name a few. There was a norm in the past, especially with regards to such mentioned plays, that instead of allowing something or someone else kill you, killing yourself is dignified as you have control of how your life ends. People will not always agree on the same thing or have the same moral outlook, however, there is a need for there to be a legal consciousness as far as reasonable advancement can be made in allowing the elderly and terminally ill people to decide the timing and the manner of their own death.

There are potentially two momentous obstacles which medical practitioners may face when treating some patients. These obstacles form two categories which are when a patient is elderly and when a patient is terminally ill. The two issues can sometimes be at crossroads with each other, for example, where a patient is frail (which can be described as elderly, fragile, physically weak, delicate and in need of nursing)[2] as well as terminally ill. However, these categories of issues are also independent concepts that would have different criterion upon which they ought to be assessed, thus necessitating a thorough critical analysis of each independently and also in relation to one another.

[1] This is a dramatization regarding a patient who is frail and terminally ill asking for the right to die.
[2] Oxford University City Press 'Frail' http://www.oxforddictionaries.com/definition/english/frail, accessed 8 April 2015.

Furthermore, frail care and terminal illness form the basis upon which persons can request euthanasia and also through advance directives. Therefore, this study deals with euthanasia and advance directives as a vehicle through which people, who find themselves terminally ill or are in such a state of frailty that their quality of life is no longer said to be achieved or is absolutely diminished, can request to end their lives with dignity.

In the analysis of the above premise, there are other factors that are at play with the determination of granting euthanasia on the grounds of frailness and terminal illness. For instance, human dignity which is a right afforded to every human being.[3] This human right encompasses self-determination and the ability to make autonomous decisions.[4] The question of whether one can claim the right to die under such a right is a question yet to be answered by South African law. Although recent cases have attempted to make such a ruling, there was no legislation made in order to govern such requests. This gap in South African law should be addressed in order for medical practitioners to know the law and act accordingly.

Thus, the objective of this dissertation is to investigate advance directives and euthanasia specifically with regards to frail care and the terminally ill. The legality of living wills shall be critically discussed together with the concept of active euthanasia. The intention of this paper is to discuss when it is legal for euthanasia and a living will to be considered and further, what our law can do to give recognition to a patient's right to die in the specific groupings. A comparison shall be conducted with regards to those who are frail and terminally ill with those who are younger and terminally ill, and if these two groups of people can or should be granted the right to die if they request same.

In achieving these objectives, few fundamental questions must be answered. These include: whose wishes are to be taken into consideration and take preference when there is an advance directive; why should active voluntary euthanasia be allowed in South Africa; why should the right to human dignity include the right to die; what are the legal implications that a medical practitioner may face when handling a patient

[3] Section 10 of the Constitution of the Republic of South Africa, 1996.
[4] H Biggs *Euthanasia Death with Dignity and the Law* (2001) 29.

with a living will or when euthanasia is concerned; what should medical practitioners take into consideration when faced with a fail and/or terminally ill patient asking for the right to die; and how can South Africa be successful in allowing the right to die?

In order to address the abovementioned issues, this dissertation will focus on the Constitution of the Republic of South Africa, 1996. This is the supreme law of the country as seen in section 2 thereof. Section 11 of the Constitution provides that everyone has the right to life. Everyone also has the right to freedom and security of the person, as seen in section 12, which includes the right to bodily and psychological integrity. Section 14 provides for the right to privacy. Further to that, every person has the right to inherent human dignity and to have that dignity respected and protected as seen in section 10.[5] These rights will be discussed further in detail in order to determine how the right to die will be affected if it were to come into existence in South African law.

Further, the National Health Act 61 of 1993 shall also be examined. The National Health Act strengthens the rights contained in the South African Constitution. It provides for consent by proxy in section 8 of the Act. This means that a patient may consent to medical treatment or mandate a person, in writing, to consent to a health service where the patient is unable to give such consent.[6] Further, section 8 also mentions that where a patient is unable to participate in the decision making, he or she must have full knowledge of the health care service after it is provided unless it would not be in the best interests of the patient in terms of section 6 of the Act.[7]

Section 6(1)(d) of the National Health Act provides that patients must be informed of their right to refuse health services as well as the implications, risks and obligations of such refusal. This highlights the aspects of patient autonomy and self-determination.[8] The relevance of this Act is that it upholds the rights which people have and it may seem that a right to consent to medical treatment has allowance for

[5] MA Dada and DJ McQuoid-Mason (eds) *Introduction to Medico-Legal Practice* (2001) 28. M Slabbert and C Van Der Westhuizen 'Death with Dignity in Lieu of Euthanasia' (2007) 22 *SAPR/PL* 373.
[6] DJ McQuoid-Mason 'Advance Directives and the National Health Act' (2006) 96 (12) *SAMJ* 1237.
[7] *Ibid.*
[8] JD Boudreau and MA Somerville 'Euthanasia and Assisted Suicide: A Physician's and Ethicist's Perspectives' (2014) 4 *Medicolegal and Bioethics* 5. Biggs (note 4 above) 95-100.

living wills and euthanasia; however, it leaves grey areas as it does not specifically state such and leaves those in the medical profession with a dilemma.

The definition of euthanasia shall be discussed and also explained in terms of the different aspects thereof which are and are not allowed in South African law; however, voluntary and active euthanasia specifically is that which will be focused on.[9]

The definitions of death and a persistent vegetative state are provided by McQuoid-Mason;[10] however, will not be necessary to dwell on in this dissertation. Unbearable suffering is defined by Ruijs et al[11] as an experience which is subjective. This is important to note as everyone has a different threshold for pain and suffering.[12] This, then, has an effect of ones decision to end their life. Different types of descriptions of pain are further discussed in order to determine what weight this carries on the decision to opt for voluntary euthanasia, or the right to die.[13] These refer to the unbearable symptoms which are considered when handling a patient who requests euthanasia.

The aspect of family or patient's wishes in relation to euthanasia shall be discussed in the chapters to follow in this dissertation. A patient has the right to refuse medical treatment. This derives from the concept that a patient needs to give informed consent for medical treatment.[14]

---

[9] GA Ogunbanjo and D Knapp van Bogaert 'Is There a Place for Voluntary Active Euthanasia in Modern-day Medicine?' (2013) 55(1) *South African Family Practice* S10. M Brazier and E Cave *Medicine, Patients and the Law Fourth Edition* (2007) 487. BJ Stoyles and S Costreie 'Rethinking Voluntary Euthanasia' (2013) 38 *Journal of Medicine and Philosophy* 674. Clarke, DL and Egan, A 'Euthanasia – Is There A Case?' (2009) 2(1) *SAJBL* 24.

[10] DJ McQuoid-Mason 'Recent Developments Concerning Euthanasia in South Africa' (1995) 1 *Law and Medicine* 8,9.

[11] CDM Ruijs et al. 'Unbearable Suffering and Requests for Euthanasia Prospectively Studied in End-of-life Cancer Patients in Primary Care' (2014) 13 *BioMed Central Palliative Care*.

[12] A Egan 'Should the State Support the 'Right to Die'?' (2008) 1(2) *SAJBL* 49.

[13] Boudreau and Somerville (note 8 above; 2).

[14] Stoyles and Costreie (note 9 above; 679). DJ McQuoid-Mason 'The Legal Aspects of the 'Living Will'' (1993) 11 *CME* 60. S Krause (2012) 'Going Gently into That Good Night: The Constitutionality of Consent in Cases of Euthanasia' *Obiter* 56. Biggs (note 4 above; 69). NL Cantor *Legal Frontiers of Death and Dying* (1987) 2.

McQuoid-Mason[15] states that where conditions of a living will are met, the physician should consult with the family as their consent is very important. Where he/she refrains from doing so, action may be taken by the family for the loss of support or have a criminal complaint lodged. As this is true, what is not discussed is where the true wishes of the patient is to die, the family may want the patient alive for reasons – such as the patient is worth more alive than dead, or an insurance would not pay out in the above circumstance.[16]

The role of the family in such decisions are discussed by Sutherland and Smith[17] and Cantor;[18] however, the approach which must be taken will vary with different situations as well as would have changed over the years. There is one aspect which it is agreed upon – that being that a spouse or family member cannot overrule an informed decision to refuse treatment by the patient even where death will ensue.[19] This indicates the importance of one's right to autonomy.[20]

The question of what the medical practitioner is to do in such circumstances where the family's wishes conflict with that of the patient's has not yet been answered. McQuoid-Mason[21] suggests that in order to avoid litigation, a medical practitioner is advised to follow the wishes of the family; however, where the treatment is useless, or rather futile, then the practitioner can approach the Supreme Court to appoint a curator to protect the patient's best interests. The best interests of a patient are best described by Stoyles and Costreie.[22] Futile treatment is defined by Nedwick[23] and Dhai and McQuoid-Mason[24] where further reference is made to the *Clarke v Hurst*[25] case.

[15] McQuoid-Mason (note 14 above) 64.
[16] RS Harper *Medical Treatment and the Law – The Protection of Adults and Minors in the Family Division* (1999) 106.
[17] E Sutherland and AM Smith *Family Rights Family Law and Medical Advance* (1990) 59.
[18] Cantor (note 14 above) 107.
[19] Sutherland and Smith (note 17 above) 59.
[20] Boudreau and Somerville (note 8 above) 5. Egan (note 12 above) 48. Stoyles and Costreie (note 9 above) 678.
[21] McQuoid-Mason (note 14 above) 64.
[22] Stoyles and Costreie (note 9 above) 678.
[23] C Nedwick *Who Should We Treat?* (1996) 280.
[24] A Dhai and D McQuoid-Mason *Ethics, Human Rights and Health Law* (2011) 128.
[25] *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) A.

The reason that a legal practitioner may not be held criminally liable for withholding treatment is due to the unlawfulness element and that according to the legal convictions of society, it is found justifiable and not wrongful where there is no hope for recovery.[26] However; Stoyles and Costreie[27] explain that where a patient has explicitly refused consent, a medical practitioner may face legal action if he or she continues with such treatment.

The duty of the medical practitioner is to alleviate pain, to preserve life and to work in the best interest of the patient.[28] Problems arise that need addressing when the best interests of the patient conflict with preserving life.[29]

Countries such as Netherlands and Belgium have legalised euthanasia for many years now.[30] The Euthanasia Act has been operative in Netherlands since 2002 although it was practiced illegally in the late 1990's.[31] This law set requirements to be met before it was practiced, such as that of consulting with another doctor, relatives and caring team.[32] This is also a requirement in Belgium.[33] These strict requirements indicate that there is a chance for euthanasia to be legalised successfully and to be governed by requirements provided in a suitable statute. There are improvements to be made to such existing statutes in the abovementioned countries, such as having an independency between the physician and consultant,[34] but this is an indication that it is possible to establish a similar system in our country. Although these laws may not be perfect, it shows that where a patient is sure and competent; they have a right to die as they wish.[35] These countries are compared to Mexico, a country that

[26] DJ McQuoid-Mason 'Withholding or Withdrawing Treatment and Palliative Treatment Hastening Death: The Real Reason Why Doctors Are Not Held Legally Liable for Murder (2014) 104(2) *SAMJ* 102.
[27] Stoyles and Costreie (note 9 above) 679.
[28] Clarke and Egan (note 9 above) 26.
[29] Harper (note 16 above) 11.
[30] F Guirimand et al. 'Death Wishes and Explicit Requests for Euthanasia in a Palliative Care Hospital: An Analysis of Patients Files' (2014) 13 *BioMed Central Palliative Care* 53.
[31] Egan (note 12 above; 47). RLP Berghmans and GAM Widdershoven 'Euthanasia in the Netherlands: Consultation and Review' (2012) 23 *King's Law Journal* 109.
[32] Egan (note 12 above) 48.
[33] J Cohen et al. 'Nationwide Survey to Evaluate the Decision-making Process in Euthanasia Requests in Belgium: Do Specifically Trained 2nd Physicians Improve Quality for Consultation?' (2014) 14 *BioMed Central* 307.
[34] *Ibid.*
[35] PSC Kouwenhoven et al. 'Opinions of Health Care Professionals and the Public After Eight Years of Euthanasia Legislation in the Netherlands: A Mixed Methods Approach' (2012) 27(3) *Palliative Medicine* 273. ML Rurup et al. 'The First Five Years of Euthanasia Legislation in Belgium and the

has not yet legalised euthanasia, for reasons being moral, ethical and religious issues, as well as the state's need to prevent suicide.[36]

Active euthanasia as well as physician-assisted euthanasia is not legal in South Africa. The Law Commission of South Africa[37] has published a report on euthanasia; however, no legislation has been produced since.[38] An alternative to euthanasia is that of palliative care; but it comes into question how effective is this and also, how patients may react to not having the right to die in a dignified manner of which they choose.[39]

A major gap in our law is that most literature refers to the fact that active or voluntary euthanasia is not allowed in our law; or there is no proper provision or statute governing such an aspect. This dissertation strives to rather address this gap with the necessary case law,[40] and literature in order to determine what our law can do for those who choose that they want to die, both by leaving a living will and/or by stating it clearly whilst they are competent to do so.

The ethical implications is what prevents South Africa from setting a proper standard for such cases as there are worries that this may open the flood gates to the promotion of suicide where one cannot handle a disease that may be later cured.[41] However; what many do not understand is that there can be limits suggested in certain legislation in order to allow for euthanasia in a morally acceptable manner.[42] Writers refer to the slippery slope that allowing euthanasia will cause leading to

---

Netherlands: Description and Comparison of Cases' (2011) 26(1) *Palliative Medicine* 43.Y Van Wesemael et al. 'Establishing Specialized Health Services for Professional Consultation in Euthanasia: Experiences in the Netherlands and Belgium' (2009) 9 *BioMed Central* 220.

[36] Alvarez Deal Rio, A and Luisa Marvan, MA 'On Euthanasia: Exploring Psychological Meaning and Attitudes in a Sample of Mexican Physicians and Medical Students' (2011) 11(3) *Developing World Bioethics* 146.

[37] South African Law Commission *Euthanasia and the Artificial Preservation of Life* Notice 109 (1994) 344(15483).

[38] Slabbert and Van Der Westhuizen (note 5 above) 372.

[39] Boudreau and Somerville (note 8 above) 9.

[40] *S v Smorenburg* 1992 (2) SACR 389 (C). *S v Agliotti* 2011 (2) SACR 437 (GSJ). *S v Marengo* 1991 (2) SACR 43 (W).

[41] Brazier and Cave (note 9 above) 512.

[42] Ogunbanjo and Knapp van Bogaert (note 9 above) S11.

people ending lives even for those who do not request it,[43] especially those patients who are vulnerable – those being frail patients. There lies a danger of which those in the aging population and are terminally ill may face with regards to treatment and the responsibility thereof.[44] This is what most writers refrain from addressing. They mention that there are these issues; however, none suggest how to address these issues and trying to avoid the negative impacts from it. Most writers focus on 'end-of-life' issues being that of which one is ill and dies; however, they tend to ignore the fact that the frail patients who are terminally ill as well offer the aspect of vulnerability which needs to be addressed with due care.

The research methodology for this dissertation will include a literature review of various writings. Further, the research of different foreign legislation in other countries shall be compared to extract the best practices which may be a suitable approach for South Africa. These countries include Mexico which opposes the idea of euthanasia; Netherlands which applies the Termination of Life on Request and Assisted Suicide Act, 2002; and Belgium with the Belgium Euthanasia Act, 2002. South African law shall be studied by way of researching the Constitution of the Republic of South Africa, common law, statutes, as well as case law. Therefore, this study shall be one that focuses on qualitative research such as explanation and discussion of legislation and precedents, and does not warrant quantitative research.

This dissertation shall begin with basic definitions of certain aspects that will be discussed further, as well as a theoretical framework. Chapter 2 will follow with the South African legal framework. This Chapter aims to explain the current position in South Africa. Thereafter, a list of Constitutional rights shall be explained so as to gain insight to the relevance of the right to die with regards to each of these Constitutional rights. Legal precedents regarding euthanasia and advance directives shall be discussed so as to provide a basis for argument in chapters to follow. Chapter 3 shall provide a comparative study with regards to the different countries allowing and disallowing euthanasia. Firstly, South Africa shall be mentioned in order to provide an insight as to the current position which shall then be compared to

[43] Boudreau and Somerville (note 8 above) 10. Egan (note 12 above) 49. Stoyles and Costreie (note 9 above) 688. Clarke and Egan (note 9 above) 25. P Lewis 'The Empirical Slippery Slope from Voluntary to Non-Voluntary Euthanasia' (2007) *Journal of Law, Medicine and Ethics* 197.
[44] Nedwick (note 23 above) 8.

Netherlands and Belgium, which allow for euthanasia, and lastly Mexico which prohibits active euthanasia. Chapter 4 applies the precedents and laws discussed in the previous chapters in order to form an argument regarding the right to patient autonomy, the role of the family in decision making, the duties of the medical practitioner and lastly, the best interests of the patient and unbearable suffering. Chapter 5 concludes this dissertation in order to explain a 'right to die' if it were to be allowed in South Africa as well as recommendations for our law in an attempt to suggest a way forward for euthanasia in South Africa.

1.2 Definitions

Euthanasia

Euthanasia is "the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma."[45] The word 'euthanasia' is derived from the Greek word 'euthanatos' – 'eu' meaning good and 'thanatos' meaning death.[46] Euthanasia is sometimes referred to as 'mercy killing' where a person is so hopelessly ill, injured or incapacitated that the ending of their life as painlessly as possible is preferred rather than living a life of unbearable pain in the shadow of terminal illness.[47] The definition of euthanasia can draw different opinions by many other writers; however, the meaning of it remains the same, that being a good dignified death.

Euthanasia is a broad term which encompasses various sub-categories. The first is that of voluntary euthanasia.[48] Voluntary euthanasia is where the patient brings about his or her own death or requests another person to terminate his or her life.[49] The second is involuntary euthanasia which is where the patient has not consented and another person takes steps to hasten the patient's death.[50] This is where a person can, but does not request death. Non-voluntary euthanasia is one which is

[45] Oxford University City Press 'Euthanasia' available at http://www.oxforddictionaries.com/definition/english/euthanasia, accessed on 6 April 2015.
[46] *Ibid*.
[47] McQuoid-Mason (note 10 above) 7.
[48] *Ibid*.
[49] Stoyles and Costreie (note 9 above) 674.
[50] McQuoid-Mason (note 10 above) 7.

sometimes ignored by many writers and sometimes confused with the aspect of involuntary euthanasia. This is basically where a patient cannot request or consent to be euthanized.[51] Active euthanasia is where a person commits a positive act to cause the death of another. And lastly, passive euthanasia is an omission to do something which results in the death of a patient.[52]

Advance Directives

"An advance directive is an instruction which is given by patients regarding their future treatment should they become incompetent to consent to, or refuse, such treatment."[53] Further to that, an advance directive can authorise a third person or a proxy to give or refuse consent for the patient; however the advance directive is not absolute and unqualified. For instance, a medical practitioner may not be required to act contrary to the law such as would be the case in euthanasia.

Advance directives can be given regarding the refusal of treatment of a patient; however, cannot be given where it requires a medical practitioner to act in a particular way ie. administering a lethal injection.[54] A living will is an advance directive that states that if at any time a person suffers from an incurable disease or injury which cannot be successfully treated, life sustaining treatment should be withheld and the patient left to die naturally.[55] Living wills are not recognised by statute; however, it is recognised at common law provided that they reflect the patient's current wishes and have not been revoked.[56] McQuoid-Mason[57] emphasises that everyone has the right to limit what may be done to them; however, there is grey area as to whether one can limit what can be done to them where they are in such a state of illness or injury that they do not want to continue living.

[51] Stoyles and Costreie (note 9 above) 676.
[52] McQuoid-Mason (note 10 above) 8.
[53] McQuoid-Mason (note 6 above) 1236.
[54] J Herring *Medical Law and Ethics* 3 ed (2009) 542.
[55] Dhai and McQuoid-Mason (note 24 above) 130. Biggs (note 4 above; 115-144). Brazier and Cave (note 9 above) 490.
[56] McQuoid-Mason (note 6 above) 1236.
[57] McQuoid-Mason (note 14 above) 60.

Dhai and McQuoid-Mason[58] list concerns as well as advantages of living wills that are relevant to the topic as a living will is not an easy document to deal with, especially when it means that someone's life is at stake. There are moments where there is a living will and the family may object to what is stated. Therefore, safeguards when it comes to making a living will are necessary.[59]

Murder

Murder, according to criminal law, is the unlawful and intentional killing of another human being.[60] This is to be proven to a court beyond a reasonable doubt. The definition of murder includes circumstances whereby a medical practitioner intentionally ends the life of a patient through some positive act, for example, administering a lethal injection.

Suicide

Suicide is the action of killing oneself intentionally.[61] Committing suicide is not unlawful in South Africa. However, where a person helps or assists one in the act of committing suicide, that person will be held criminally liable for that death.

Palliative Care

Palliative care focuses on the care of the patient rather than the treatment of the patient. It is that care which keeps the patient comfortable. It "emphasises pain relief and psychological and emotional support to assist in the last stages of life."[62]

[58] Dhai and McQuoid-Mason (note 24 above) 131.
[59] Harper (note 16 above) 106.
[60] J Burchell *Principles of Criminal Law* 3 ed (2006) 667.
[61] Oxford University City Press 'Suicide' http://www.oxforddictionaries.com/definition/english/suicide, accessed 8 April 2015.
[62] Herring (note 53 above) 542.

Autonomy

Autonomy refers to the right of every individual to make decisions for themselves – this is the final decision regarding their treatment after being informed of all the necessary and relevant information.[63]

The Right to Life

Section 11 of the Constitution of the Republic of South Africa, 1996 provides everyone with the right to life. The right to die is not included in this right; however it can be argued by those who are pro-euthanasia that the right to life should include the right to choose how one wants their life to end.

The Right to Human Dignity

Section 10 of the Constitution of the Republic of South Africa, 1996 states that everyone has the right to inherent dignity and the right to have their dignity respected and protected.

1.3 Theoretical Framework

Conventional legal principles have had to be re-evaluated in light of the cases that seek clarity on the question of euthanasia. South Africa has recently faced a situation whereby it is now placed in position to decide on promulgating legislation allowing and regulating the use of euthanasia – that being active euthanasia or physician-assisted suicide – and whether this would be a promotion of Constitutional values and principles or an infringement thereof and of certain Constitutional rights.

It is raised that the allowance of euthanasia could possibly result in an adverse effect with regards to many issues, such as more patients opting for the choice of euthanasia rather than other treatments or families influencing terminally ill family members in terms of inheritance to list a few. A comparative study is conducted in

[63] K Moodley (ed) *Medical Ethics, Law and Human Rights: a South African Perspective* (2011) 41.

Chapter 3 to investigate how the legislature may apply euthanasia laws in South Africa, if this is seen as possible at all. Countries such as the Netherlands and Belgium are used to demonstrate how euthanasia is practiced and the resultant success or consequences thereof are highlighted. The Termination of Life on Request and Assisted Suicide Act has been regulated in the Netherlands since 2002.[64] Belgium allows for euthanasia under strict conditions, also, since 2002.[65] Mexico, unlike the Netherlands and Belgium, does not allow for euthanasia; however, there is a legislative initiative to allow active euthanasia.[66] These countries are further analysed and compared with South Africa in order to determine what methods South Africa can adopt to approach such issues.

Medical practitioners often turn to the option of euthanasia where treatment is futile to the patient's condition and the patient is unable to communicate their wishes. Passive euthanasia is allowed in South Africa; however active euthanasia is not. South Africa does not allow a patient the right to die (specifically, the right to choose the timing and manner of their own death); however living wills are accepted under common law to facilitate death. This indicates that although a patient's intention is considered in an advance directive, the patient cannot or rather, is not allowed in law to choose to die in the manner they wish in order to avoid suffering unless they have reached such a condition where treatment is futile or they are incapable or unconscious. This indicates that the law does not give a person the right to die with dignity if they so choose and are capable to choose. Some may argue that a patient has to live in pain or attempt palliative care until the conditions are met in order for passive euthanasia to be allowed.

Further, it is submitted that where a patient chooses to leave a living will or not, there may be uncertainty as to how a doctor should react where the family's wishes differ from that of the patient. This causes a dilemma for the medical practitioner as he or she may be faced with legal threats from that family. Families may have an ulterior motive wanting a patient dead, for example where there is a large estate, or for wanting a patient alive such as where a person is worth more alive than dead. It is

[64] Kouwenhoevn and Raijmakers (note 35 above) 273.
[65] Cohen (note 33 above) 1-9.
[66] Del Rio and Marvan (note 36 above) 146.

also an issue as to how long one may be kept alive where treatment is futile and these resources could be used for another patient with better chances of survival.
The law may allow for euthanasia in certain circumstances, such as where there is no chance for recovery for the patient and there is an omission which results in their death.[67] However, it is clear that there are still a few gaps in the law to properly handle situations in frail care and the terminally ill. A person who is frail may not be allowed the same right to die as a person who is terminal because of the issue of ethical consideration. Some of these patients can consent or can leave a living will, but the true intention of these patients can also be influenced by their illness or the burden or strain they believe they would put on their family (emotionally, financially and physically).

Therefore, with the right to choose to die, also comes an ethical concern regarding the patient and their state. Dignity is a right which is afforded to all, however, whether the right to die is included in this is still a question that needs to be addressed. Therefore, the debate around this topic brings research which may help with arriving at legal certainty to regulate complex issues around euthanasia.

[67] *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) A.

CHAPTER 2 – SOUTH AFRICAN LEGAL FRAMEWORK ON ADVANCE DIRECTIVES AND EUTHANASIA

This chapter analyses South Africa in relation to advance directives and euthanasia. Cases have led to the countries current position and it is this adaptation of the law that is important to understand as it will depict a move forward with regards to the allowance of active euthanasia and issues to be dealt with in frail care and terminal illnesses.

2.1 South Africa's position with regards to Advance Directives

In South Africa, living wills have not been recognised by statute as yet. It is, however, recognised by common law provided that they reflect the current wishes of the patient.[68] Living wills are similar to a will; however they are not included in the Wills Act 7 of 1953 and therefore, cannot be governed by this Act. They are however regarded as legally valid "on the basis that they are advance refusals of treatment."[69] Furthermore, the patient would have had to have made the living will at a time when they were considered to be mentally capable, reflect the present wishes of the patient and also would not have been revoked at any stage.[70]

The National Health Act 61 of 2003 does provide for consent by proxy where a patient mandates a person to consent to a health service on their behalf where there are unable to do so; however this must be in writing. Section 8 of the Act provides for such circumstances. Section 7(1)(a) provides for the hierarchy of people who would be allowed to consent on the patient's behalf where the patient is incapable of consenting to a health service themselves.

McQuoid-Mason (2005)[71] provides that doctors cannot be charged for murder. The death is a result of the "failure to treat in terms of the advance directive and the underlying illness or injury." This means that that although there was an omission on

[68] McQuoid-Mason (note 6 above) 1236.
[69] DJ McQuoid-Mason 'Pacemakers and 'living wills': Does turning down a pacemaker to allow death with dignity constitute murder?' (2005) 1 *SACJ* 25.
[70] *Ibid*.
[71] *Ibid*.

the medical practitioner to treat the patient, the illness or injury would be seen as the cause of death and not the omission of the medical practitioner. A medical practitioner can be held liable where there was a duty on him or her to act. It is submitted that it is clear that the advance directive addresses the aspect of there being a duty on the medical practitioner to act.

2.2 South Africa's position with regards to Euthanasia

In South Africa, there is no statute made which currently governs active euthanasia. However, active euthanasia is seen as unlawful and regarded as murder yet passive euthanasia is allowed. South African law allows for no liability for a mere omission – that being passive euthanasia – except where there is a legal duty to act.[72] It is legally allowed for a withdrawal or withholding of treatment of a patient suffering from a terminal illness or injury which is so serious that prospects of recovery are nil.[73]

Active euthanasia is regarded as a crime as it involves a positive act by a person or the medical practitioner which results in the death of the patient.[74] It was further stated that courts have held that where a person supplies the required and necessary instrument for the intended suicide knowing that it is required and that they want to commit suicide, that person will be held guilty of murder.[75]

The South African Law Commission has proposed a Euthanasia Act to provide for the various definitions and circumstances in order to ensure that there is clarity as to what is legal and illegal regarding euthanasia; however there had been no light as to whether this Act will materialise.[76] The '*Report on Euthanasia and the Artificial Preservation of Life: South African Law Commission*, Report, Project 86' recommended such an Act so as to offer some insight on where the 'poor quality of life raises the question of whether treatment is a benefit or a burden.'[77] The Act would propose that where the patient is mentally competent, the administering of a

[72] McQuoid-Mason (note 10 above) 8.
[73] Dhai and McQuoid-Mason (note 24 above) 126.
[74] Dada and McQuoid-Mason (note 5 above) 28.
[75] *Ibid*.
[76] McQuoid-Mason (note 10 above) 8.
[77] '*Report on Euthanasia and the Artificial Preservation of Life: South African Law Commission*, Report, Project 86' *x.*

lethal substance to the patient can occur in order to end their unbearable suffering; however there must be protection of the patient and their rights. The Commission had recommended the enactment of legislation giving effect to the principles such as: to cease medical treatment where the patient is being maintained artificially and has no spontaneous respiratory or circulatory functions, or the brainstem does not register any impulses;[78] where the patient is competent and refuses life-sustaining treatment; or where the medical practitioner may cease further medical treatment of the terminally ill patient who is unable to communicate their decision but in accordance with the family's wishes or by court order.[79]

The Commission had offered different options to deal with such issues, these being the confirmation of the present legal position, decision making by the medical practitioner and decision making by a panel or committee. The Act is not to oblige a medical practitioner to conform to what the patient requests which is in conflict with their conscience or any ethical code. Further, the Act would give the Court powers to make decisions on cessation of treatment based on facts and evidence of the patient's condition and medical history as well as allow for the medical practitioner not to be held liable whatsoever.[80]

2.3 The Constitution of the Republic of South Africa

The Right to Dignity

It is submitted that it is trite how important the right to human dignity is in South Africa. Section 10 of the Constitution of the Republic of South Africa, 1996 provides every person with the right to human dignity.

Dignity as a value does not lend itself to easy interpretation. A few aspects regarding dignity may facilitate its understanding and thus is meaning. Human dignity is a

[78] '*Report on Euthanasia and the Artificial Preservation of Life: South African Law Commission*, Report, Project 86' *xi.*
[79] *Ibid.*
[80] *Ibid.*

foundational value[81] in the South African Constitution and is mentioned many times in many important sections such as section 1, section 7(1), section 10 as a specific right (which provides that everyone has inherent dignity), section 35(2)(e), the limitations clause section 36 and section 39(1)(a).[82] The Constitutional Court seems to have followed an approach first set out by Immanuel Kant. For Kant, humans are to be treated as an end in themselves, not as a means to an end.[83] That is, human beings, simply by virtue of that the fact that they are human have an inherent, equal dignity.[84] Such a dignity in inviolable, it cannot be reduced or traded, suspended or confiscated and belongs in equal amounts to everyone from the smallest child to the most dangerous criminal.[85] Dignity is a central and defining feature of equality.[86]

Dignity means the state or quality of being worthy of honour or respect.[87] The issue which is faced with regards to euthanasia is whether the right to human dignity in fact includes the right to die how we may chose or the right to die a dignified death.

The Right to Life

Section 11 of the Constitution of the Republic of South Africa, 1996 provides for the right to life. This is basically the right to live as a human being. The right to life can be seen as infringed if euthanasia were to be allowed. This right is intertwined with that of human dignity in that there is no dignity without life.[88]

[81] *S v Dodo* 2001 (5) BCLR 423 (CC), *Barkhuizen v Napier* 2007 (7) BCLR 691 (CC).
[82] Constitution of the Republic of South Africa, 1996.
[83] A Wood 'Kant's Formulation of the Moral Law' in Graham Bird (ed) *A Companion to Kant* (2006) 299. In *S v Makwanyane and Another* 1996 (6) BCLR 665 (CC) at page 668 where the death penalty allowed a person to be treated as an object to was disposed of.
[84] *S v Dodo* 2001 (5) BCLR 423 (CC). *Thomas and Another v Minister of Home Affairs and Others* 2000 (8) BCLR 837 (CC). *Prinsloo v Van der Linde and Another* 1997 (6) BCLR 759 (CC). L Ackermann *Human Dignity: Lodestar for Equality in South Africa* (2012) 55.
[85] Ackermann (note 84 above) 57. In *S v Makwanyane and Another* 1996 (6) BCLR 665 (CC) O' Regan held that without dignity, human life is substantially diminished.
[86] Ackermann (note 84 above) 56.
[87] Oxford University City Press 'Dignity' http://www.oxforddictionaries.com/definition/english/dignity, accessed 8 April 2015.
[88] A Govindjee and P Vrancken *Introduction to Human Rights Law* (2009) 83.

The Right to Freedom and Security of the Person

Section 12 provides for this right specifically by stating that everyone has a right not to be treated or punished in a cruel, inhumane or degrading manner. Further, the right includes that everyone has a right to bodily and psychological integrity and allows them to have control over their body.[89] Although this right provides that no harm should arise to one's body, it also allows for one to have control of their body, therefore, highlighting the aspect of patient autonomy.

The Right to Freedom of religion, belief and opinion

Section 15 of the Constitution provides for the right to make one's own choices by stating that everyone has the right to freedom of conscience, religion, thought, belief and opinion. It is of course limited as it is allowed provided that it does not infringe on any other person's rights as suggested in section 36 of the Constitution.

2.4 Legal Precedents in South Africa

- ***S v Hartmann* 1975 (3) SA 532 (C)**

In this case, the accused was a medical practitioner. His father had been suffering from prostate cancer for a number of years and it was spreading throughout his body. The accused had injected the deceased with pentothal – a drug used in "anaesthetic and unless properly controlled will have fatal effects."[90] This was injected into the drip which was administered to the patient and he had died a few seconds after.

It was stated that the motive was that of compassion and to relieve the endurance of pain; however, the Court held that it "nonetheless constitutes the crime of murder even if all the accused has done is to hasten the death of a human being who was due to die in any event."[91] It was stated that the desire of the deceased was

[89] Section 12 of the Constitution of the Republic of South Africa, 1996.
[90] *S v Hartmann* 1975 (3) SA 532 (C) 533.
[91] *Idem* 534.

unknown as he only nodded when asked if he wanted to sleep. The accused was then found guilty as charged.

Mitigating factors, such as all hope for a cure vanishing, suffering of a fatal condition and the severe and continuous pain the patient was in, were taken into consideration.[92] It was also taken into consideration that the Medical Council were also going to take disciplinary action against the accused. The accused was sentenced to one year imprisonment until the rising of the Court and the balance thereof suspended for one year provided that he does not commit an offence involving intentional infliction of bodily injury during the period of suspension.[93]

- ***S v Marengo* 1991 (2) SACR 43 (W)**

The accused was a 45 year old woman charged for murder of her 81 year old father who was terminally ill due to suffering from prostate cancer. She had taken the deceased's firearm and shot him twice in the head resulting in his death. She pleaded guilty to the charge of murder; however, it was mentioned that she had done the act due to her desire to end her father's suffering. He was in constant pain, and in a hopeless position. Further, the deceased would not allow anyone else to care for him and refused to be put in an old-age home.[94] His general condition had deteriorated badly and the accused had decided to end his life by granting him a quiet and merciful death.[95]

Due to the accused's personal circumstances and condition, she was sentenced a wholly suspended sentence of three years imprisonment on condition that she was not convicted of an offence involving an intentional infliction of bodily injury on any person and that she submits herself to supervision of a social welfare worker.[96]

[92] *Idem* 536.
[93] *Idem* 537.
[94] *S v Marengo* 1991 (2) SACR 43 (W).
[95] *Idem* 45.
[96] *Idem* 47.

- ***Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) A**

Patient, Frederick Cyril Clarke, suffered cardiac arrest. This had resulted in "serious and irreversible brain damage due to prolonged deprivation of oxygen to the brain."[97] The patient was in a persistent vegetative state. It was stated in this case that the patient had no prospect of improving his state or recovering. The wife of the patient was the applicant applying for the withdrawal and withholding of treatment of her husband as she was appointed as curatrix.

The patient was stated to be a member of the SA Voluntary Euthanasia Society where he had made a living will requesting for his life to be terminated and not to be kept alive by artificial means. He had further made public speeches in his lifetime depicting his opinion regarding the right to die.[98]

The Court held that the wife of the patient is, in fact, acting in the best interests of the patient and appointed her as curatrix. Further, the court provided her with the power to withhold or withdraw treatment without being declared to be acting wrongfully or unlawfully.[99]

This case basically discusses the aspect of passive euthanasia. The curatrix was allowed to withhold treatment where the patient was in a state where there were no prospects of improvement of the patient's health. This was seen to be acting in the patient's best interests. Although this demonstrates passive euthanasia, it is submitted that this is a step forward with regards to allowing the right to die to patients capable of asking for same. There are patients who can speak and tell a doctor, nurse or family members that they want to die. However, with regards to this case and law, we are given the impression that it is acceptable to withdraw treatment of those who are in a persistent vegetative state but an offence to end the life of a patient who is suffering and asking to die.

[97] *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) A 632.
[98] *Idem* 633.
[99] *Idem* 660-661.

- ***S v Smorenburg* 1992 (2) SACR 389 (C)**

A nursing sister is charged for two counts of attempted murder. The two incidents had happened 19 days apart and both instances occurred by the accused injecting them with large doses of insulin.[100] The patients had died shortly after being injected. The accused had pleaded guilty, stating that she had unlawfully and intentionally acted "out of empathy and compassion for a terminally ill patient" for whom she was responsible. She had stated that her actions were bringing an end to the dying process which had already commenced and further, it was her sincere belief that she had done so in accordance of the patients' wishes and desires as well as the severe emotional stress on her part.[101]

It is established in this case that the accused had felt the strain and stresses of working with the terminally ill[102] and it is submitted that it is clear that her actions were as a way of behaving mercifully. The patient's conditions were getting progressively worse and although all that was possible was being done, the accused was stated to have felt they were "suffering tremendous indignity."[103] It was further stated that the accused "was not trained to deal with the problem of dying and how to cope with the terminally ill"[104] as she was trained to work with other patients but none which were in these conditions. It was however, not disputed that the accused had acted in a manner that she had "conceived to be the best interests of her patient."[105]

According to the State in this case, neither patient had expressed a desire to be euthanised and nor did their family members.[106] The state had further argued that the actions of the accused should have been performed under controlled circumstances.[107] The accused was sentenced three months imprisonment wholly suspended for twelve months on certain conditions.

[100] *S v Smorenburg* 1992 (2) SACR 389 (C) 390.
[101] *Ibid*.
[102] *Idem* 392.
[103] *Idem* 392.
[104] *Idem* 395.
[105] *Idem* 397.
[106] *Idem* 400.
[107] *Idem* 400.

- ***Airedale NHS Trust v Bland*** **[1993] 1 All ER 821**

Although this may not be a South African precedent, it is a case worth mentioning as it has had influence in South African law with regards to passive euthanasia. In this case, the patient had a football injury resulting in him being in a persistent vegetative state. He has irreversible damage to the brain and was being fed artificially.[108] The hospital consultant and other medical experts saw it as fit that they should cease further treatment, which would then result in the patient starving to death, as there was no hope for recovery.

The medical team had then applied to the Court to lawfully discontinue 'all life-sustaining treatment and medical support."[109] This application was also to allow for the patient to die a peaceful and dignified death.[110] There was opposition to this as this was seen to be "a breach of the doctor's duty to care for his patient, indefinitely if necessary, and a criminal act."[111] The Court had held that the doctor would have been allowing for the underlying illness to be the cause of the death and that it would not have been in the best interests of the patient to allow for 'intrusive life-support.'[112] The Court then allowed for the discontinuance of treatment of the patient.[113]

It is submitted that although this case focuses on the aspect of passive euthanasia since the medical practitioner withdraws treatment, it is important as it focuses on the best interests of the patient. The word 'intrusive' tends to describe it well, as it is submitted that from the knowledge of recent cases, it is seen that patients do not want to submit themselves to many treatments that just 'keep them going', but want a death where they are in a state to say goodbye to their loved ones and die in a peaceful manner.

[108] McQuoid-Mason (note 10 above) 13.
[109] *Ibid*.
[110] *Ibid*.
[111] *Idem* 14.
[112] *Ibid*.
[113] *Ibid*.

- ***S v Agliotti* 2011 (2) SACR 437 GSJ**

In this case, the accused was charged for, amongst other counts, one count of murder.[114] This case had cited and referred to other cases regarding euthanasia and assisted dying in order to reach a verdict regarding the application for a section 174 discharge in terms of the Criminal Procedure Act 51 of 1977. Firstly, the case had distinguished the differences between assisted suicide and euthanasia stating that assisted suicide is when one helps on to die but euthanasia consists of the aspect where a patient is terminally ill.[115]

The case of *Rex v Peverette* 1940 AD 213[116] had been referred to. This case had involved two parties in a vehicle where the accused introduced exhaust fumes into the vehicle. The accused was then convicted of attempted murder.

A case which was mentioned in opposition to the above, was that of *R v Nbakwa* 1956 (2) SA 557 (SR). Briefly, this case involved a man who provided the means to commit suicide to the deceased, namely, the noose and block of wood for the deceased to stand on. The Court had held that the deceased was responsible for her own death as she had committed the act resulting in her death. The accused was accordingly acquitted.[117] The case of *S v Gordon* 1962 (4) SA 727 (N) applied the same thinking which was in this case.

The *Agliotti* case made mention that the South African Law Commission had devised criteria which should be taken into consideration when handling the cessation of treatment and/or assisting a terminally ill person to die.[118] The criteria is as follows:

- Patient need be terminally ill;
- The suffering must be subjectively unbearable;
- The patient must consent to the cessation of treatment or administration of euthanasia;

[114] *S v Agliotti* 2011 (2) SACR 437 (GSJ) 441.
[115] *Idem* 442.
[116] Cited in *S v Agliotti* 2011 (2) SACR 437 (GSJ) 445.
[117] Cited in *S v Agliotti* 2011 (2) SACR 437 (GSJ) 445.
[118] *Idem* (note 114 above) 447.

- The situation of precipitating the decision to euthanize must be certified by at least two medical practitioners.[119]

It was stated that the conclusion that one can safely reach is that where a person assists another to commit suicide, that person will be guilty of an offence.[120]

- **Avron Moss**

Although this is not a precedent, it was a matter of a person requesting the right to die in South Africa and could have possibly been a precedent if the matter had reached Court. Avron Moss was 49 years old when he was diagnosed with melanoma. He then began searching for methods in which he could end his life with dignity. He was to feature as an applicant in the High Court for an application for the right to an assisted death; however, he had ended his life before this could happen. He had ended his life by using medication which he smuggled into South Africa from Mexico.[121]

At the time of his death, he was of sound and sober senses and had ingested the drug unknowing of what would happen. He was unable to obtain palliative care although it was requested.[122] Moss stated that this was something "every person with a terminal illness should experience" right before his death.[123] Further, according to his brother, this was the dignified death which he had wanted. He was a member of DignitySA and was a perfect candidate for the application which was to be brought before court; however, his health had deteriorated.

It is submitted that it was mentioned that there should an allowance for mentally capable terminally ill patients to die with dignity, and not experience "or suffer the terror of having to shoot or hang themselves."[124] Moss was of the view that South

[119] *Idem* (note 114 above) 447.
[120] *Idem* (note 114 above) 449.
[121] M Thamm'Assisted Dying: Avron Moss – Another Casualty of Legal Uncertainty' *The Daily Maverick* 10 March 2015 at 2.
[122] *Idem* 3.
[123] *Idem* 3.
[124] DignitySA 'Dignity South Africa's Patrons' available at http://www.dignitysa.org/blog/dignitysas-patrons/, accessed on 1 September 2015.

African law "actively perpetuates suffering, in conflict with our Constitution and with Human Rights, and is indefensibly unjust."[125]

- ***Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP)**

This case had gained an immense amount of media attention. It is submitted that this case is just the beginning for a move forward with regards to assisted dying becoming legal in South Africa.

The applicant was an Advocate of the High Court of South Africa. He was highly qualified and rather experienced in the law profession.[126] He was even examined by a clinical psychologist who described him as "totally rational." Stransham-Ford was diagnosed with terminal stage 4 cancer and had died on the day the order was made.

The applicant basically applied for an order allowing him to end his life with some lethal agent by a medical practitioner and for the medical practitioner to not be held accountable and to be free from any civil, criminal or disciplinary liability which may arise.[127]

It was not disputed that the Applicant had had a terminal disease with not long to live. He did not want palliative care and one of the main reasons for such an application was the issue to achieve a dignified death.[128] The Applicant's quality was described in the case in detail; however, most importantly gained from this was that death was imminent and his condition would worsen.[129]

The current legal position regarding euthanasia was analysed by the Court in quite some detail. It began by stating that active voluntary euthanasia was unlawful. Further, the Court discussed the Constitution of the Republic of South Africa, more

[125] *Ibid*.
[126] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP) 53.
[127] *Idem* 54.
[128] *Idem* 55.
[129] *Idem* 55-56.

specifically the right to human dignity and the right to freedom and security of the person.[130] The Court then went on to discuss human dignity and its importance, such as human dignity being fundamental to the new Constitution.

The Counsel for the Applicant very cleverly referred to the case of *Clarke v Hurst N.O and Others*[131] stating that they had seen no difference between assisted suicide by switching off a life support device and injecting the patient with a lethal agent; especially with regards to the legal principle of *dolus eventualis.*

When the court had discussed dying as a part of living,[132] it was mentioned that the state "cannot afford to fulfil all socio-economic demands, but it assumes the power to tell an educated individual of sound mind who is gravely ill and about to die, that he must suffer the indignity of the severe pain, and is not allowed to die in a dignified, quiet manner with the assistance of a medical practitioner."[133] Further, this patient is still alive and has certain rights which need to be respect – such as that of personal autonomy. One of the statements made which holds an impact was that "we are told from childhood to take responsibility for our lives but when faced with death we are told we may not be responsible for our own passing."[134]

The Counsel for the Applicant made mention of how the death would be undignified if the choice of dying was not given to the Applicant. A very interesting analogy was also used regarding animals – that it is humane to end an animal's life but not a human?[135] The court decided to look at the case with its own merits and further, found that there was no "ripple effect" put to it.

There were safety measures which the Applicant's had put forward, those being confirmation of the terminal disease, being adequately informed of same, a persisted decision to end his life, request to be released from an eventual unbearable suffering and extensive research regarding the condition.[136]

---

[130] *Idem* 57-58.
[131] Clarke v Hurst (note 25 above) 630.
[132] *Stransham-Ford v Minister of Justice and Correctional Services and Others* (note 76 above) 61.
[133] *Idem* 62.
[134] *Idem* 62.
[135] *Idem* 63.
[136] *Idem* 67.

The Respondents disputed that the Applicant was being treated in any inhumane or degrading way. Further, they had stated that there was no infringement on dignity as the Applicant's view was merely subjective. The Applicant; however, put forward the argument of no distinction between active and passive euthanasia.[137] Attention was brought to the fact that suicide and attempted suicide not being regarded as offences by the Applicants, as well as the aspect of abortion.[138] Laws from Netherlands and Belgium were considered.

In conclusion of the case, the Court held that it was of the view that "the absolute prohibition on assisted suicide in common law does not accord with the rights that the Applicant relies on.[139] However, the Court made it very clear that this was judgment for this case only and not to be regarded as a precedent. Any other person requesting the right to die is to make their own application based on their own facts and to be decided upon on its own merits entirely. The Court held that the Applicant is entitled to be assisted by a qualified medical practitioner who is willing to do so, and if they are, then they would not be held legally liable.[140] Unfortunately, the Applicant died the day this order was made and the order was not placed into action.

[137] *Idem* 69.
[138] *Idem* 69.
[139] *Idem* 70.
[140] *Idem* 71.

CHAPTER 3 – COMPARATIVE STUDY

In order to form a law, it is rather necessary to examine other countries and how they have applied a law relating to euthanasia in their countries. This is a method in order to form a guideline which a country can use, as well as a method in order to view how successful such a law was and the changes it brings with it. Euthanasia is not a simple topic and there are many differing views to such an aspect. It is for these reasons a comparative study shall be conducted.

Firstly, the position in South Africa shall be described as it is the jurisprudence that is to be discussed in order to find a way forward for the right to die. This is discussed in the chapter as a method of comparing the position in South Africa currently to those laws already in place in the other countries listed. Thereafter, a comparison to the Netherlands and Belgium shall as be done in order to examine the success of a Euthanasia law. Netherlands, being the first country to legalise euthanasia, will be discussed in order to highlight the progress of such law.[141] Belgium is also discussed in order to depict how the Netherlands law had influenced the law in Belgium and also the progress thereof.[142] Lastly, Mexico shall be discussed in view of the reasons as to why euthanasia is not allowed in that specific country.[143] This country is used as a comparison in order to highlight the difference in opinion and law and the reasons as to why. From analysing this, a conclusion can be drawn as to what would be most suitable for South Africa to apply.

3.1 South Africa

As it was stated in the previous chapter, South Africa has not implemented a statute with regards to a living will; however, it allows the recognition of living wills through common law.[144] It has been noted that there has not been any recent change to this and has been the stance in South Africa for quite some time.

[141] Berghmans and Widdershoven (note 31 above) 109.
[142] Slabbert and Van Der Westhuizen (note 5 above) 372.
[143] Del Rio and Marvan (note 36 above) 152.
[144] McQuoid-Mason (note 6 above) 1236.

With regards to euthanasia, as stated in the previous chapter, active euthanasia is regarded as murder; however, passive euthanasia is allowed in South Africa. It is noted from the recent application that the *Stransham-Ford* case[145] had made that there may be a change. However, this judgment does not apply to everyone in the same position as the Court had held that each case must be decided upon on its own merits. Therefore, this judgment cannot be used as a precedent for every patient requesting the right to die as each matter will be decided upon its own circumstances.

There are increasing cases of people who are terminally ill and want to end their life. It is submitted that this is something that will, in a way, compel the implementation of some sort of law to govern such situations. However, what is then expected is that this will open the flood gates to many other issues such as a person who is terminally ill and frail. Having a law with too many restrictions, on the other hand, would then defeat the purpose as it is submitted that one would have to also look at the ordinary man and whether they can afford such a decision. If South Africa intends on allowing assisted suicide in the future, there are many issues that have to be dealt with properly or else there will most definitely be a "slippery slope"[146] reaction.

As mentioned before, the South African Law Commission did propose an Act regarding Euthanasia; however, this never materialised. The proposed Act had covered aspects such as definitions, the recognition of advance directives as well as enduring a power of attorney.[147] Further, the '*Report on Euthanasia and the Artificial Preservation of Life: South African Law Commission*, Report, Project 86' recommends addressing issues such as those patients who are brain dead, when a person refuses medical treatment, recognition of a living will and the provision of drugs to end one's life due to terminal illness suffering.[148]

[145] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (note 126 above).
[146] Lewis (note 43 above) 197-210.
[147] Dhai and McQuoid-Mason (note 24 above) 132.
[148] Slabbert and Van Der Westhuizen (note 5 above) 372.

It is submitted that with the correct criteria in place, assisted suicide can, and actually should, be allowed for a terminally ill person requesting to die. It is a way forward rather that remaining in one train of thought. Further, it has been done in other countries as will be explained further in this chapter. There is no doubt that this law will come into place, but how soon remains untold. And how this will affect frail patients will remain a worry.

3.2 Netherlands

The Netherlands was among the first countries to legally permit euthanasia and physician-assisted suicide under specific circumstances.[149] Netherlands had enforced the Termination of Life on Request and Assisted Suicide Act (also referred to as the Dutch Euthanasia Act) in 2002 which legalises euthanasia as well as physician-assisted suicide.[150] This was enacted after many Dutch people believed that they were to be free to make their own decisions about their lives, 'including when and how their life should end.'[151] A large majority of the population then believed that assistance in death should be allowed. The position on euthanasia was then made after consideration by society and Parliament in order to ensure proper control and acceptability of voluntary euthanasia and assisted dying.[152] "The euthanasia law contains provisions governing requests for termination of life or assisted suicide by minors, and recognises the validity of written living wills."[153] This Act; however, does not allow for active euthanasia at any instance but has certain factors which need to be taken into consideration first.

The Act only allows for a physician's actions not to be found punishable where he or she performs euthanasia.[154] There is a criteria of 'due care' whereby the Act applies and is summarised as follows[155]:

1. Firstly, there must be a voluntary and well-considered request by the patient;

[149] Berghmans and Widdershoven (note 31 above) 109.
[150] B Farham 'Editors Comment: End-of-life practices in the Netherlands' 2012 *CME* 30 (8) 271.
[151] U Schuklenk, JMJ Van Delden et al. *End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making* (2011) 25 *Bioethics* 55.
[152] *Ibid.*
[153] Berghmans and Widdershoven (note 31 above) 111.
[154] Kouwenhoven (note 35 above) 274.
[155] *Ibid.*

2. The presence of unbearable suffering with no prospects of improvement;
3. The patient is to be well-informed of the situation and prospects;
4. There are no reasonable alternatives to relieve the suffering of the patient;
5. A consultation by an independent physician;
6. Euthanasia or physician-assisted suicide to be performed with due medical care and attention.

The Act does not state that one has to be suffering from a terminal illness, but states that there must be a factor of unbearable suffering present of which cannot be alleviated.

Physicians must further report the death to a review committee (of which there are five) to ensure that the criteria were met.[156] The purpose of reporting each case is to ensure that they conform to the criteria for "careful practice and due care criteria."[157] Further, it was importantly stated that the Act does not entail a legal right to euthanasia nor does it contain a limit on a patient's life expectancy.[158]

It was stated in reported cases, according to Berghmans and Widdershoven (2012), that there are difficult issues which physicians have to confront such as assessing unbearable suffering, responding to the patient's fears, establishing the wishes of the patient, improving communication with the patient and family, and when is the right moment for the performance of euthanasia.[159] Although all this may seem like much to take into consideration, one needs to keep in mind that this is what a practitioner must deal with in order to ensure that the act is performed correctly and patients are not merely taken advantage of. Furthermore, that the converse is also true because patients who may want to take their lives prematurely may take advantage of being assisted to die.

[156] *Ibid.*
[157] Berghmans and Widdershoven (note 31 above) 110.
[158] Kouwenhoven et al. (note 35 above) 274.
[159] Berghmans and Widdershoven (note 31 above) 116-117.

3.3 Belgium

Euthanasia was legalised in Belgium in 2002 shortly after the Netherlands had done so and was largely based on that legislation which Netherlands had enacted.[160] The Belgium Act was aimed to modify the behaviour of physicians as it was found that many were actively ending lives of patients without request.[161] Like the Netherlands, the act has to be carried out by a physician and the due care requirements must be followed.[162] In Belgium the death must be reported to the Federal Control and Evaluation Committee, unlike Netherlands where it must be reported to any one of the five available review committees.[163]

The Belgium Euthanasia Act differs from the Dutch Euthanasia Act in that it makes a distinction between those patients that are expected to die in the near future and those that are not expected to die in the near future. The Act adds two more requirements to those that are not expected to die in the near future; these being that the physician is to "consult two independent physicians instead of just one" and that there must be "at least one month between the patient's explicit request for euthanasia and the performance."[164] Further, according to Belgium law, palliative care must be provided before euthanasia.[165]

The aspect of consulting independent physicians is emphasised in many readings as it is rather important. The slightest influence, whether it be from the family or the patient themselves on a previous occasion, can impact on the final decision. The physicians must be impartial and "competent to judge the patient's condition."[166] It is advised that the physicians be objective and also, not opposed to euthanasia as this may have an obvious effect on the outcome.[167]

[160] Rurup et al. (note 35 above) 43.
[161] Schuklenk and Van Delden et al. (note 151 above) 57.
[162] Rurup et al. (note 35 above) 44.
[163] *Ibid*.
[164] *Ibid*.
[165] Guirimand et al. (note 30 above) 53.
[166] Van Wesemael et al. (note 35 above) 220.
[167] *Ibid*.

3.4 Mexico

Active euthanasia is not legalised in Mexico; however, it does allow for passive euthanasia since 2008 where a terminally-ill patient, or close relatives if unconscious, can refuse further medical treatment extending life.[168] It is no doubt that when referring to euthanasia there are many aspects involved such as ethical, legal, religious, social and psychological.[169]

"Doctors have to act with consent from the patient or the patient's family. The regulation stipulates that the patient will have the option of "voluntarily requesting the suspension of healing treatment and selecting integral care to control pain."[170]

Mexico has had, upon research, situations referred to as 'suicide tourism.' This is where people would come to Mexico seeking to terminate their own lives by administering a drug which is easily available at all pet stores in Mexico. This drug, called liquid pentobarbital, is used in order to put down pets.[171]

So far, even though passive euthanasia is allowed, there are strong views regarding active euthanasia, mainly moral and religious views. Like Netherlands, it is seen that Mexico is heading to legalised active euthanasia; however, it will not be very soon. Religious views claim that there is no right to death nor does anyone have the right to intervene for anyone's death.[172]

---

[168] Del Rio and Marvan (note 36 above) 152.
[169] *Idem* 146.
[170] Euthanasia Research and Guidance Organization 'World Laws on Assisted Suicide' available at http://www.finalexit.org/assisted_suicide_world_laws_page2.html, accessed on 14 August 2015.
[171] R Emott 'Euthanasia tourists snap up pet shop drug in Mexico' available on http://www.reuters.com/article/2008/06/03/us-mexico-euthanasia-idUSN0329945820080603?sp=true#xT0qYubqGMHtH3jB.97, accessed on 25 August 2015.
[172] C Bremer 'Euthanasia Stance Affirmed in Mexico' *The Washington Post* 9 July 2005 available at http://www.washingtonpost.com/wp-dyn/content/article/2005/07/08/AR2005070801730.html, accessed on 16 August 2015.

CHAPTER 4 – PATIENT AUTONOMY VS FAMILY WISHES VS MEDICAL PRACTITIONER'S DUTIES

Active euthanasia is not legalised in South Africa as yet, as South African law has to overcome certain issues that may arise from it. These issues are explained further in detail in this Chapter.

4.1 The Right to Patient Autonomy

The Constitution of the Republic of South Africa affords people of many rights, most importantly, those contained in the Bill of Rights, such as the right to equality, the right to human dignity, the right to life, the right to freedom and security of the person and the right to privacy.[173] There are also ethical principles which tend to shape the law, to say the least. These basic ethical principles are autonomy, beneficence, non-maleficence and justice. These principles assist with regards to ethical problems which one faces in medical practice and medical research.[174]

Autonomy basically means 'self-rule' and that everyone has a right to make decisions for themselves.[175] Autonomy provides for one to make decisions as to how they want to live their lives and control over one's body.[176] Everyone has their own view as to what is a dignified death; however, supporters of euthanasia state that not allowing one to end their life in a manner of which one may want is an attempt to impose a certain ethical or religious belief on a person.[177] It must be noted that autonomy is not unlimited, but weighed against other principles. It is also governed by customs, culture and laws in so that "no other person's rights and liberties are infringed or destroyed by another."[178]

Of course autonomy is rather prevalent when it comes to analysing cases. For example, where one may require a medical operation, a doctor is to explain the consequences, the procedure, the requirements, the risks and the benefits in order

[173] The Constitution of the Republic of South Africa, 1996.
[174] Moodley (note 63 above) 41.
[175] *Idem* 42.
[176] Herring (note 53 above) 501.
[177] *Ibid*.
[178] Egan (note 12 above) 49.

for that patient to provide informed consent. Only then, can such a procedure go further. This exercises the principle that everyone has that choice to accept or reject medical treatment and that they are not forced into putting their body through something which they do not wish.

Autonomy is seen to be at issue when dealing with active euthanasia in South Africa. This is so because the Constitution provides for the right to life, the right to privacy, the right to dignity; but does not allow one to request the right to die. At the end of the day, argument is that the law provides you with the material to say you can do what you please with your own body; however, when you are dying and terminally ill, you cannot ask to die. One can refuse medical treatment, but where treatment is of no help and the patient is suffering, is allowing the patient to slowly await their impending death an enforcement of these rights?

It is suggested that where a person is mentally capable and of sound mind, they should be allowed to voice their choice and in turn have their choice acted upon. There may be difficulty when referring to patients who are terminally ill as well as frail as sometimes these decisions are influenced by other factors. Therefore, although it is submitted that autonomy is to be respected; there is a need for certain patients to be consulted further as to what their true wishes are.

Being referred to as a frail care patient is where one is of such an age that they are elderly, fragile, physically weak and in need of nursing. Now, where the patient has these characteristics, it is no doubt that they are more vulnerable to being influenced into easily turning to the option of active euthanasia. This may be because of feeling undignified if they are to suffer, embarrassed if they cannot do every day human activities, or feeling like a burden upon others. Therefore, the right to die must be balanced against concerns that other patients who do not want to die will be pressurized into saying they do.[179]

It is suggested that frail care patients may turn to this as an easy option even though there could be a possibility of recovery. It is submitted, to counteract such issues, a

[179] Herring (note 53 above) 502.

terminal illness should be a requirement, unlike the Netherlands, as well as unbearable suffering. Further, it is suggested that the state of mind of patients opting for a request to die should be examined by a psychologist.

4.2 The Role of the Family in Decision Making

A decision requesting the right to die does not only affect the patient themselves, but the family members as well. It is clear that family would have a role to play with regards to passive euthanasia as consultation with the family members is important and the decision may rest upon them as a patient may be incapable of expressing their opinion (for example, due to unconsciousness).

A problem arises where the choice of the patient conflicts with the choice of the family of the patient. This, then, causes a dilemma which the medical practitioner is then faced with as they can encounter legal threats from that family. It was simply stated by McQuoid-Mason (1993) that where a patient is in a persistent vegetative state and has left a living will; where the family of that patient is opposed to cessation of treatment, the medical practitioner is then advised to follow through with the family's wishes.[180] However, where the medical treatment views that treatment as useless, he or she may approach the Supreme Court to appoint a curator to act in the best interests of the patient.[181]

Further, it is submitted that families may have an alternative motive wanting a patient dead, and this is sometimes very difficult to notice especially where a patient is not mentally capable. Family members may want a patient's life terminated sooner where there is a large estate waiting for them upon death, they do not want the unnecessary expense of further lengthy treatment, or they simply do not have the means or do not want the 'burden' of taking care of the patient (where a patient cannot do basic daily activities). Therefore, families may rush into opting for active euthanasia or even influence a patient into making that decision.

[180] McQuoid-Mason (note 14 above) 64.
[181] *Ibid*.

It is submitted that this can be counteracted by having easily available nurses to take care of the patient and possibly have a qualification necessary to view the relationship and concerns between the patient and family where the patient is capable of making their own decision. If this is a then too costly option, the assessment of the state of mind of the patient by a psychologist should at least take place in order to ensure that the patient is acting of their own free will. Where a patient is seen to be influenced in an extensively negative manner, an option of having the patient taken care of in a facility elsewhere should be made available by the law.

There are also scenarios where the family may not want the patient's request to die to be allowed for reasons such as emotional attachment, the patient being worth more alive than dead, or the insurance not paying out due to the cause of the death. McQuoid-Mason[182] states that where conditions of a living will are met, the physician should consult with the family as their consent is very important. Where he/she refrains from doing so, action may be taken by the family for the loss of support or have a criminal complaint lodged. In such cases, the method proposed by McQuoid-Mason above should suffice as a safe approach to such a situation. The medical practitioner can adhere to the family's wishes and if that is not in the best interests of the patient, they can approach the Supreme Court.

The role of the family in such decisions is discussed by Sutherland and Smith (1990),[183] and Cantor (1987);[184] however, the approach which must be taken will vary with different situations as well as would have changed over the years. There is one aspect which it is agreed upon – that being that a spouse or family member cannot overrule an informed decision to refuse treatment by the patient even where death will ensue.[185] This indicates the importance of one's right to autonomy.[186]

[182] McQuoid-Mason (note 14 above) 64.
[183] Sutherland and Smith (note 17 above) 59.
[184] Cantor (note 14 above) 2.
[185] Sutherland and Smith (note 17 above) 59.
[186] Boudreau and Somerville (note 8 above) 5. Egan (note 12 above) 48. Stoyles and Costreie (note 9 above) 678.

4.3 Duties of the Medical Practitioner

One can imagine the stress a medical practitioner can be faced with when handling a patient who requests to die. There are an exceptional amount of factors to be taken into consideration such as the medical practitioner's ethical and moral values, the legal convictions of the community at large, the best interests of the patient and the patient's autonomy. These factors play an important role as it ultimately results in whether a medical practitioner can lose a licence to practice or be held legally liable.

It is well known that each medical practitioner takes the Hippocratic Oath at the start of their career. Essentially, it is an oath taken by medical practitioners whereby they promise to be ethical and do their job the best way they can. A doctor's role is to heal a patient.[187] What comes into question is that where this role then conflicts with euthanasia as the doctor is now ending a life. Further, the World Medical Association "reaffirmed its strong belief that euthanasia conflicts with basic principles of good medical practice."[188]

It is accepted that no medical practitioner is or will be forced to perform an act of euthanasia on a patient. This is clear from the case of *Stransham-Ford v Minister of Justice and Correctional Services and Others*[189] where the Court held that the applicant will be allowed to be assisted with regards to the request to die, but no medical doctor will be obliged to accede to the request.[190] However, where one is willing to perform euthanasia, there is a worry about the message which the medical practice is sending as now, instead of healing, there is an option that a medical practitioner can end your life on request. This is also seen as a promotion of suicide to those who are opposed to the legalisation of euthanasia.

Section 6(1)(d) of the National Health Act[191] provides that patients must be informed of their right to refuse health services as well as the implications, risks and obligations of such refusal. It is trite law that a medical practitioner must seek

[187] Boudreau and Somerville (note 8 above) 8.
[188] Herring (note 53 above) 511.
[189] 2015 (4) SA 50 (GP).
[190] *Idem* 35.
[191] Act 61 of 1993.

informed consent before subjecting the patient to any investigations or treatment as this is both a legal and ethical requirement.[192] Therefore, it is submitted with regards to active euthanasia, nothing can actually take place without the patient's informed consent or rather their informed request for euthanasia. This means that they must know the risks, benefits, consequences and procedure to what they are requesting.

Even though the medical practitioner may act in accordance with the patient's wishes, an issue arises as to the legal implications on the medical practitioner. Currently, it is a crime to perform active euthanasia in South Africa. Therefore, a medical practitioner will be found guilty if he or she were to act on the patient's request to die. The correct procedure is for the patient to make an application to the Court as *Stransham-Ford*[193] had done and only if that order is granted, then can the medical practitioner be found free from any civil or criminal law implications.

It is suggested that a law regarding euthanasia can be made and further provide the necessary protection for medical practitioners. There is a worry of being sued in civil litigation by the family of the patient, and a huge risk of being found guilty for murder. Other implications include losing the right to practice as a medical field as well as the possibility of being punished by the Health Professions Council.

Passive euthanasia allows for the element of 'unlawfulness' to fall away and therefore does not hold a medical practitioner criminally liable. According to the legal convictions of society, it is found justifiable and not wrongful where there is no hope for recovery.[194] Therefore, with regards to active euthanasia, it is clear that the 'unlawfulness' element can also fall away as there is consent from the patient. Further, with the proper criteria created with a law, where a medical practitioner complies with such a criteria that is in accordance with that law, he or she can be protected whilst carrying out their duties and the patient's wishes.

[192] Moodley (note 63 above) 43.
[193] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP).
[194] McQuoid-Mason (note 26 above)102.

4.4 Best Interests of a Patient and Futile Treatment

The purpose of medical care is to ultimately act in the best interests of the patient. However, there is uncertainty as to what 'best interests' entail. Many writers argue that the best interests of the patient is for the medical practitioner to treat the patient to the best of their ability. Euthanasia, on the hand is not a method of treating the patient, but ending the suffering of the patient. It is argued that this can fall within the definition of 'best interests' of the patient.

It is submitted that the best interests of the patient is not always treating the patient. Referring back to chapter 2, in the discussion of the case of *Airedale NHS Trust v Bland [1993] 1 All ER 821,* 'intrusive life-support' seems rather pointless. There are resources that are being used to sustain the life of a terminally ill patient who is legitimately and voluntarily asking for the right to die. Further, if this treatment is not what the patient wants, how can we then say it is in their best interests? Where a patient is suffering and medication serves of no use but to keep the patient breathing or alive, how can it be explained to be in the best interests of the patient?

Although the main purpose of medical treatments is to treat the patient, it can together with the underlying illness also cause harm to the patient and their dignity in that they could become unresponsive, be submitted into a persistent vegetative state, lose functionality of their body. Therefore, to state that keeping the patient alive in those circumstances is in the best interests of that patient seems rather unreasonable, especially where a patient makes the informed decision that that is what they do not want.

An alternative to euthanasia is palliative care. Although this is an option, it is submitted that there are many flaws relating to palliative care. Firstly, palliative care is that which "emphasises pain relief and psychological and emotional support to assist in the last stages of life."[195] Basically, it is that care which is to keep the patient comfortable until their death. This is seen as an alternative to euthanasia as it is not

[195] Herring (note 53 above) 542.

a rushed thought to 'kill' a patient where there is no hope for recovery. However, there are problems that may arise such as the palliative care being of no help.

It is stated that palliative care is not a means just to focus on the patient's physical needs, but also emotional, spiritual and psychological needs.[196] It was further stated in Herring that the goal of palliative care is the achievement of the best quality of life for patients and families.[197] The problem arises with regards to where a patient does not want to be kept comfortable until they die. The request for death, especially in recent cases,[198] has shown that the purpose of it was to have control of how to die – to have a death with dignity. Some patients see the palliative care as being kept in a condition where someone has to still keep attending to them, where they lie on a bed, being fed pain medication resulting sometimes in unresponsiveness until that moment that they die.

It is then argued that the question of 'does palliative care really solve the problem?' is unanswered. Patients requesting the right to die are doing so in order to avoid the suffering and not having that good few last moments of life. Some may argue that we are not in control of our death and should not be, as well as who are we to play God? However, it is submitted that we live in an era where abortion in legalised. Therefore, why not euthanasia? Further, if we are not meant to be in control of anything regarding life and death, then how is it that we have hospitals that treat patients – should we not leave everyone on their own and let nature take its course? These are the questions that seem to arise where we do not apply our minds.

Further, palliative care is a great concept and alternative where treatment cannot completely heal a patient; however, its application may not be presented that way. There are controversial issues regarding the right to health and access thereof in South Africa. Many cannot afford the proper medical facilities. Therefore, the frail terminally ill patients who do not want to be a financial burden to others could 'suffer in the end.' This is stated because palliative care is not always going to be available for free, and even if it were, South Africa would not be able to afford it for too long.

---

[196] *Ibid*.
[197] *Ibid*.
[198] Specifically *Stransham-Ford* and Avron Moss.

Frail care centres are not seen as easily available and are referred to as 'expensive' and a 'last resort'.[199] Patients can even be forced into such centres when what they really want is a peaceful and dignified death. Simply put, palliative care may not have the best outcomes nor are they very cost effective.[200]

4.5 Futile Treatment and Unbearable Suffering

"There is no legal duty on doctors or health professionals to provide futile treatment to patients – even if requested by the patients, their representatives, relatives or persons close to them.[201] 'Futility' was discussed by Dhai and McQuoid-Mason[202] by referring to Have and Janssens[203] as a term which refers to 'useless', 'ineffective', 'vain', or 'serving no purpose.' Futility was then viewed in two schools of thought, or both; these being quantitative futility and qualitative futility.[204] Quantitative futility basically meant 'treatment is unlikely to work because it will have no or very minimal effect' and qualitative futility meaning 'a treatment that has an effect on the patient will not necessarily benefit the patient'.[205]

Patients with a terminal illness are not necessarily patients whose treatment is futile. This is important to realise especially when handling patients who are considering the request to die. Terminal illnesses can be treated; however, it is submitted that medical practitioners should explore various treatments available to patients before reaching the discussion of euthanasia. It is submitted that where treatment is futile, the patient is suffering from a terminal illness, and it is seen that euthanasia is their true choice, then should it be considered.

A terminal illness is not a requirement or listed as the criteria with regards to requesting the right to die in Netherlands as seen in Chapter 3. However, unbearable suffering needs to be existent in order to be allowed to request to die.[206] Unbearable

---

[199] 'Frail care 'last resort'' *The Post* October 7-11 2015 at 6.
[200] Herring (note 53 above) 544.
[201] DJ McQuoid-Mason 'Emergency Medical Treatment and 'Do not Resuscitate' Orders: When can they be used?' 2013 *Medicine and the Law SAMJ* 103(4) 224.
[202] Dhai and McQuoid-Mason (note 24 above) 127.
[203] Cited in Dhai and McQuoid-Mason (note 24 above) 127.
[204] Dhai and McQuoid-Mason (note 24 above) 127.
[205] *Idem* 127-128.
[206] Ruijs et al. (note 11 above) 13.

suffering was referred to as a 'subjective experience of suffering that is so serious and uncontrollable that it overwhelms one's bearing capacity.'[207]

It is agreed that suffering is not something that is known to everyone. It can be simply said that what is painful to one may not be to another – everyone has different pain thresholds. A strong man can find no pain in a needle; however, a little girl might scream in pain. It is argued that the state of suffering can be analysed as stated in Ruijs (2014)[208] as medical symptoms, loss of function, personal aspects, environment and nature and prognosis of disease. In this way, it is contended that it will take the examination of the medical practitioners, together with a psychologist to reach a true reflection of the suffering of the patient.

[207] *Ibid*.
[208] *Ibid*.

CHAPTER 5 – CONCLUSION AND RECOMMENDATION

5.1 The Right to Die

The right to life, the right to privacy, the right to human dignity – all accounted for in the Constitution of the Republic of South Africa. It is argued by some that the right to die is included in these rights, yet others argue that this right has no place in South African law and contradicts the abovementioned rights.

If life ends in death, the right to life should then include the right to die and how a person dies. Further, the right to privacy ensures that one has a right over their body and what they want to do with it. Lastly, the right to human dignity is that which pro-euthanasia patients rely on. It is seen that a dignified death would be one where the patient has control of. It is argued that the choice of how one dies, when one dies and who is around at that time of death that results in dignified death. Many patients do not want to be 'decomposing' slowly until death takes over their bodies. This is why many opt for applying for the right to die to be allowed in South Africa, such as Avron Moss and Stransham-Ford.

The law allows for the refusal of medical treatment by a patient (with regards to the National Health Act)[209]; however where a patient asks for a certain act to end their suffering, the law prohibits this. There are patients capable of consenting, yet are being refused active euthanasia. It is submitted that the law is contradicting itself to some extent and realisation of this by terminally ill patients has begun.

There are alternatives, such as palliative care; however, these are costly methods to the country, and further, where a patient is unhappy with palliative care, they would still prefer euthanasia. It is then the question of how do we refuse a patient a request which they are making voluntarily and as informed persons. There needs to be a proper and cost effective procedure with regards to palliative care and further, this is to be made available for all patients if South Africa seeks to continue refusing active euthanasia.

[209] Section 7 of the National Health Act 61 of 2003.

It is suggested that a proper statute is capable of being put in place in order to govern active euthanasia in South Africa. With the proposed Bill before Parliament, it is argued that this may not cover everything and could possibly lead to a 'slippery slope' reaction, especially when handling frail care terminally ill patients. With the correct criteria, it is possible that a statute can avoid certain consequences.

5.2 A Move Forward for South Africa

In many instances it boils down to an individual's preferences on how they want to die however, such individual choices would have to be tested against the Constitution. If South Africa can give women the choice to abort a pregnancy in 1996[210], it is submitted that the law can allow for terminally ill patients to have the right to die. The law changes to adapt and improve as time passes by as a method to ensure it is current with the interests of society. It is not doubted that South Africa will allow for the right to die eventually. However, how soon cannot be determined.

There will always be a 'slippery slope' argument. Allowing for euthanasia will then bring about issues such as frail care patients and the abuse and influence by others. Further, where a person is allowed a choice to die when terminally ill, how do we then determine the ages of which one is capable of making such a decision. Other issues may include the aspect of how much suffering would be regarded as unbearable. There are many questions arise, this is agreed upon. However, as any other statute, with strict consideration of these issues, it is possible for an appropriate law to be put into place.

The South African Constitution allows for the right to dignity, the right to life, the right to privacy, even the right to refuse medical treatment. However, neither the Constitution nor does any South African statute allow for the death of a person when one requests it. The patient, as described in the introduction, asks to die. There is no doubt that she is suffering from a terminal illness. There is no doubt that she is suffering. However, according to the law, we must keep treating her until she dies or is submitted into a persistent vegetative state. On the other hand, horses that have a

[210] The Choice of Termination of Pregnancy Act 92 of 1996.

broken leg are put down due to ending their suffering because it is the 'humane' thing to do. A person who is suffering, and able to tell you how they feel, is being refused to die due to them being a human. This sort of thinking seems rather contradictory, unsettling, and also, produces this image that diminishes human autonomy.

South Africa is beginning to see a rise in the requests for death by terminally ill patients and this is starting to achieve much media attention. With reference to Avron Moss[211] and *Stransham-Ford*[212], it is seen that a step forward is now being taken. Even though the judgment of the *Stransham-Ford* case was not applied, it is seen as hope for those in the same position to apply to achieve the death they want. The Courts will view each case by its own merits; however, it is strongly submitted that with the increase of these applications, a law governing such a right will soon be seen as necessary. The law adapts to the change in society, therefore, it is submitted that there is a change in society now whereby patients are making the informed decision to die. Not by shooting or hanging themselves, but in the peaceful and appropriate method.

5.3 Recommendations for a Law

South Africa needs a law in place; however, it is submitted that even if a law is approved of, there is a need for strict criteria in order to ensure that there is no abuse of such a law. This law is not intended for medical practitioners to go on a 'killing spree' where patients ask to die, but rather to appropriately allow for the right to die in a morally correct and respectful manner. This is to protect the vulnerable such as frail care patients as they seem to be most at risk if there was such a law.

There are certain criteria that should definitely be contained in the statute, for example, two independent medical practitioners should examine the illness of the patient; a psychologist should examine the mental state of the patient; all information regarding the patient's illness should be known to the patient; all alternatives to euthanasia should be known to the patient; the illness must be a terminal one; and

[211] Thamm (note 121 above) 2.
[212] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP).

there should be a state of unbearable suffering which is confirmed by the psychologist. This together with additional criteria in place, as well as the appropriate punishment for those not following the procedure should be listed in this statute.

With reference to the countries mentioned above in chapter 3, it is submitted that South Africa can adopt certain laws in order to allow for the right to die. Currently, South Africa has the same stance as Mexico in that it does not allow for the right to die, but allows for passive euthanasia. Netherlands and Belgium both have created legislation governing the right to die and that it should be allowed. Netherlands follows the criteria of 'due care' as mentioned in depth in chapter 3. This criteria is beneficial to South Africa as a means of adopting such criteria to allow for the right to die in such a way that is morally acceptable. Belgium also allows for certain requirements such as the number of medical practitioners that must see the patient before a right to die is granted. South Africa can benefit from such use of requirements by Belgium as a method of comparison and how to ensure that the procedure carried out for the right to die is acceptable with regards to an ethics point of view.

Further, it is submitted that a review procedure should also be created in South Africa, like that which exists in Belgium and Netherlands, in order to ensure that an overview of the procedure is being done. South Africa has begun experiencing many requests for the right to die and this is currently achieving media attention. It is submitted that like Netherlands, majority of South African society will begin to demand a law in place to govern euthanasia in order to avoid patients and medical practitioners taking their own actions.

Therefore, it is submitted that with the proper law in place and the criteria above, the vulnerability of frail care patients can be avoided and South Africa could successfully allow for active euthanasia like Netherlands and Belgium.

5.4 Conclusion

In conclusion, South Africa may not be ready for the ‘Right to Die’ just yet. There are many concerns that many will be unhappy about, and it is only once these concerns are addressed, can this law be properly governed. Terminally ill frail care patients are vulnerable and will be more at risk if active euthanasia is allowed; however, with the abovementioned recommendations, it can alleviate such risks.

It is further submitted that active euthanasia cannot be seen as a promotion of suicide, but a method to deter people from a violent suicide. Many have the gruesome thought to kill themselves by disturbing or violent methods; however, want a peaceful death. It only seems right to allow the right to a peaceful and dignified death.

People are suffering with terminal illnesses and are voluntarily asking to die. Human beings allow for animals to be put down as a sense of mercy; however, those very same human beings do not allow the same for their fellow suffering humans. It is about time that some action and some change are made in the law. It is not a method of promoting suicide or allowing people to kill, but a method to show mercy and allow people to have a dignified death. It is allowed for people to make their own choices regarding their own body and treatment; therefore, it only makes sense that people should be allowed to make a choice regarding their death in a sensible manner.

Therefore, with the strict criteria, proper control and overview, active euthanasia can be allowed in South Africa. It is then in the medical practitioners hands to take the proper precautions when assisting such patients. In this way, South Africans can have the right to die a dignified death and leave the suffering behind, a way to say goodbye to loved ones in a manner they chose and slip away in a peaceful manner.

BIBLIOGRAPHY

BOOKS

Ackermann, L *Human Dignity: Lodestar for Equality in South Africa* Cape Town: Juta and Co, (2012).

Biggs, H *Euthanasia Death with Dignity and the Law* Portland Oregon: Hart Publishing (2001).

Brazier, M and Cave, *E Medicine, Patients and the Law Fourth Edition* England: Penguin Books (2007).

Burchell, J *Principles of Criminal Law* 3rd Edition Juta (2006).

Cantor, NL *Legal Frontiers of Death and Dying* Medical Ethics Series Indianna University Press (1987).

Dada, MA and McQuoid-Mason, DJ (eds) *Introduction to Medico-legal Practice* Durban: Butterworths (2001).

Dhai, A and McQuoid-Mason, DJ *Ethics, Human Rights and Health Law* Claremont: Juta and Co Ltd. (2011).

Govindjee, A and Vrancken, P, *Introduction to Human Rights Law* Durban: Lexis Nexis (2009).

Harper, RS *Medical Treatment and the Law – The Protection of Adults and Minors in the Family Division* London: Family Law (1999).

Herring, J *Medical Law and Ethics* 3rd Edition Oxford University Press (2009).

Moodley, K (ed) *Medical Ethics, Law and Human Rights: a South African Perspective* Van Schaik Press (2011).

Nedwick, C *Who Should We Treat?* New York: Oxford University Press (1996).

Wood, A *Kant's Formulation of the Moral Law* in Bird, G (ed) *A Companion to Kant* (2006) Australia: Blackwell Publishing 2006.

Sutherland, E and Smith, AM *Family Rights Family Law and Medical Advance* Edinburgh University Press (1990).

JOURNALS

Alvarez Del Rio, A and Luisa Marvan, MA 'On Euthanasia: Exploring Psychological Meaning and Attitudes in a Sample of Mexican Physicians and Medical Students' (2011) 11(3) *Developing World Bioethics* 146-153.

Berghmans, RLP and Widdershoven, GAM 'Euthanasia in the Netherlands: Consultation and Review' (2012) 23 *King's Law Journal* 109-120.

Boudreau, JD and Somerville, MA 'Euthanasia and Assisted Suicide: A Physician's and Ethicist's Perspectives' (2014) 4 *Medicolegal and Bioethics* 1-12.

Cohen, J, Van Wesemael, Y et al. 'Nationwide Survey to Evaluate the Decision-making Process in Euthanasia Requests in Belgium: Do Specifically Trained 2nd Physicians Improve Quality for Consultation?' (2014) 14 *BioMed Central* 307 available at http://www.biomedcentral.com/1472-6963/14/307, accessed on 18 April 2015.

Egan, A 'Should the State Support the 'Right to Die'?' (2008) 1(2) *South African Journal of Bioethics and Law* 47-52.

Guirimand, F, Dubois, E, et al. 'Death Wishes and Explicit Requests for Euthanasia in a Palliative Care Hospital: An Analysis of Patients Files' (2014) 13 *BioMed Central Palliative Care* available at

http://web.b.ebscohost.com.ezproxy.ukzn.ac.za:2048/ehost/pdfviewer/pdfviewer?sid=85f3a292-c6f0-4fa3-b3b5-6c073bd7ef93%40sessionmgr114&vid=1&hid=109, accessed on 28 February 2015.

Farham, B 'Editors Comment: End-of-life practices in the Netherlands' 2012 *Continuing Medical Education* 30 (8) 271.

Kouwenhoven, PSC, Rajmakers, NJH et al. 'Opinions of Health Care Professionals and the Public After Eight Years of Euthanasia Legislation in the Netherlands: A Mixed Methods Approach' (2012) 27(3) *Palliative Medicine* 273-280.

Krause, S 'Going Gently into That Good Night: The Constitutionality of Consent in Cases of Euthanasia' (2012) *Obiter* 56-59.

Lewis, P 'The Empirical Slippery Slope from Voluntary to Non-Voluntary Euthanasia' (2007) *Journal of Law, Medicine and Ethics* 197-210 available at http://onlinelibrary.wiley.com.ezproxy.ukzn.ac.za:2048/doi/10.1111/j.1748-720X.2007.00124.x/abstrac, accessed on 8 February 2015.

McQuoid-Mason, DJ 'Advance Directives and the National Health Act' (2006) 96(12) *South African Medical Journal* 1236- 1238.

McQuoid-Mason, DJ 'Emergency Medical Treatment and 'Do not Resuscitate' Orders: When can they be used?' 2013 *Medicine and the Law South African Medical Journal* 103(4) 223-225.

McQuoid-Mason, DJ 'Recent Developments Concerning Euthanasia in South Africa' (1995) 1 *Law and Medicine* 7-23.

McQuoid-Mason, DJ 'Pacemakers and 'living wills': Does turning down a pacemaker to allow death with dignity constitute murder?' (2005) 1 *South African Computer Journal* 25.

McQuoid-Mason, DJ 'The Legal Aspects of the 'Living Will'' (1993) 11 *Continuing Medical Education* 59-64.

McQuoid-Mason, DJ 'Withholding or Withdrawing Treatment and Palliative Treatment Hastening Death: The Real Reason Why Doctors Are Not Held Legally Liable for Murder (2014) 104(2) *South African Medical Journal* 102-103.

Ogunbanjo, GA and Knapp van Bogaert, D 'Is There a Place for Voluntary Active Euthanasia in Modern-day Medicine?' (2013) 55(1) *South African Family Practice* S10.

Ruijs, CDM, Van Der Wal, G et al. 'Unbearable Suffering and Requests for Euthanasia Prospectively Studied in End-of-life Cancer Patients in Primary Care' (2014) 13 *BioMed Central Palliative Care* available at http://web.b.ebscohost.com.ezproxy.ukzn.ac.za:2048/ehost/pdfviewer/pdfviewer?sid=21a7612c-a06b-4532-a72d-dd51f4994e85%40sessionmgr114&vid=1&hid=109, accessed on 8 February 2015.

Rurup, ML et al. 'The First Five Years of Euthanasia Legislation in Belgium and the Netherlands: Description and Comparison of Cases' (2011) 26(1) *Palliative Medicine* 43-49.

U Schuklenk, JMJ Van Delden et al. *End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making* (2011) 25 *Bioethics* 55..

Slabbert, M and Van Der Westhuizen, C 'Death with Dignity in Lieu of Euthanasia' (2007) 22 *SAPR/PL* 366-384 available at http://search.sabinet.co.za.ezproxy.ukzn.ac.za:2048/WebZ/FETCH?sessionid=01-59020-527979001&recno=24&resultset=1&format=F&next=/html/t2/fullisap.html&bad=html/t2/error/badfetch.html&&entitytoprecno=24&entitycurrecno=24, accessed on 8 February 2015.

Stoyles, BJ and Costreie, S 'Rethinking Voluntary Euthanasia' (2013) 38 *Journal of Medicine and Philosophy* 674-695 available at

http://web.b.ebscohost.com.ezproxy.ukzn.ac.za:2048/ehost/pdfviewer/pdfviewer?sid=da635f66-bde3-40d2-bc88-b8d364cf1514%40sessionmgr198&vid=1&hid=109, accessed on 8 February 2015.

Van Wesemael, Y et al. 'Establishing Specialized Health Services for Professional Consultation in Euthanasia: Experiences in the Netherlands and Belgium' (2009) 9 *BioMed Central* 220 available at http://www.biomedcentral.com/1472-6963/9/220, accessed on 18 April 2015.

TABLE OF CASES

Barkhuizen v Napier 2007 (7) BCLR 691 (CC).

Clarke v Hurst NO and Others 1992 (4) SA 630 (D) A.

S v Agliotti 2011 (2) SACR 437 (GSJ).

S v Dodo 2001 (5) BCLR 423 (CC).

S v Gordon 1962 (4) SA 727 (N).

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

Prinsloo v Van der Linde and Another 1997 (6) BCLR 759 (CC).

R v Nbakwa 1956 (2) SA 557 (SR).

Rex v Peverette 1940 AD 213.

S v Makwanyane and Another 1996 (6) BCLR 665 (CC).

S v Marengo 1991 (2) SACR 43 (W).

S v Smorenburg 1992 (2) SACR 389 (C).

Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 50 (GP).

Thomas and Another v Minister of Home Affairs and Others 2000 (8) BCLR 837 (CC).

LEGISLATION

Belgium Euthanasia Act 2002

Criminal Procedure Act 51 of 1977

The Constitution of the Republic of South Africa, 1996

The National Health Act 61 of 2003

The Termination of Life on Request and Assisted Suicide Act, Netherlands 2002

The Choice of Termination of Pregnancy Act 92 of 1996

Wills Act 7 of 1953

WEBSITES AND WEB REFERENCES

Bremer, C 'Euthanasia Stance Affirmed in Mexico' *The Washington Post* 9 July 2005 available at http://www.washingtonpost.com/wp-dyn/content/article/2005/07/08/AR2005070801730.html, accessed on 16 August 2015.

DignitySA 'Dignity South Africa's Patrons' available at http://www.dignitysa.org/blog/dignitysas-patrons/, accessed on 1 September 2015.

Emott, R 'Euthanasia tourists snap up pet shop drug in Mexico' available on http://www.reuters.com/article/2008/06/03/us-mexico-euthanasia-idUSN0329945820080603?sp=true#xT0qYubqGMHtH3jB.97, accessed on 25 August 2015.

Euthanasia Research and Guidance Organization 'World Laws on Assisted Suicide' available at http://www.finalexit.org/assisted_suicide_world_laws_page2.html, accessed on 14 August 2015.

Oxford University City Press 'Dignity' available at http://www.oxforddictionaries.com/definition/english/dignity accessed on 6 April 2015.

Oxford University City Press 'Euthanasia' available at http://www.oxforddictionaries.com/definition/english/euthanasia accessed on 6 April 2015.

Oxford University City Press 'Frail' http://www.oxforddictionaries.com/definition/english/frail accessed 8 April 2015.

Oxford University City Press 'Suicide' http://www.oxforddictionaries.com/definition/english/suicide accessed 8 April 2015.

NEWSPAPER ARTICLES

Thamm, M 'Assisted Dying: Avron Moss – Another Casualty of Legal Uncertainty' *The Daily Maverick* 10 March 2015 at 2.

'Frail care 'last resort'' *The Post* October 7-11 2015 at 6.

REPORTS

‘*Report on Euthanasia and the Artificial Preservation of Life: South African Law Commission*, Report, Project 86’