



UNIVERSITY OF TM
KWAZULU-NATAL
—
INYUVESI
YAKWAZULU-NATALI

**PAEDIATRIC EUTHANASIA: DO
TERMINALLY ILL MATURE MINORS
HAVE THE RIGHT TO DIE?**

BY

SIMONE JACQUELINE GRAY

212515438

SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE
AWARD OF MASTER OF LAW, COLLEGE OF LAW AND
MANAGEMENT STUDIES, UNIVERSITY OF KWAZULU- NATAL,
PIETERMARITZBURG

SUPERVISOR: SUHAYFA BHAMJEE

DECEMBER 2016

DECLARATION

This dissertation was undertaken in the School of Law, College of Law and Management Studies University of KwaZulu-Natal, Pietermaritzburg under the supervision of Ms Suhayfa Bhamjee. This is an original work by the author and has not been submitted in any form for any other degree or diploma to any other university. Where the work of others has been used, it has been duly acknowledged.

Signature _____

DEDICATION

This dissertation is dedicated to my late grandfather and my biggest cheerleader, Dr Hugh Wallace. Pa, your guidance, support, advice and encouragement throughout my life has been indispensable. I am so privileged to have had such a strong, intelligent and loving grandfather and although I am devastated by your passing, I am glad that you are finally at peace. I hope that you are proud of the woman I have become.

ACKNOWLEDGEMENTS

Thank you to my supervisor, Suhayfa Bhamjee, for her guidance and encouragement throughout the year and for having such a great sense of humour.

I express my sincere gratitude as well to my family for their on-going support. Thank you especially to my mother for her endless support and love, without which I might have given up a long time ago.

Thank you also to my wonderful Christopher for your endless supply of encouragement and silly jokes. My studies thus far were also made so much easier and enjoyable with friends who not only understand 'the struggle' but who also make life so much better by sharing a laugh. To my law class friends – Thank you for sharing this journey with me.

To Robynne at the Postgraduate centre thank you for your efficiency, for making the whole postgrad process run so smoothly and for always being willing to have a chat. I am also indebted to Dr Goodier for her excellent workshops and notes that really helped make writing this dissertation less daunting.

I further acknowledge the University of KwaZulu-Natal for making my undergraduate studies financially possible and to all the lecturers at the School of Law in Pietermaritzburg who indeed 'inspired greatness' and encouraged me to pursue postgraduate study. In addition, I am also grateful for the generous financial assistance from the ML Kisch Scholarship which has made my postgraduate study financially viable.

ABSTRACT

Euthanasia is a highly controversial and topical issue in South Africa at the moment. Following recent developments in common law, the need for euthanasia legislation in South Africa needs to be considered and further whether such legislation should allow for a mature minor to request euthanasia provided they are considered sufficiently mature to make such a decision. The purpose of this dissertation is to show the need for implementation of euthanasia legislation which would also permit terminally ill mature minors to request euthanasia.

This research will involve a rights-based analysis in order to show that a terminally ill mature minor can successfully rely on his or her Constitutional rights to dignity, bodily integrity, privacy, equality, healthcare and freedom to request active euthanasia. There is a duty on the state to protect and promote the rights of terminally ill minors and it can be shown that it does such a minor more harm than good to force him or her to suffer unbearable pain until their natural death occurs.

Having shown that minors can rely on the rights above, this dissertation will conduct an investigation of a child's right to autonomy and bodily integrity in order to show that to limit a child's right to make decisions about his or her own body is an overextension of legal paternalism. In all matters concerning a child, the child's best interests are always of paramount importance. The purpose of this research is to show that it cannot be in the child's best interests to force a terminally ill child to continue to suffer until their natural death despite the child requesting otherwise.

In the discussion of paediatric euthanasia, the concept of competence to make a decision will also be considered. It is essential that should a child be permitted to request euthanasia, that child must be sufficiently competent and mature to make the decision to die. Methods of assessing competency and maturity will be analysed in addition to existing legislation, such as the Children's Act,¹ which specifically provides instances in which a child can make a decision regarding their own body, showing an acknowledgement by the legislature of the need to promote and protect a child's right to autonomy.

The final section of this dissertation considers the foreign jurisdictions of Belgium and the Netherlands in order to critically assess how euthanasia legislation can be implemented with the inclusion of children. These are the only two jurisdictions worldwide which allow for a child to request euthanasia. The South African Law Commission's report on euthanasia is also considered to contemplate the need for safeguards in respect of euthanasia that will ensure minimal abuse.² The

¹ Children's Act 38 of 2005.

² South African Law Commission Issue Project 86 *Euthanasia and the Artificial Preservation of Life* (1998).

research is concluded by suggesting safeguards for implementation in legislation which permits terminally ill adults and mature minors to request euthanasia.

TABLE OF CONTENTS

DECLARATION	ii
DEDICATION	iii
ACKNOWLEDGEMENTS	iv
ABSTRACT.....	v
CHAPTER ONE: INTRODUCTION.....	1
1.1 Introduction and background of the research problem	1
1.2 Outline of the topic	3
1.3 Definitions.....	6
1.3.1 Euthanasia	6
1.3.2 Physician assisted suicide	6
1.4 Limitations of the research.....	7
1.5 Research goals	7
1.6 Research methodology	8
1.7 Structure of the dissertation	9
CHAPTER TWO: EUTHANASIA AS A CRIME AND COMMON LAW DEVELOPMENTS	11
2.1 Introduction.....	11
2.2 Active and Passive euthanasia	11
2.3 Ethical perspective on active euthanasia.....	14
2.4. Assisted suicide and euthanasia	15
2.5 Considering the elements of the crime of murder in respect of euthanasia and assisted suicide 16	
2.5.1 Intention	16
2.5.2 Causation.....	18
2.5.3 Consent as a defence for unlawfulness	19
2.6. A history of assisted suicide and euthanasia at common law level.....	24
2.6.1 Assisted suicide.....	24
2.6.1.1 <i>R v Peverett 1940 AD 213</i>	25
2.6.1.2 <i>R v Nbakwa 1956 2 SA 557 (SR)</i>	25
2.6.1.3 <i>S v Gordon 1962 (4) SA 727 (N)</i>	27
2.6.1.4 <i>Ex Parte Die Minister van Justisie: In re S v Grotjohn (1970) 2 All SA 491 (A)</i>	28
2.6.1.5 <i>S v Hibbert (1979) 2 All SA 323 (D)</i>	28

2.6.2	Voluntary active euthanasia	29
2.6.2.1	<i>R v Dawidow WLD 155 (unreported)</i>	29
2.6.2.2	<i>S v De Bellocq (1975) 1 All SA 6 (T)</i>	30
2.6.2.3	<i>S v Hartmann 3 1975 All SA 87 (C)</i>	30
2.6.2.4	<i>S v Marengo (1991) 3 All SA 784 (W)</i>	31
2.6.2.5	<i>S v Smorenburg 1992 (2) SACR 389 (C)</i>	32
2.6.2.6	<i>Clarke v Hurst NO and Others 1992 (4) SA 630 (D)</i>	33
2.6.2.7	<i>Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 50 (GP)</i>	35
2.7	Conclusion	36
CHAPTER THREE: APPLICATION OF BIOETHICAL PRINCIPLES AND HUMAN RIGHTS ...		38
3.1	Introduction.....	38
3.2	Bioethical principles protecting human rights	38
3.2.1	Patient autonomy.....	39
3.2.2	Beneficence.....	39
3.2.3	Non-Maleficence.....	40
3.2.4	Justice and fairness.....	41
3.3	Children’s rights.....	41
3.4	International legal framework protecting children’s rights.....	44
3.5	Analysis of rights	45
3.5.1	Dignity	46
3.5.2	The right to life	49
3.5.3	The right to bodily integrity	52
3.5.4	The right to privacy.....	54
3.5.5	The right to equality	55
3.5.6	The right to healthcare	57
3.6	Conclusion	61
CHAPTER FOUR: CHILD AUTONOMY		62
4.1.	Introduction.....	62
4.2.	Legislation.....	62
4.2.1.	Children’s Act.....	62
4.2.2.	Choice on Termination of Pregnancy Act.....	67
4.3.	Child autonomy	68
4.4.	Determining competence	72

4.5. Best interests of the child principle.....	75
4.6. Conclusion	79
CHAPTER FIVE: FOREIGN LEGISLATION AND THE SOUTH AFRICAN PROPOSAL	80
5.1 Introduction.....	80
5.2 Belgium.....	80
5.2.1 Legislative safeguards.....	81
5.2.2 Criticisms and counter-arguments.....	84
5.3 Netherlands	89
5.3.1 Dutch legislative safeguards	90
5.4 Proposed South African legislation.....	91
5.5 Conclusion	95
CHAPTER SIX: RECOMMENDATIONS AND CONCLUSION	97
6.1 Summary of research	97
6.2 Recommendations.....	99
6.2.1 Introduction.....	99
6.2.2 Safeguards.....	100
6.3 Final remarks	104
7. BIBLIOGRAPHY	106

CHAPTER ONE: INTRODUCTION

1.1 Introduction and background of the research problem

Consider the following analogy. Olly is suffering from leukaemia and is in his final stages of life. The doctor tells him that he only has six months to live but Olly wishes his death would come sooner. He is suffering from unbearable pain every day and he can do nothing for himself without the help of his carer. He requires help to go to the toilet, bath, dress and eat and most days he is so weak that he cannot even get out of bed. The doctor keeps giving him medication to help with the pain but he is still suffering immeasurably. He has heard stories of people in similar positions who, towards the end of their lives, are so highly medicated that they cannot even recognise their family or loved ones and may slip away without even having the chance to properly say goodbye. Olly knows that he is not going to get any better. He is tired of waking up every day in pain with no hope of it abating and he wishes to end the life he now considers to be completely worthless and undignified. Olly is 17 years and 7 months old but is mature beyond his years. He is fully competent to refuse treatment yet he is unable to request active euthanasia. Olly has considered committing suicide on a number of occasions but firstly, he cannot acquire the means to commit suicide and secondly, he does not wish his family to find his corpse after he has committed suicide in a horrific manner.

If Olly is South African, he is unable to request active euthanasia where a doctor would act to bring about his death, for instance by means of a lethal injection, and must be forced to suffer until his natural death. It may, however, be possible for him to refuse any medical treatment although this is not explicitly stated in the Children's Act.¹ The Act merely provides that when a child is over the age of 12 and is sufficiently mature to understand the 'benefits, risks, social and other implications of treatment' then such a child can consent to treatment.² Despite there being no explicit provision for refusal of treatment, it could possibly be argued that such a child can also refuse treatment even if the decision would result in death. However, this refusal is likely to be challenged and result in extended litigation, none of which Olly wants to have to face. If the legislation does allow for him to refuse medical treatment, this only means that he will still have to suffer until death, only perhaps the suffering will be shorter than waiting for natural death to occur.

If Olly lived in Oregon, he would only be permitted to request physician assisted suicide, which would involve the acquisition of lethal medication which he would take to bring about death, if he

¹ Children's Act 38 of 2005.

² Children's Act supra, s 129(2).

was 18 years old.³ Olly would have to suffer until he reaches the age of 18 at which point he would be able to end his own life in a dignified manner. Olly will not have matured vastly in 5 months time, at least not to the extent that he now is competent to make the decision to die where before the age of 18 he was not. He will not magically attain competency at the stroke of midnight on his 18th birthday – If he is incompetent now, he will be incompetent then and vice versa. Olly fully understands the consequences of his request for death and he is as competent as an adult to make such a decision.

If Olly is Belgian or Dutch he would be able to make use of the euthanasia law in his country. In such an instance he would be able to request death and, provided he is considered to be competent and mature to make the decision as assessed by professionals, he would be able to die with dignity. He would be able to say goodbye to his family properly before death. He would be able to have autonomy over his body and choose the moment of his death. If he were Belgian or Dutch, the law would respect that Olly, despite his age, also has the right to die if he understands the implications thereof. Olly's rights would be respected and he would die a peaceful death instead of being forced to suffer until death.

Unfortunately for Olly, he is South African. Olly has no option but to continue to suffer immeasurable pain until his natural death occurs. He has begged his doctor a number of times to end his life but his oncologist knows that if he helps Olly to die, he might be criminally prosecuted and he cannot afford to take the risk. Olly will continue to live what he considers to be a meaningless life. He will continue to suffer unbearable pain every day. He will live without dignity, he will die without dignity.

The right to dignity is a cornerstone of our democracy and the Constitution is founded on the values of human dignity, equality and the advancement of human rights and freedoms.⁴ Fundamental to a person's right to dignity and to freedom is to be able to make choices about one's own body. This dissertation looks at whether the rights of terminally ill patients are unjustifiably infringed by prohibiting voluntary active euthanasia. If the right to die is constitutionally guaranteed, it must further be decided whether this right extends to terminally ill children as well. The aim of this dissertation is to show that if a child, like Olly, is suffering from a terminal illness and is sufficiently mature to make the decision to die, which is something that must be assessed in line with legislative safeguards, then such a mature minor should be given the right to make use of euthanasia.

This research is particularly necessary in light of recent common law developments in the field. In the 2015 case of *Stransham-Ford*,⁵ it was held that Mr Stransham-Ford who was suffering from stage 4 terminal cancer was permitted to acquire the assistance of a physician to end his life and the physician

³ Oregon Death With Dignity Act 1997.

⁴ s 1, Constitution of the Republic of South Africa.

⁵ *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 4 (GP)*.

would not be criminally prosecuted for helping. The applicant relied on his constitutional rights to dignity, freedom, bodily integrity and privacy and ultimately argued that he had a right to die and end his unbearable suffering. Following the abovementioned case which, at the time of writing, is being appealed in the Supreme Court of Appeal, the discussion on euthanasia has been re-opened. In 1998, the South African Law Commission published a report entitled '*Euthanasia and the Artificial Preservation of Life*'⁶ which included draft legislation that was never implemented. Following the court's decision in *Stransham-Ford*, it is necessary to reconsider if legislation should be promulgated in this regard and if so, what the legislation should include.

Of specific importance is consideration of whether children should be permitted to request death and make use of euthanasia. This dissertation will discuss whether a terminally ill child would be able to successfully rely on the rights afforded to them in terms of the Constitution, as was done by the applicant in the *Stransham-Ford* case⁷ or whether a minor would be prohibited from making use of the practice based on their age. This will require a discussion of a child's right to autonomy and methods of assessing competence. It will be argued that provided a terminally ill child is assessed and declared to be competent and mature to make the decision to die, such a child should be permitted to make use of euthanasia. As in any matter concerning a child, the best interests of the child will also be considered in respect of the decision to die with the aim being to show that it is not in the child's best interests to force him or her to continue to suffer unbearable pain if they have requested death and are sufficiently competent to make such a decision.⁸

In addition to considering the need for euthanasia legislation, this dissertation will also attempt, with the help of foreign law analysis, to contemplate what safeguards should be included in legislation in order to ensure minimal abuse. This discussion is especially important in respect of terminally ill children, should they be included in legislation as recommended.

1.2 Outline of the topic

Euthanasia is defined as the practice of 'bringing about death in a manner that causes the least amount of suffering to the patient.'⁹ Many patients who are diagnosed as terminally ill frequently spend their last few months in unbearable pain and on a regime of pain medication which often makes them

⁶ South African Law Commission Issue Project 86 *Euthanasia and the Artificial Preservation of Life* (1998).

⁷ *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 4 (GP).

⁸ S 28(2) of the Constitution of the Republic of South Africa, 1996 provides that in all matters affecting a child, the best interests of the child are always of paramount importance.

⁹ M Stauch et al *Text, Cases & Materials on Medical Law* 3 ed (2005) 627.

unaware of their surroundings or the presence of their loved ones. In such an instance, the question arises, should terminally ill patients be permitted to end their life with the assistance of a medical practitioner in order to terminate their suffering? This dissertation will extend the question further to children and will question whether, or in what circumstances, a child would be able to request euthanasia. The Constitution is founded on the values of human dignity and the advancement of human rights and freedoms.¹⁰ In light of this, it is necessary to consider whether legislation is necessary in regard to euthanasia in order to give effect to the rights enshrined in the Constitution.

There are currently only two jurisdictions that allow terminally ill children to request euthanasia although there are a number of other jurisdictions which allow for adults to request euthanasia or to acquire assistance to die.¹¹ In Belgium there is no age limit in terms of the legislation and in the Netherlands, a child must be over the age of 12 to be able to request euthanasia. This dissertation looks specifically at children's rights in relation to euthanasia and whether the current South African law pertaining to children would allow for children to request euthanasia and further, what legislation, if any at all, should be promulgated in order to allow for children to make end-of-life decisions and/or to provide safeguards in respect of the practice.

Death is a certainty for everyone and many people fear that they will suffer at the end of their life. Terminally ill patients can obtain palliative care but such care can only go so far in easing suffering. In South Africa, many poor people are unable to access palliative care at all. Furthermore, health care institutions are very often under resourced which means that resources are more readily allocated to those patients who are not terminally ill. In many instances this means that a patient suffering from a terminal illness is not even afforded the opportunity of going on a pain management regime and suffers incredibly until his or her natural death. In such an instance, it is submitted that a patient should be given the opportunity to request euthanasia instead of being forced to suffer until death and the need for legislation in this regard needs to be considered. Euthanasia has historically been a controversial issue because of the moral implications associated with consenting to one's own death and religious arguments against it. In respect of children, the issue becomes even more complex and controversial.

However, it is ultimately the duty of the courts and indeed the Legislature when legislating, to uphold and protect the rights enshrined in the Constitution. It is argued that the prohibition on voluntary active euthanasia is a violation of a patient's right to dignity (s 10) and their right to freedom and security of the person (s12), specifically s 12(1)(e): the right not to be treated or punished in a cruel,

¹⁰ S 1: Constitution of the Republic of South Africa, 1996.

¹¹ Jurisdictions that have legislation allowing for voluntary active euthanasia include Switzerland, Luxemburg, Oregon, Washington and Vermont among others. In these jurisdictions, however, a person must legally be an adult in order to request death.

inhuman or degrading way and s 12(2)(b): the right to security in and control over their body. Perhaps most importantly, the Constitution promotes the right to freedom of choice. Just as in life everyone has freedom of choice, so should everyone have the right to make their own end of life choices. It appears anomalous that people have the right to refuse medical treatment, the result of which is death, yet common law does not allow voluntary active euthanasia.

To allow children to consent to their own death is very controversial and requires further consideration. However, our Constitution provides for equality before the law (s 9) and that nobody can be discriminated against on any of the listed grounds. If our Constitution would allow for adults to request euthanasia, then would this extend to children as well? Would it constitute a violation of children's right to autonomy if only adults were allowed the right to make end of life decisions? This involves a delicate balancing act between the need to protect children, being vulnerable groups, with their rights as human beings. The discussion on paediatric euthanasia may be an uncomfortable one to have but it is one which needs consideration in light of recent common law development in the field.¹²

One of the main arguments in favour of prohibiting euthanasia is that palliative care can go sufficiently far in relieving pain and suffering. However, palliative care is unable to relieve all pain and suffering and overlooks a patient's loss of dignity and independence. This topic is of significant importance in a South African context because of the lack of palliative care available to people in the country and also the high rate of poverty. Many South Africans cannot afford palliative care and lack of health care resources mean that state institutions have to allocate resources selectively. A patient who is suffering from a terminal illness is less likely to receive care over a patient who has a prospect of survival.¹³

Children have the right to self determination and autonomy and this dissertation will look at whether it is justifiable to limit the fundamental right to autonomy in respect of children making end of life decisions. S 129 of the Children's Act provides that a child may consent to medical treatment if he/she is over the age of 12 and has sufficient maturity and mental capacity to understand the benefits, risks and social implications of it. Such a child may also consent to a medical operation if duly assisted by his/her parent or guardian. This means that such a child could theoretically also refuse medical treatment. It can be argued that after assessing a child's maturity and ascertaining that the child can understand the consequences of their choice sufficiently, such a child who is suffering from a terminal illness should be given the option of euthanasia. A girl child of any age is permitted to

¹² See the case of *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 4 (GP)*.

¹³ See *Soobramoney v Minister of Health, KwaZulu-Natal 1998 (1) SA 765 (CC)* where the court held that the state's obligations to provide health care are only to the extent that they have available resources. It is necessary to allocate resources wisely.

request an abortion in terms of the Choice on Termination of Pregnancy Act. It therefore seems that in respect of issues pertaining to a child's bodily integrity, the law allows for a child to exercise their autonomy and make their own decisions. Why should it be any different in respect of the choice to die? Failing to acknowledge a minor's autonomy in the circumstances of a terminal illness does more harm than good to that minor. Instead of protecting the minor, it is condemning a child to a life of unbearable pain and suffering which they have no choice but to endure.

1.3 Definitions

1.3.1 Euthanasia

Euthanasia is a term that encompasses different forms of aid in dying. Active euthanasia is a "positive act which is intended to kill" whereas passive euthanasia is "an omission to act which, equally intentionally, allows the patient's death to occur."¹⁴ Ethically speaking, it is argued that as both forms of euthanasia have the same outcome, they are no different morally. Passive euthanasia is often carried out, where for instance, a patient is in a vegetative state and the machines keeping that patient alive are switched off. This is not an unlawful act as it is argued that it is the disease which is the cause of death in such an instance rather than the act of the machines being switched off. However, giving a terminally ill patient lethal medication that will result in their death is an unlawful act on the part of the doctor as this is active euthanasia. Even if the patient asks to die and the doctor is merely carrying out the patient's request, this is still an unlawful act. This dissertation considers voluntary active euthanasia which is an act of the doctor which brings about a patient's death, at the request of the patient.

1.3.2 Physician assisted suicide

This is a form of aid in dying where a doctor administers or supplies a patient with lethal medication that will bring about the patient's death.¹⁵ It makes no difference whether the doctor prescribes lethal medication for the patient knowing that the patient will ingest the medication which will result in death or whether the doctor administers the lethal medication to the patient himself, the legal consequences are the same.¹⁶ In both instances, the physician will be criminally liable for bringing about the death of the patient. This will be considered in further detail in the following chapter.

¹⁴ J Rachels, J 'Active and Passive Euthanasia' (1975) 292(2) *New England Journal of Medicine* 78 -80.

¹⁵ D J McQuoid-Mason 'Doctor-assisted suicide: What is the present legal position in South Africa?' (2015) 105(7) *SAMJ* 527.

¹⁶ *Ibid.*

1.4 Limitations of the research

It is common for people to formulate what is known as a 'living will' when they are still in a competent state of mind. This document states that a person does not want to be kept alive artificially and that should they land up in a position where they are solely dependent on machines to survive, they wish these machines to be switched off so that death will naturally occur. People also issue advance directives on what medical treatment they would not like to receive. Advance directives are, however, not legally binding although it is often used as a guide by medical practitioners in making decisions relating to treatment. A discussion of advance directives, their application and whether legislation should include provisions relating to advance directives fall outside the scope of this dissertation.

This dissertation will also not discuss involuntary euthanasia and will be limited to cases where a patient is mentally competent to make an end of life decision, regardless of their age. This discussion of euthanasia is further limited to patients suffering from a terminal disease or illness that is of a physical nature only and will not consider non-physical ailments.

1.5 Research goals

One of the primary goals of the research is to show that prohibiting voluntary active euthanasia for a child who is terminally ill and sufficiently competent and mature to make the decision to die, does that child more harm than good and is not in the child's best interests. In arriving at the above conclusion, the research will consider the Constitutional rights to dignity, bodily integrity, privacy, healthcare and equality and their unjustifiable infringement through the prohibition of voluntary active euthanasia for the terminally ill, considering the rights as they relate to children in particular.

An attempt will also be made to consider how competence and maturity of a child could be assessed in order to show that a mature minor who is assessed to be competent to make the decision to die should in fact be given the opportunity to request euthanasia. In addition, the right to autonomy will be considered in the context of a mature minor suffering from a terminal disease in order to show that it is an overextension of legal paternalism and in fact not in a child's best interests to disallow a mature minor to request death.¹⁷

¹⁷ S 28 of the Constitution provides that in all matters affecting the child, the best interests of the child are of paramount importance.

The final aim of the research is to consider the current legal position in South Africa and to decide how the law can be amended in order to allow for euthanasia to take place. Comparisons with foreign jurisdictions will be considered in order to pave the way forward. Considering the legislation proposed by the South African Law Commission, this research aims to show that such legislation falls short to the extent that it does not provide that a mature minor may request euthanasia. Additional safeguards in respect of minors requesting euthanasia will be considered, drawing on the law in foreign jurisdictions, in order to ensure that abuse of the practice is minimal.

1.6 Research methodology

This dissertation will not be based on empirical research. Instead, it will involve critical analyses of existing law on the subject including existing legal principles, case law, legislation and general discussion of the topic both in a South African context and in foreign jurisdictions.

Initially, this dissertation will involve a descriptive approach to explain the law in respect of euthanasia as it currently stands in South Africa. This will also involve a critical analysis of court cases heard in South Africa on the issue of euthanasia, assessing the decisions of the court critically.

Secondly, a rights-based analysis will be conducted in respect of the issue at hand in order to decide what rights are in play and further whether there is an unjustifiable infringement of these rights by prohibiting terminally ill children from requesting euthanasia. This involves an analysis of whether the right to die is constitutionally guaranteed and further whether this right extends to children as well. This Constitutional approach means a discussion and analysis of the rights in terms of the Constitution, how far they extend and how they apply to terminally ill children in particular. Bioethical principles, including those and other rights specified in international frameworks, will be considered in this rights-based analysis.

The penultimate stage will consider and contrast the law in the international jurisdictions of Belgium and the Netherlands. The euthanasia legislation in these jurisdictions will be considered in order to ascertain the extent to which such legislation promotes and protects the rights of terminally ill minors. An analysis in this regard is helpful in order to establish if similar legislation should be promulgated in South Africa. In this stage of the enquiry, an analysis of the South African Law Commission report on euthanasia and the draft legislation will also be critically considered.

After having conducted the rights-based analysis and having considered the legislation in foreign jurisdictions in respect of pediatric euthanasia, recommendations will be made in respect of how the law in South Africa should be adapted.

1.7 Structure of the dissertation

The next chapter will examine the different forms of euthanasia and how, at common law level, euthanasia is considered to be a crime. This will involve a discussion of the artificial difference between passive and active euthanasia. Following this, the elements of the crime of murder will be considered in respect of euthanasia and assisted suicide in order to critically assess the current law in South Africa which prohibits the practice. This will also involve discussion of literature on the matter in order to reflect on whether the elements of the crime of murder are legitimately fulfilled when a doctor euthanizes a patient. In considering the defense of consent to death, popular arguments against euthanasia, and their validity, will also be contemplated. The final part of the chapter will consider the history of euthanasia and assisted suicide at common law level in South Africa and an analysis of the existing case law will be conducted.

Chapter three (3) will involve a rights-based analysis of the practice of euthanasia. At the outset, the bioethical principles protecting human rights and their relation to the matter at hand will be assessed, making reference to the existing legal frameworks and ethical principles relevant in this matter. Prior to an in-depth analysis of each right involved, the chapter will make reference to where children's rights fit in a constitutional context, drawing on theories of rights relevant to children. Following this, a critical analysis of the right to dignity, life, bodily integrity, privacy, equality and healthcare will be conducted to show that by prohibiting voluntary active euthanasia for mature minors, these rights are being unjustifiably infringed.

Chapter four (4) will consider children's decision making capacity in particular. This will involve an examination of the existing legislation relating to a child's right to make a decision with regards to their own body. Drawing on the rights-based analysis in chapter 3, the chapter will consider how far the right to autonomy extends in relation to children. Further, the concept of competence in the sense of decision making will be expanded in order to determine if and how a child's capacity for decision making can be assessed, especially in respect of the decision to die. The chapter will conclude by expanding the 'best interests of the child' concept in order to show that it cannot be in the best interests of a terminally ill mature minor to force him or her to suffer until his or her natural death.

Having established that a mature minor's rights in terms of the Constitution may be unjustifiably infringed by prohibiting voluntary active euthanasia and that provided decision making capacity and maturity are accurately assessed to determine competence to make the decision to die, chapter five (5) will explore the euthanasia legislation in Belgium and the Netherlands in relation to pediatric euthanasia. This will involve a discussion of the euthanasia legislation in these foreign jurisdictions

and the criticisms thereof. The chapter will also discuss the draft bill produced by the South African Law Commission which proposes South African legislation on the matter.

Finally chapter six (6) will seek to conclude the discussion on voluntary active euthanasia for mature minors by summarizing the arguments, legal principles, common law and legislation previously discussed. This chapter also contains recommendations in respect of how South African law can, and should, be adapted in order to recognize and promote the rights of terminally ill mature minors.

CHAPTER TWO: EUTHANASIA AS A CRIME AND COMMON LAW DEVELOPMENTS

2.1 Introduction

In South Africa, there is currently no legislation regulating the practice of euthanasia and so in terms of common law, it is considered a crime. Anyone who assists another to end their own life is guilty of murder. This is even the case if the person whose life is ended is terminally ill and requests assistance in death. Euthanasia and assisted suicide, or any other form of aid in dying, is not permissible in terms of South African criminal law. Murder is defined as the unlawful and intentional causing of the death of another human being.¹ The act of a doctor, or anyone else, assisting a terminally ill patient to die can be seen as an intentional act to cause the death of a human being. It is also an unlawful act and so if any person, adult or minor, is assisted by another to die, that person who provides assistance, even if it is done for compassionate reasons, will be guilty of the crime of murder. The case law,² however, tends to indicate that the courts seem reluctant to punish a person who assists another to die where it is seen as a compassionate act or ‘mercy killing,’ particularly in cases where the patient is terminally ill.

2.2 Active and Passive euthanasia

Active euthanasia is ‘a positive act intended to kill’³ where a doctor directly causes the death of a patient by, for instance, administering a lethal injection. Passive euthanasia, on the other hand, involved what is seen as an omission to act on the part of the doctor in that the doctor will, for instance, remove life sustaining machinery or cease treatment on the patient which ‘intentionally allows the patient’s death to occur.’⁴ It is generally considered to be acceptable that passive euthanasia is permissible if it is in the interests of the patient that treatment of the patient be ceased.⁵

¹ C R Snyman *Criminal Law* 6 ed (2014) 437.

² See the cases of *S v De Bellocq* (1975) 1 All SA 6 (T); *S v Hartmann* 1975 All SA 87 (C); *S v Marengo* (1991) 3 All SA 784 (W) and *S v Smorenburg* 1992 (2) SACR 389 (C) where the court handed down suspended sentences and showed a lenient approach to euthanasia.

³ M Stauch et al *Text, Cases & Materials on Medical Law* 3 ed (2006) 642.

⁴ Ibid.

⁵ J Montgomery *Health Care Law* 2 ed (2003) 463.

It is often regarded as morally reprehensible for a person to kill another, even if it is considered to be 'mercy killing' although letting someone die is often considered not to be morally wrong.⁶ The rationale behind permitting passive euthanasia, such as ceasing or withholding treatment, is that the patient will die anyway and the doctor is merely ensuring that they do not suffer for longer than is necessary.⁷ The patient will, however, still continue to suffer after the doctor has ceased the treatment. In a case where, for instance, a patient has a breathing tube which is removed to cause death, the patient will suffocate to death which is incredibly frightening.⁸ Essentially, it could then be argued that in such an instance, active euthanasia is preferable because then suffering is ended instantaneously instead of a patient having to continue to suffer for days or even weeks following the cessation of treatment.⁹ To argue that passive euthanasia is ethically better is not in line with humanitarian principles because it is advocating that an individual suffer unnecessarily when such suffering could be ended immediately through active euthanasia.¹⁰

Ethically speaking, it is argued that as both forms of euthanasia have the same outcome, they are no different morally. The Smith/Jones scenario¹¹ proffered by James Rachels is the most commonly used philosophical means of describing how both an act and omission can be reprehensible. The thought experiment is as follows: Both Smith and Jones stand to gain from the death of their six year old cousin. Smith sneaks into the bathroom one night when his cousin is bathing and secretly drowns him. Jones walks into the bathroom with the intention of drowning his cousin only to find that his cousin has slipped, hit his head and is drowning. Jones does nothing to help the child and watches as he drowns. In both cases, nobody knows who is responsible for the death and both Smith and Jones receive their inheritance. This thought experiment is used to show that if an act and omission have the same outcome and there was intention to cause that outcome in both cases, there is really no moral difference between the two actions.

In considering the actions of Jones, it would be absurd to say that his omission is morally less reprehensible to that of Smith merely because he did not actually act despite the fact that he had the same motive as Smith and the outcome of both actions was the same. This thought experiment can be applied in respect of euthanasia in that it shows that morally there is no difference between killing and

⁶ P Singer *Applied Ethics* (1986) 171.

⁷ J Rachels 'Active and Passive Euthanasia' (1975) 292(2) *New England Journal of Medicine* 78.

⁸ R Ogden 'The Right to Die: A Policy Proposal for Euthanasia and Aid in Dying' (1994) 20(1) *Canadian Public Policy/Analyse de Politiques* 3.

⁹ J Rachels (note 7 above; 78).

¹⁰ *Ibid.*

¹¹ J Rachels (note 7 above; 79).

letting die.¹² Whether a doctor removes life sustaining machines from a terminally ill patient or injects such a patient with a lethal injection to cause death, the doctor is still in the same moral position and it is immaterial how the outcome is achieved.¹³

Many people perceive killing to be more morally reprehensible than 'letting die' merely because when someone kills another it is often with a reprehensible motive and the murders portrayed in the media are often gruesome and definitely immoral.¹⁴ 'Letting die' on the other hand is often perceived as being for compassionate reasons and is therefore considered not to be morally reprehensible.¹⁵ These are ill conceived perceptions because they have more to do with motive than with the act or omission in question. If killing is done with a morally reprehensible motive, then it is ethically wrong just as an omission can in certain circumstances also be unethical.

To argue that in the case of passive euthanasia the doctor is 'doing nothing' whereas in active euthanasia it is his act that causes death and he is therefore more morally culpable is a logically unsound argument because in criminal law one can be culpable for both acts and omissions. A doctor that, for instance, ceases treatment is performing an act; he is actively removing life sustaining machines or is no longer treating the patient.¹⁶ Each case should be considered separately because, as argued above, passive euthanasia may also be morally impermissible where, for instance, a doctor can easily treat a patient but does not and instead leaves the patient to die.¹⁷ Similarly, the act of a doctor performing active euthanasia on a patient where there is a prospect of that patient recovering is also morally reprehensible. Following from the above arguments, it is submitted that morally, ethically and legally active and passive euthanasia are no different and that if passive euthanasia is permissible, active euthanasia should be as well.

¹² J Rachels (note 7 above; 79).

¹³ Ibid.

¹⁴ J Rachels (note 7 above; 80).

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid.

2.3 Ethical perspective on active euthanasia

HPCSA Guidelines for the Withholding and Withdrawal of Treatment¹⁸ which are in line with the World Medical Association (WMA) Declaration of Venice on Terminal Illness,¹⁹ stipulate that active euthanasia is both unlawful and is in opposition to the ethics of healthcare that should be adopted by all medical practitioners. The guidelines do, however, provide that a physician may alleviate pain and suffering by withholding treatment from a patient in order to allow that patient to die from natural causes at a quicker rate, and a doctor may also administer palliative care which may have the double effect of hastening death. By implication, the guidelines permit a doctor performing passive euthanasia provided that they are withholding or withdrawing treatment in order to alleviate pain and suffering.²⁰ Active euthanasia is categorically prohibited. This distinction appears to be anomalous given that the reason stated for permitting passive euthanasia is to alleviate pain and suffering. Passive euthanasia means that treatment may be withdrawn but it does not end suffering immediately and the patient may still continue to suffer until death. If there is a real commitment on the part of physicians to alleviate pain and suffering, then active euthanasia should be permissible in order to allow for pain to be ended instantaneously.

The WMA Resolution on Euthanasia²¹ states much of what is provided for in the Declaration on Terminal Illness,²² although it does not categorically appear to refer to either active or passive euthanasia, provides that doctor-assisted suicide and euthanasia are contrary to medical ethical principles.²³ The WMA Declaration on Terminal Illness provides, however, that it is a medical practitioner's duty to act in the best interests of the patient and to relieve pain and suffering. It can be argued that euthanasia or assisted suicide is in the best interests of a patient and aimed at relieving

¹⁸ Health Professions Council of South Africa *Guidelines on Ethical Rules, Booklet 12: Guidelines for the Withholding and Withdrawing of Treatment* (2008) available at <http://www.hpcs.co.za/conduct/Ethics> accessed on April 14 2016.

¹⁹ World Medical Association *Declaration of Venice on Terminal Illness* (2006) available at <http://www.wma.net/en/30publications/10policies/i2/> accessed on 15 August 2016.

²⁰ D J McQuoid-Mason 'Stransham-Ford v. Minister of Justice and Correctional Services and Others: Can active voluntary euthanasia and doctor-assisted suicide be legally justified and are they consistent with the biomedical ethical principles? Some suggested guidelines for doctors to consider' (2015) 8(2) *SAJBL* 38.

²¹ World Medical Association *Resolution on Euthanasia* (2002) available at www.wma.net/en/30publications/10policies/e13b/ accessed on 15 August 2016.

²² World Medical Association *Declaration of Venice on Terminal Illness* (note 19 above).

²³ D J McQuoid-Mason (note 20 above; 38).

pain and suffering²⁴ making it the duty of the medical practitioner to respect the choice of a patient in this regard. The WMA Declaration on Euthanasia²⁵ does, however, draw a distinction between active and passive euthanasia and provides that it is not permissible for a doctor to intentionally end the life of a patient, even if that patient consents to death but a doctor may withhold or withdraw treatment from a patient who wishes to let nature take its course if they are terminally ill.²⁶ The Hippocratic Oath, which all medics are bound by and have a duty to obey also states that a medical practitioner must “neither prescribe nor administer a lethal dose of medicine to any patient even if asked.”²⁷

The World Medical Association Resolution on Euthanasia²⁸ provides that the practice of euthanasia is in opposition to medical ethical principles and should not be carried out by medical professionals. Despite these provisions of the Resolution, however, the Constitution is supreme law in South Africa so if it can be shown (as was done in the *Stransham-Ford*²⁹ case) that a person’s rights are being unjustifiably limited by disallowing euthanasia, then a doctor should be permitted to respect a patient’s autonomy and assist a patient to die if such a request is legal.³⁰ Ultimately, the ethical principles of a profession must yield to the Constitution and such principles should not be adhered to if they are shown to unjustifiably limit the rights as enshrined in the Constitution.³¹

2.4. Assisted suicide and euthanasia

The phrase ‘assisted suicide’ is used to define situations where a person receives help from another person to commit suicide. For the purposes of this dissertation, it is necessary to consider the legal position in respect of assistance given by a doctor to a terminally ill patient to end their life as this is essentially what influences legislation. However, the decisions of the court in regard to assisted suicide, even where it is not a doctor who provides assistance, is of importance because it sheds light

²⁴ K Moodley ‘The Fabricius decision on the Stransham-Ford case – an enlightened step in the right direction’ (2015) 105(6) *SAMJ* 434.

²⁵ World Medical Association *Resolution on Euthanasia* (note 21 above).

²⁶ D J McQuoid-Mason (note 20 above; 38).

²⁷ See G van der Walt and E K Du Plessis “‘I don’t know how I want to go but I do know that I want to be the one who decides’ – The right to die – The High Court of South Africa rules’ (2015) 36(3) *Obiter* 813.

²⁸ World Medical Association *Resolution on Euthanasia* (note 21 above).

²⁹ *Stransham-Ford v Minister of Justice and Correctional Services 2015 (4) SA 50 (GP)*.

³⁰ D J McQuoid-Mason (note 20 above; 39).

³¹ D J McQuoid-Mason (note 20 above; 39).

on the current legal position in respect of this matter. The case law in this regard tends to indicate that where the deceased causes their own death by, for instance, ingesting lethal medication, their action is seen as a *novus actus interveniens* which breaks the causal chain of events and even if another person assisted them in acquiring the means to commit suicide, that person will not be guilty of murder. If this reasoning is followed, it can be argued that in a case of physician assisted suicide, the doctor would not be liable because it is the final action of the patient ingesting the medication that causes their own death.

This differs from euthanasia in that it is the act of the doctor specifically (or another such person) that is the final act which causes the death of someone. In physician assisted suicide, the physician is considered merely to be a facilitator, whereas the role of the doctor in respect of euthanasia is active.³² A common example is where, for instance, a doctor administers a lethal injection to a terminally ill patient in order to end their suffering. Despite this being considered an act of mercy and is in fact often referred to as “mercy killing,” it is still regarded as murder in terms of criminal law.

2.5 Considering the elements of the crime of murder in respect of euthanasia and assisted suicide

2.5.1 Intention

In a case of passive euthanasia, the ‘eventual’ intention of the physician is to hasten death of the patient as they foresee that by removing life sustaining treatment, the patient will die. ‘Eventual’ intention is intention in the form of *dolus eventualis*. It can be argued that even the risk of eventuality is sufficient for intention in the form of *dolus eventualis*. This is because they subjectively foresee that by withdrawing or withholding treatment or by providing a patient with certain palliative care, it will hasten the death of the patient. Active euthanasia means only that the doctor has ‘actual’ intention to cause death by providing the patient with lethal medication.³³ In both cases, the physician has some form of intention to cause death and it can be argued that if the type of intention for passive euthanasia is permissible, then active euthanasia should also be permissible.

It is important to note that motive plays no role in deciding whether a perpetrator has intention or not. In a case of euthanasia, even if the person who assists another to die does so out of mercy and has

³² A Dhai ‘Physician-assisted dying and palliative care: Understanding the two’ (2015) 8(2) *SAJBL* 2.

³³ D J McQuoid-Mason ‘Doctor-assisted suicide: What is the present legal position in South Africa?’ (2015) 105(7) *SAMJ* 527; also see D J 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* 102-103.

good motives, they will still be seen to have intention and will be held criminally liable. Motive only plays a role in sentencing, as one who has a good motive is likely to receive a lighter sentence.³⁴ However, in the case of a doctor assisting a patient to die, the professional consequences are generally no lesser even if the physician had a good motive.³⁵ In certain instances, a bad motive may make what was originally a lawful act, unlawful. This would be, for example, where a person removes another from life sustaining treatment (ie ‘passive’ euthanasia) merely because they will inherit a large sum on the death of the patient.³⁶ It has to be decided on a case by case basis whether or not the act of removing or withdrawing treatment is unlawful or not, taking into account whether the motive behind the omission is to alleviate pain and suffering or not.³⁷

Intention should also be considered in respect of the difference between doctor-assisted suicide and doctor-assisted death (or commonly referred to merely as euthanasia). In a case of physician assisted suicide, the doctor prescribes lethal medication which the patient is then responsible for taking and which causes their death. In such a case, the patient may be considered to be the cause of death and the doctor would then not be liable, although case law on the subject, as discussed below, shows that the court takes different approaches based on the circumstances of the particular case. It is argued in terms of South African law that even in a case of physician assisted suicide, the doctor can foresee that the patient will take the medication prescribed and that it will result in the patient’s death. This is intention in the form of *dolus eventualis*³⁸ and the doctor can still be held liable.

For doctor assisted death, or euthanasia, the intention of the doctor is seen as direct intention (*dolus directus*) in that the doctor directs his will to the harm – He administers a lethal injection or gives the patient medication which immediately causes the patient’s death. The intention element of the crime is fulfilled in the sense that there is *dolus directus*. The doctor in such a case has taken the patient’s life, and not the patient him/herself as in the case of suicide, and it is this that makes the doctor liable in South African law, even if the patient consented to his own death. Currently, consent to death is not regarded as a defence to unlawfulness.

³⁴ See *S v De Bellocq* 1975 1 All SA 6 (T); *S v Hartmann* 3 1975 All SA 87 (C); *S v Marengo* 1991 3 All SA 784 (W); *S v Smorenburg* 1992 (2) SACR 389 (C); J Burchell *Principles of Criminal Law* 5 ed (2016) 353-355.

³⁵ In the case of *S v Hartmann* 3 1975 All SA 87 (C), even though the doctor’s primary motive was to relieve his father’s pain and suffering, this did not mean that he could escape disciplinary action from the Health Professions Council.

³⁶ D J McQuoid-Mason (note 20 above; 37).

³⁷ *Ibid.*

³⁸ *Dolus eventualis* is defined as follows: ‘A person acts with intention in the form of *dolus eventualis* if the commission of the unlawful act or the causing of the unlawful result is not his main aim, but:

- (a) He subjectively foresees the possibility that, in striving towards his main aim, the unlawful act may be committed or the unlawful result may be caused, and
- (b) He reconciles himself to that possibility.’ (C R Snyman *Criminal Law* 6 ed (2014) 178).

2.5.2 Causation

In order for a person to be guilty of the crime of murder, the person must be both the factual and legal cause of the death. In determining whether a person is the factual cause of death, the *condition sine qua non* test is applied: 'but for' the actions of the accused, the death would not have occurred.³⁹ In respect of both voluntary active euthanasia and physician assisted suicide, the doctor is considered to be the factual cause of death. It is argued with physician assisted suicide that 'but for' the doctor prescribing the lethal medication to the patient, the patient would not have been able to take the medication and would not have died. In the case of voluntary active euthanasia where, for instance, the doctor gives the terminally ill patient a lethal injection, the doctor is obviously regarded as the factual cause of death.

In turning to the legal cause of death, it is necessary to consider whether there is a new intervening act (*novus actus interveniens*) which breaks the causal chain of events between the act and the death.⁴⁰ In respect of physician assisted suicide, it is often argued that the patient breaks the causal chain of events by ingesting the medication which results in their death and it is therefore the act of the patient that ultimately causes death. In the states in the USA⁴¹ that allow for physician assisted suicide, voluntary active euthanasia where the doctor for instance injects the patient to cause death, is not permissible because in such a case the doctor is considered to be the direct cause of death and not the patient and therefore in such a case the doctor is criminally liable.

Passive euthanasia is permissible in South African law because in respect of the causation element of the crime of murder, the disease or illness is seen as the cause of death and not the act of the doctor removing the life sustaining treatment. By the doctor removing the treatment or life sustaining machinery, it is seen merely as an omission and then the disease is what results in the death of the patient. However, the act of the doctor removing the treatment could also be seen as a positive act and if he did not do that, the patient would still be living. Where a doctor gives the patient lethal medication or removes a ventilator to cause death, it is still his positive act which causes the death of the patient.⁴² It could further be argued that it is the act of the doctor removing the life sustaining machinery that causes the death of the patient and not the disease. Ultimately, the intention of the doctor is to hasten the death of a patient in order to protect their Constitutional rights to dignity and

³⁹ See C R Snyman (note 1 above; 81-83).

⁴⁰ See C R Snyman (note 1 above; 86-87).

⁴¹ The states of Oregon, Montana, Washington, Vermont and California permit physician assisted suicide.

⁴² D J McQuoid-Mason 'Doctor-assisted suicide: What is the present legal position in South Africa?' (2015) 105(7) *SAMJ* 527.

quality of life and whether this is done through active or passive euthanasia should be irrelevant.⁴³ If the argument is legitimate that the distinction made between active and passive euthanasia is an artificial one and passive euthanasia is permissible in terms of our law, then active euthanasia should also be permissible. It was argued that if it is established that there is a duty on a doctor to withdraw treatment (ie an omission) from a terminally ill patient in order to protect their dignity, then that duty exists through an act of euthanasia as opposed to an omission.⁴⁴

What should also be noted in the discussion of causation is the ‘doctrine of double effect’ in respect of palliative care. This principle is that a doctor may provide a patient with palliative care which relieves pain and suffering but at the same time hastens death.⁴⁵ In such a case, it is the administration of the medication which hastens death even though administering such medication is not considered to be unlawful.⁴⁶ In such a case, even though it is ultimately the medication administered to the patient which hastens the death of the patient from the underlying disease or condition from which they are suffering, the administration of such palliative care is considered to be lawful and a physician will not be held liable for the patient’s death.⁴⁷

2.5.3 Consent as a defence for unlawfulness

One of the defences to criminal liability is consent. Consent will exclude unlawfulness if 3 requirements are met: (1) Consent is recognized in law as a possible defense; (2) The consent is real consent; (3) The consent is given by a person who in law is capable of consenting. This means that it is actually possible for a person to consent to their own injury and such consent may in certain instances be a defence to criminal liability. For instance, a person may consent to certain forms of injury that may result from taking part in a sport.⁴⁸ Where consent is a defence against criminal liability (for instance in the case of rape), the act is no longer unlawful because of the principle of *volenti non fit injuria*. The question here that arises is whether a person, and in particular a minor, can consent to their own death and as such exonerate the doctor, who assists them to die, from criminal liability.

⁴³Ibid; also see D J McQuoid-Mason (note 20 above; 37).

⁴⁴ D J McQuoid-Mason (note 20 above;37) ; Also see *Stransham-Ford v Minister of Justice and Correctional Services 2015 (4) SA 50 (GP)* at para 38-39.

⁴⁵ J K Mason & G T Laurie (eds) *Mason and McCall Smith’s Medical Law and Ethics* 8 ed (2011) 579-580.

⁴⁶ D J McQuoid-Mason (note 20 above; 37).

⁴⁷ D J 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 102-103.

⁴⁸ C R Snyman (note 1 above; 125).

A person may consent to injury, or even death, if such is a risk associated with medical treatment or an operation which a patient has consented to. However, the common law does not allow for a person to consent to being killed⁴⁹ or for a doctor to administer a lethal drug which causes death.⁵⁰ The principle of *volenti non fit injuria* is not always a defence and the state may still punish people for victimless crimes.⁵¹ Ultimately, it is public policy which dictates whether consent is valid or not.

Consent will only be successful as a defence where “it is in the interests of public policy that the act of the offender should be rendered not unlawful by the consent of the victim.”⁵² Although in terms of common law, consent to bodily injury or the risk of it is permissible, it is not permissible to consent to one’s own death. Neither suicide nor attempted suicide is considered to be a crime⁵³ although assisting another person in the act of committing suicide, even if that person has consented to death, is not permissible.⁵⁴ In the foreign case of *Baxter v Montana*⁵⁵, the court stated that consent is not a defence when the actions are a threat to public peace and there is harm to public policy. In assault cases, for instance, where there is disturbance to peace and possible further physical harm to others, consent is never a defence.⁵⁶ However, where a terminally ill patient consents to physician assisted suicide, that is a private act which does not encroach on public peace or endanger other members of society and such consent is therefore not contrary to public policy.⁵⁷

In considering arguments in favour of allowing terminally ill minors to consent to their own death, it is submitted that allowing for such causes no physical harm to others nor does it disturb public peace or security. It is a highly private and personal decision and therefore cannot be seen to be against public policy. If anything, public policy should dictate that to force a child to continue to suffer unbearable pain until their death is inhumane and that allowing for such a terminally ill minor to end their life in a dignified manner is in fact a necessary promotion of basic human rights.

⁴⁹ *Ex Parte Die Minister van Justisie: In re S v Grotjohn* (1970) 2 All SA 491 (A) at pg 499.

⁵⁰ *S v Hartmann* 3 1975 All SA 87 (C) at pg 89.

⁵¹ S Bhamjee ‘Is the right to die with dignity constitutionally guaranteed? *Baxter v Montana* and other developments in patient autonomy and physician assisted suicide’ (2010) 31 (2) *Obiter* 347.

⁵² *Ibid.*

⁵³ J Burchell *Principles of Criminal Law* 5 ed (2016) 582.

⁵⁴ S Krause ‘Going gently into that good night: the constitutionality of consent in cases of euthanasia’ (2012) 33(1) *Obiter* 48; It was also held in the case of *Grotjohn* supra that if the person assisting another is the effective cause of death, then that person assisting will be guilty of murder.

⁵⁵ *Baxter v Montana* [2009] MT 449.

⁵⁶ *Baxter v Montana* supra at 17. In arriving at its decision, the court considered the case of *State v. Mackrill*, 2008 MT 297, 345 Mont. 469, 191 P.3d 451 in which the court looked at disturbance of peace which would be considered to be against public policy.

⁵⁷ *Baxter v Montana* supra at 23.

If consent is regarded as *contra bonos mores* (it goes against the legal convictions of the community or it is against public policy) then it cannot be valid.⁵⁸ The requirement that consent be in line with public policy means that despite consent being voluntary it must still meet an objective legal standard in order to be valid.⁵⁹ The primary things to consider in order to determine if consent is valid is Constitutional values, public opinion and prevailing legal norms.⁶⁰

The values upon which our Constitution is founded – dignity, equality and freedom – are fundamental to determining public policy. In fact the concept of *boni mores* is ‘now deeply rooted in the constitution and its underlying values.’⁶¹ In considering the fundamental values upon which the Constitution is based, it can be argued that the right to freedom of choice and dignity are values which can only be upheld by allowing a terminally ill child who is suffering incredible pain to opt for euthanasia. These rights will be discussed in greater detail in the proceeding chapters but at present it is necessary to acknowledge that consent cannot be considered to be against public policy if it in fact has the effect of promoting a person’s right to dignity and freedom of choice.

Secondly, for consent to be in line with public policy, it must be consistent with the prevailing legal norms that govern the act in question.⁶² This means analyzing the existing law in relation to the matter and ensuring that the act in question is in line with this. In respect of children, s 28(2) of the Constitution is of the highest consideration. This section states that the best interests of the child must always be of paramount importance in any decision relating to the child. The following chapter will deal with this aspect in greater depth but what is necessary is to acknowledge that it may indeed be in the best interests of a terminally ill child to choose to end their pain by way of euthanasia instead of being forced to suffer indefinitely.

In deciding whether an act is *contra boni mores* or not, the courts may also consider the views and opinions of the public. This would mean a consideration of the moral or ethical arguments in opposition to the practice in question. Public opinion is only really considered, however, where public opinion on the matter is strongly in favour of legal sanction.⁶³

⁵⁸ See A E Storde et al ‘*Boni mores and consent for child research in South Africa*’ (2015) *SAJBL* 8(1) 22 for discussions on *boni mores* in respect of children and consent issues.

⁵⁹ A E Storde (note 58 above; 23).

⁶⁰ *Ibid.*

⁶¹ *African Dawn Property Finance 2 (Pty) Ltd v. Dreams Travel and Tours CC and Others* 2011 (3) SA 511 (SCA) at para 22.

⁶² A E Storde (note 58 above; 24).

⁶³ A E Storde (note 58 above; 23).

Popular arguments against allowing euthanasia are listed below:

- (1) Religious and cultural arguments – It is argued that allowing for assisted suicide is a form of liberal individualism which is seen as part of a Western, urban philosophy rather than African philosophy which is more community centred as opposed to looking merely at the interests of the individual.⁶⁴ It is therefore argued that little support for euthanasia law will be forthcoming in South Africa. This remains untested, however, and it is therefore not certain whether this philosophy applies to traditional rural communities only or whether it also applies in an urban setting.

There is a lot of emphasis on individual choice in terms of the Constitution and legislation such as the Children’s Act⁶⁵ and the Choice on Termination of Pregnancy Act⁶⁶ provides young children with the right to make choices in terms of their own body. This legislation is has been part of South African law for a while now and is not challenged on the basis of *ubuntu*.⁶⁷ Ultimately the purpose of such legislation is to provide people with a choice, it does not mean that a person is forced to make use of legislation. If an individual is against euthanasia for religious or cultural reasons, and if there was legislation in place allowing for it, they would by no means be obligated to request death even though they would have the option to do so. Similarly, a doctor can refuse to assist a patient to die if it is against his beliefs to do so and legislation would need to include the option of conscious objection for doctors.⁶⁸

- (2) ‘Slippery slope’ argument – This argument is that to allow for euthanasia would mean that there is greater chance of doctors allowing for more and more patients to make use of euthanasia, possibly in circumstances where it is not even really what the patient wants. This is especially a worry in respect of children who could easily be taken advantage of and may be euthanized against their wishes. The Dutch legislation which allows euthanasia has limited the circumstances in which a person can request death to only those cases in which a person is suffering from a terminal illness but despite this there have been reports that some doctors are allowing euthanasia to be carried out on patients with less serious illnesses.⁶⁹ It can be argued,

⁶⁴ K Moodley (note 24 above; 434).

⁶⁵ Children’s Act 38 of 2005.

⁶⁶ Choice on Termination of Pregnancy Act 92 of 1996 provides that a child of any age may undergo an abortion.

⁶⁷ K Moodley (note 24 above; 434).

⁶⁸ K Moodley (note 24 above; 435).

⁶⁹ K Moodley (note 24 above; 434).

however, that there will inevitably be members of the profession who will transgress the rules and in such instances the professional bodies governing doctors and the courts will need to intervene.⁷⁰ The fact that there are transgressions does not mean that the slippery slope argument is a valid one.

It is also necessary for the Dutch position to be considered carefully and South Africa should learn from it when drafting its own legislation in respect of euthanasia, adopting safeguards to minimise abuses.⁷¹ It is especially necessary that end of life legislation have stringent safeguards in respect of children if children are included in the legislation as children require even more protection, being more vulnerable to abuses. The South African Law Commission draft legislation provides strict criteria that must be fulfilled in order for a person to get assistance in death. This will be discussed in greater detail in the chapters to come.

- (3) There are alternatives to death –Palliative care can be used to reduce a patient’s pain and suffering over a period of time and it is even suggested that advances in medicine mean that cancer patients can die pain-free deaths.⁷² Hospice also provides care for the terminally ill and many medical aids will even pay for home nursing.⁷³ Palliative care, however, often goes only so far in relieving suffering and even if a patient’s pain is minimized, their quality of life might be extremely low and they may suffer a loss of dignity. This can be prevented if the patient is given the option of requesting euthanasia. Furthermore, not every person can afford good palliative care, if any at all. Under resourced health facilities also mean that some terminally ill patients do not benefit from any form of pain management at all.
- (4) It is always possible that a person may be misdiagnosed, a cure might be found for their disease or they could go into remission.⁷⁴ Euthanasia is final and cannot be reversed. In most cases, however, the diagnosis is correct and there is no prospect of recovery and to hope that there is a chance of recovery is unrealistic.⁷⁵ In a case where a patient is suffering from terminal cancer and they catch pneumonia, a doctor will usually not administer antibiotics to help the patient fight the pneumonia but will instead leave nature to take its course because it is considered inhumane to prolong the patient’s suffering in the hope of recovery where the

⁷⁰ K Moodley (note 24 above; 434).

⁷¹ Ibid.

⁷² G van der Walt and E K Du Plessis (note 27 above; 806).

⁷³ Ibid.

⁷⁴ P Singer (note 6 above; 179).

⁷⁵ Ibid.

chances of such a person recovering are minimal.⁷⁶ If this sort of lack of treatment is ethically permissible in order to hasten death, then it can also be argued that any other terminally ill patient who does not acquire an opportunistic disease but is nearing death, should be permitted to request a doctor to cause their death as it could also be considered cruel to allow such a patient to continue to suffer.⁷⁷

- (5) It has been argued that to permit euthanasia would mean that there would be less motivation to conduct research on terminal diseases.⁷⁸ This argument is not logically sound to the extent that the purpose of the research is to cure the disease and eradicate it whereas the purpose of euthanasia is to ease pain and suffering.⁷⁹ Given the different aims, it is unlikely that research on terminal diseases will cease in favour of euthanasia.

The other moral and ethical arguments mentioned above specifically with reference to the superficial difference between passive and active euthanasia, tend to indicate that morally, active euthanasia, is an acceptable practice to the extent that it can end pain and suffering and allow a person to die with dignity. This idea would also extend in respect of a terminally ill child.

2.6.A history of assisted suicide and euthanasia at common law level

2.6.1 Assisted suicide

The phrase 'assisted suicide' is used to define situations where a person receives help from another person to commit suicide. For the purposes of this dissertation, it is necessary to consider the legal position in respect of assistance given by a doctor to a terminally ill minor to end their life as this is essentially what influences legislation. However, the decisions of the court in regard to assisted suicide, even where it is not a doctor who provides assistance, is of importance because it sheds light on the current legal position in respect of this matter. The case law in this regard tends to indicate that where the deceased causes their own death by, for instance, ingesting lethal medication, their action is seen as a *novus actus interveniens* which breaks the causal chain of events and even if another person assisted them in acquiring the means to commit suicide, that person will not be guilty of murder. If this reasoning is followed, it can be argued that in a case of physician assisted suicide, the doctor would not be liable because it is the final action of the patient ingesting the medication that causes

⁷⁶ P Singer (note 6 above; 179).

⁷⁷ Ibid.

⁷⁸ R Ogden (note 8 above; 3-4).

⁷⁹ Ibid.

their own death. There is, however, no South African case law indicating what the legal position would be should the terminally ill patient be a minor. Nevertheless, the development of common law generally in respect of euthanasia is necessary in order to ascertain whether such a practice should be permissible and whether it should further extend to children.

2.6.1.1 R v Peverett 1940 AD 213

This is one of the earliest cases dealing with the issue of assisted suicide. In this case a couple – Mr Peverett and Mrs Saunders - both decided to commit suicide by using a pipe to pump poisonous fumes from the exhaust pipe of the car into the car itself which would cause their deaths. They sat in the car with the windows closed and started the car to cause the fumes to be emitted. Neither of them died but were instead found unconscious the next day and Mr Peverett was accused of attempted murder. He was convicted on the basis that it was the final act of turning on the engine which was an attempt to kill Mrs Saunders – an act which he did intentionally, knowing that it could result in their deaths. Watermeyer JA stated the following:

“In the present case it is clear that the accused contemplated and expected that as a consequence of his acts Mrs Saunders would breathe the poisoned gas and die. In the eye of the law, therefore, he intended to kill her, however little he may have desired her death.”⁸⁰

The court also found that his actions went beyond mere acts of preparation but were a means to an end: to cause their deaths.⁸¹ The verdict of attempted murder was confirmed in the Appeal Court.

The court in this case tends to indicate that where a person assists another to commit suicide and it is their final act which either causes death, or in this instance, causes injury, that person is guilty of a crime. It does not matter that the other party consented to death or to the act which the accused performs, the act of the accused in such an instance is still considered to be unlawful.

2.6.1.2 R v Nbakwa 1956 2 SA 557 (SR)

Unlike in the case of Peverett, the actions of the accused in this case were seen merely as acts of preparation and were insufficient to warrant a conviction of murder. The facts of the case are as follows: the deceased requested that the accused help her to commit suicide. The accused hung a noose from the rafters of a hut and told the deceased to hang herself. The deceased asked the accused

⁸⁰ *R v Peverett 1940 AD 213* at pg 219.

⁸¹ *Peverett supra* at pg 219.

to assist her to get up and for a block she could stand on to hang herself. The accused then watched as the deceased hung herself.

It was held in that case that although the accused had provided the deceased with the means to hang herself and had persuaded her to do it, it was the actions of the deceased herself in securing the noose around her neck and hanging herself that was the ultimate cause of death. The deceased's own actions were seen as a *novus actus interveniens*. A *novus actus* is a new intervening act which breaks the chain of causation and negates liability of the accused.⁸² The actions of the victim herself were seen in this instance as the direct cause of death.

Although this case is a South Rhodesian court case, it can have persuasive value in South Africa. In assessing liability, the court considered the final act of the deceased to be an act which negated the liability of the accused. Despite the fact that the accused assisted the victim in committing suicide, he escaped liability on the basis that it was her final act of hanging herself that ultimately caused death. In applying this reasoning to a case of physician assisted suicide, it could be argued that the act of a doctor prescribing lethal medication is not the final act that causes the death of a patient, just as the tying of the noose and helping the deceased onto the block in this instance was not the final cause of death. Instead it is the act of the patient in ingesting the lethal medication, as it is the act of the deceased in this case in hanging herself that is the final cause of death. It is this act which is a *novus actus* and which breaks the chain of causation and exonerates the party who assisted in the preparatory acts leading to the suicide.

If this logic can be followed, the liability does not rest with the doctor. As suicide is not considered a crime in South African law, the act of the deceased causing their own death obviously has no legal consequence. By extension, this could mean that a doctor who provides a terminally ill minor with lethal medication would not be considered to be liable and in such an instance it would then be the decision of the minor whether to ingest the medication or not. There would need to be stringent safeguards in place to ensure that this is not abused and that only mature minors are provided with this opportunity, however, which will be considered throughout the course of this dissertation.

⁸² *R v Nbakwa 1956 2 SA 557 (SR) at 599 A-E.*

2.6.1.3 *S v Gordon 1962 (4) SA 727 (N)*

The facts in this case are similar to that of *Peeverett*⁸³ in that the accused and the deceased also formed what is commonly known as a 'suicide pact.' In terms of this agreement as such, they both decided to take lethal tablets acquired by the accused which would result in their death.⁸⁴ Although the accused supplied the deceased with the tablets it could not be shown that he assisted the deceased to take the tablets. The accused was charged with murder in that he gave the deceased the lethal medication knowing that she would take them and this would cause her death.

In arriving at a conclusion, the court referred to the case of *Nbakwa*⁸⁵ and *Peeverett*.⁸⁶ The court distinguished the facts of this case from those in *Peeverett* because in that case it was the final act of Mr Peeverett turning on the engine that caused the death of Mrs Saunders whereas in this case, it was the act of the deceased taking the tablets herself which caused her own death.⁸⁷ The circumstances in this case are similar to those in *Nbakwa*: in this case it was in fact the final act of the deceased in swallowing the tablets that caused her death and such an action could be seen as a *novus actus interveniens*:

“The mere fact that he provided the tablets knowing the deceased would take them and would probably die cannot be said to constitute, in law, the killing of deceased. The cause of her death was her own voluntary and independent act in swallowing the tablets. He undoubtedly aided and abetted her to commit suicide, but that is not an offence.”⁸⁸

The judgment in this case tends to indicate that in a circumstance where a person voluntarily swallows lethal medication to bring about their death, the party which supplied the deceased with the medication will not be held liable. By this logic, any doctor who were to supply a patient with lethal medication should not be held liable for that act because it is the final act of the patient swallowing the medication that leads to their death. This is even despite the doctor foreseeing that the patient would take the medication which would result in the patient's death. As was discussed above, strict safeguards need to be put in place, however, to ensure that this is not abused and especially in respect of minors to ensure that a child understands the implications of their decision to die.

⁸³ *R v Peeverett 1940 AD 213.*

⁸⁴ *S v Gordon 1962 (4) SA 727 (N)* at pg 729.

⁸⁵ *R v Nbakwa 1956 2 SA 557 (SR).*

⁸⁶ *Peeverett supra.*

⁸⁷ *Gordon supra* at pg 730.

⁸⁸ *Gordon supra* at pg 731.

2.6.1.4 Ex Parte Die Minister van Justisie: In re S v Grotjohn (1970) 2 All SA 491 (A)

According to the court in this case, it depends on the circumstances of each case as to whether a person who had assisted another to commit suicide is found guilty of murder. The court stated that the decisions reached in *Nbakwa*⁸⁹ and *Gordon*⁹⁰ are not always necessarily correct in other circumstances. In the *Grotjohn* case the accused handed the deceased a loaded gun after the deceased asked him to help her commit suicide. She then used that gun to kill herself. In his judgement, Steyn J stated that the final act of the deceased which causes his or her own death does not in all circumstances allow for the acquittal of the appellant. It is only in circumstances where the act of the deceased is a completely independent act which interrupts or excludes causality of the accused, that the accused may escape liability.⁹¹ In this case it was held that the accused was both the factual and legal cause of the death of the deceased.

This judgement appears to be different to those given previously in that the act of the accused handing the deceased a loaded gun was considered to be more than a mere act of preparation but was seen as an act which made the accused liable for the death of the deceased. The judge in this case instead decided that the act of the victim shooting herself could not be seen as a new independent intervening act which breaks the causal chain of events. If this approach were to be followed in respect of a physician providing a terminally ill patient with lethal medication, the physician would be considered the factual and legal cause of death for providing the means to commit suicide and such a physician would then be held liable.

2.6.1.5 S v Hibbert (1979) 2 All SA 323 (D)

The accused in this case handed his depressed wife a gun and she proceeded to use this gun to shoot herself dead. She had previously expressed a desire to commit suicide. The judge in this case, following on from the decision in *Grotjohn*,⁹² stated that even though the final act of pulling the trigger was not that of the accused, the accused had begun the events that led to his wife's death and her final act could not be seen as an independent act which broke the causal chain of events.⁹³ It was also found that the accused had the necessary intention required for a conviction of murder. Despite the conviction, however, the accused's sentence was suspended wholly.

⁸⁹ *R v Nbakwa* 1956 2 SA 557 (SR).

⁹⁰ *S v Gordon* 1962 (4) SA 727 (N).

⁹¹ See discussion of this case in S Bhamjee 'Is the right to die with dignity constitutionally guaranteed? Baxter v Montana and other developments in patient autonomy and physician assisted suicide' (2010) 31 (2) *Obiter* 343.

⁹² *Ex Parte Die Minister van Justisie: In re S v Grotjohn* (1970) 2 All SA 491 (A).

⁹³ *S v Hibbert* (1979) 2 All SA 323 (D) at pg 328.

The fact that the court did not hand down a hefty sentence in this case tends to indicate that the judge saw no reason to impose a harsh punishment on the accused, especially given the fact that the victim had requested death. Ultimately, however, this interpretation of actions dictates that a doctor who was to assist a patient to commit suicide would also be guilty of murder. In this case the final act of the deceased pulling the trigger of the gun was not considered to be a *novus actus*. If this line of reasoning is followed in respect of a case of physician assisted suicide, it would be decided that the final act of the patient, adult or minor, ingesting the lethal medication could not be considered a *novus actus* either and the doctor would be unable to escape liability for the murder.

2.6.2 Voluntary active euthanasia

This differs from assisted suicide because it is the act of the doctor specifically (or another such person) that is the final act which causes the death of someone. In physician assisted suicide, the physician is considered merely to be a facilitator, whereas the role of the doctor in respect of euthanasia is active.⁹⁴ A common example is where, for instance, a doctor administers a lethal injection to a terminally ill patient in order to end their suffering. Despite this being considered an act of mercy and is in fact often referred to as “mercy killing,” it is still regarded as murder in terms of criminal law. The cases, thus far, are as follows:

2.6.2.1 R v Dawidow WLD 155 (unreported)

The mother of the accused in this case was suffering from a terminal illness and suffering from unbearable pain. Her son (the accused) did what he could to try and help his mother but her condition did not improve. She was very depressed and requested that her pain and suffering be ended by way of lethal injection. The accused, eventually and largely as a result of his own emotional suffering, shot his mother. He did not end his mother’s life in the manner requested but he saw it as a merciful death nonetheless.

The accused in this case was acquitted on the basis that he did not have mental capacity at the time of commission of the crime due to the emotional state he had been in. Despite his acquittal, however, it was clear that his act was considered unlawful.

It is commonly known that in the case where a person is suffering from a terminal illness, their relatives also often suffer emotionally. As can be seen in this case, the accused, a relative of the deceased could no longer bear the suffering of his parent and in this emotional state of turmoil, ended

⁹⁴ A Dhari ‘Physician-assisted dying and palliative care: Understanding the two’ (2015) 8(2) *SAJBL* 2.

her life. What is important to take note of from this case is that the court still regarded the action of the accused in this case as unlawful despite the fact that the deceased had requested death and had thus consented to it. It could perhaps be argued, however, that in this instance even if consent to death were valid, the deceased had consented to death by lethal injection not by being shot and therefore the action of the accused would go beyond the scope of the consent given anyway.

2.6.2.2 *S v De Bellocq (1975) 1 All SA 6 (T)*

The accused in this case was a young, unmarried woman who gave birth to a premature baby. It soon became apparent that the child has a disease called toxoplasmosis. Being a medical student, the mother understood the prognosis and that there was ‘no chance of the child living for any length of time or becoming an intelligent human being.’⁹⁵ The accused decided it would be best to end the child’s life and so she drowned the child.

The court accepted that at the time of the perpetration of the act, the accused was in a highly emotional state.⁹⁶ However De Wet JP stated that being in a state of emotional turmoil did not have the effect of reducing intention and that she was therefore guilty of murder.

However, on account of extenuating circumstances, the accused was discharged under the condition that she appear for sentencing if called upon to do so. This was the first case showing a reluctance by a court to punish a person for ‘mercy killing’ and the conviction appeared to be more of a symbolic gesture of upholding the law rather than aimed at punishment.

2.6.2.3 *S v Hartmann 3 1975 All SA 87 (C)*

The accused in this case, the son of the deceased and a medical practitioner, had treated his father for cancer for an extended period of time. His father’s condition deteriorated to the extent that there was no longer any question of a cure, he was bedridden and suffering great pain.⁹⁷ Eventually, the accused injected a lethal dose of Pentothal into his father’s drip which caused the latter’s death in seconds. Van Winsen J stated that while the deceased may have died of natural causes mere hours later, “the

⁹⁵ *S v De Bellocq 1975 1 All SA 6 (T)* at pg 7.

⁹⁶ *De Bellocq supra* at pg 8.

⁹⁷ *S v Hartmann 3 1975 All SA 87 (C)* at pg 87.

law is clear that it nonetheless constitutes the crime of murder even if all that an accused has done is to hasten the death of a human being who was due to die in any event.”⁹⁸

Although the act of the accused could be seen as ‘mercy killing’ the court nevertheless held that the motive of his act, to relieve his father’s pain and suffering, was irrelevant. The accused was found to have the necessary intention for the crime. Even though the accused contended that the deceased had consented to his death, the court held that even if this was accepted, it would not exclude criminal responsibility.

Although the accused was convicted of murder the sentence handed down was one year’s imprisonment, he was only detained until the rising of the court and the sentence given was suspended for one year. The court stated that the chances of the accused committing a similar crime were negligible and so a hefty sentence was not warranted. The Medical and Dental Council took disciplinary action against Hartmann, however, and he was suspended temporarily.

Once again, the court imposed a lenient sentence on the accused which indicates a reluctance of the court to punish in an instance of ‘mercy killing.’ Ultimately it could be argued that there is no point in having a criminal sanction for a particular act if there is no sanction attached to the commission of the crime. Instead it can be argued that it would be preferable to have legislation in place allowing for a person to request euthanasia and for there to be stringent safeguards in place in order to prevent abuse of the practice.

2.6.2.4 S v Marengo (1991) 3 All SA 784 (W)

In this case the accused shot and killed her elderly father who was suffering from cancer. She pleaded guilty to the charge of murder and stated that her act was an act of mercy. The deceased was terminally ill and required incessant care. Eventually the build up of pressure on her and the emotional turmoil culminated in her shooting and killing the deceased. She thought that by doing this she was providing her father with a quiet and merciful death.⁹⁹

The court found the accused guilty but held that the sentence did not need to involve a deterrent factor as the circumstances in which the accused found herself were extreme and it was very unlikely that the accused would commit a similar crime again.¹⁰⁰ She was sentenced to three years’ imprisonment

⁹⁸ S v *Hartmann* supra at pg 89.

⁹⁹ S v *Marengo (1991) 3 All SA 784 (W)* at pg 785.

¹⁰⁰ S v *Marengo* supra at pg 787.

which was suspended for five years. Following the approach in the *De Bellocq*¹⁰¹ and *Hartmann*¹⁰² cases, it is clear that the court in such instances is reluctant to impose punishment, taking into account the uniqueness of the particular situation.

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

The accused in this case was a nursing sister who was charged with two counts of attempted murder for injecting two patients with a large dose of insulin.¹⁰³ The case is interesting because it deals with the conflict faced by medical professionals between their ethical and moral duty to preserve life on one hand and on the other hand, not wanting to see a patient suffer immense pain.

She admitted to her conduct and was found guilty of attempted murder on both counts. She stated that she had acted in the manner she had done because she wanted to end the suffering of the patients in question.¹⁰⁴

In sentencing the accused, the court considered her position at the time when the acts were perpetrated. She was under severe stress as a result of her job, especially as she witnessed suffering of terminally ill patients on a daily basis and could do nothing to alleviate their pain.¹⁰⁵ The first deceased, Mr Hobbs, was suffering from cancer and following certain medical procedures, he had become incontinent. He suffered a loss of dignity and became withdrawn and depressed as a result.¹⁰⁶ The second victim was Mrs Frames. She suffered from a number of ailments and had also been diagnosed with cancer. After she suffered a stroke, her family requested that treatment should be ceased. In order to give the patient what she considered to be a dignified death, the accused injected the victim to bring about such a death.¹⁰⁷

In sentencing the accused, the court considered that she had reported her acts immediately after doing them and that she had believed at the time that what she had done was right although she later realised that this was not the case as a matter of law.¹⁰⁸

¹⁰¹ *S v De Bellocq 1975 1 All SA 6 (T)*.

¹⁰² *S v Hartmann 3 1975 All SA 87 (C)*.

¹⁰³ *S v Smorenburg 1992 (2) SACR 389 (C)* at pg 391.

¹⁰⁴ *Ibid*.

¹⁰⁵ *S v Smorenburg supra* at pg 392.

¹⁰⁶ *S v Smorenburg supra* at pg 393.

¹⁰⁷ *S v Smorenburg supra* at pg 394.

¹⁰⁸ *S v Smorenburg supra* at pg 395.

Friedman JP stated that in determining a sentence, the interests of society need to be considered – Both at large and the nursing profession. The court was satisfied that the accused was remorseful and that having resigned from her job and being deregistered as a nurse, she poses no threat to the community at large.¹⁰⁹ In respect of the nursing profession, it was stated that it was the task of the Nursing Council to uphold the ethics of the profession and the actions of the accused should be seen individually as an isolated circumstance which does not cause permanent damage to the profession.¹¹⁰ Taking into consideration all the mitigating factors, the accused was sentenced to three months' imprisonment which was suspended in its entirety provided that she did not contravene the Nursing Act¹¹¹ again.¹¹²

Once again in this case the court took a lenient approach in sentencing. What should be taken from this case is the sheer pain and suffering experienced by the patients to the extent that the accused wanted to end their lives. Although she realised that what she had done was unlawful, she justified her actions by saying that she wanted the victims to have a dignified death and the court took this into account when it came to sentencing. The manner in which the conditions of the victims are described show that the victims suffered what was considered to be an undignified existence, so much so that the accused felt that it would be best to end their suffering and allow them to die a dignified death. The court did, to an extent, recognise that her motive was not a malevolent one and this further played a role in the lenient sentence imposed.

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

Although this case dealt specifically with the legality of a legal will, it is still imperative that this dissertation consider the verdict to the extent that a form of passive euthanasia was decided to be permissible. In this case the applicant applied to be appointed as *curatrix personae* for her husband (the patient) so that she could have the ability to take the decision to cease life sustaining treatment of the patient, namely removal of a naso-gastric or other 'non-natural feeding regimes' despite the fact that this would hasten the death of the patient.¹¹³ Mr Clarke, the patient, was in a persistent vegetative state with no prospect of recovery.¹¹⁴

¹⁰⁹ *S v Smorenburg* supra at pg 402.

¹¹⁰ *Ibid.*

¹¹¹ s16(1) read with s27(1) and (2) and s44 of the Nursing Act 50 of 1978.

¹¹² *S v Smorenburg* supra at pg 402.

¹¹³ *Clarke v Hurst NO and Others 1992 (4) SA 630 (D)* at pg 679.

¹¹⁴ *Clarke v Hurst* supra at pg 686.

The question before the court was essentially whether it would be wrongful for Mrs Clarke to consent to treatment that would shorten the life of the patient or consent to removal of treatment on his behalf.¹¹⁵ Thirion J stated, in arriving at a decision, that it would be necessary to consider the interests of society. Public policy dictates that it is acceptable for a doctor to remove life-sustaining treatment from a patient. It was argued that in fact there is no difference between the removal of treatment and not beginning treatment at all.¹¹⁶ Furthermore, it was successfully argued that the applicant was acting in the best interests of the patient and was consequently successful.¹¹⁷

The court in this case acknowledged that a person's quality of life is of utmost importance, more so than the sanctity of life. In looking at a person's right to dignity and acknowledging that they should have autonomy, a respect for the sanctity of life is arguably promoted as well. The court in this case allowed for passive euthanasia to take place and this makes it necessary to consider whether active euthanasia would also be permissible. As considered above, there are many philosophical arguments (see 2.1. above) to the effect that the two forms of euthanasia are actually no different. If the court in *Clarke* allowed for passive euthanasia to take place, and active and passive euthanasia can in fact be considered to be one and the same, the voluntary active euthanasia would also be permissible. It is especially important to note in this case that the court did take cognisance of the fact that the patient was a member of the South African Voluntary Euthanasia Society (SAVES) and had a living will in which he stated that he did not want to be kept alive artificially if there was no prospect of recovery. The patient had made it clear that should such a situation arise, he essentially consented to the artificial means being removed and death resulting. Following from this, it could be argued that if such a request in this instance is granted, a similar request for voluntary active euthanasia should also be granted.

In the case of a minor making a request for active euthanasia, as stated before, their maturity would need to be considered and further safeguards would need to be in place in order to ensure that the child actually understands the decision they are making. Further, what is interesting to note from this case is that it was considered to be in the best interests of the patient to remove the life sustaining treatment in order to bring about death. If it was concluded in this case that the patient did not have a good quality of life and that it was in fact in his best interests for treatment to be ceased, then it could be argued that similar logic could be applied in respect of a minor. In an instance where a child is suffering from a terminal illness and has a poor quality of life, it could be argued that it is in the best interests of that child, should the child request it, to have their suffering ended by way of active euthanasia.

¹¹⁵ *Clarke v Hurst* supra at pg 695.

¹¹⁶ *Clarke v Hurst* supra at pg 701.

¹¹⁷ *Clarke v Hurst* supra at pg 703.

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

This case is considered to be a landmark case in that the court granted an order allowing a medical practitioner to assist the applicant to commit suicide by supplying him with a lethal substance that would cause death. The applicant, Mr Stransham-Ford, had stage 4 terminal cancer and sought an order that would allow him to gain assistance from a medical practitioner to end his life and in doing so, that medical practitioner would not face criminal sanction.¹¹⁸ Despite the fact that the court granted the above-mentioned order, the applicant was in fact unable to make use of it because he died on the day that the judgement was given.

The applicant, a highly qualified individual who was also a practicing advocate, detailed to what extent he was in extreme pain and suffered from nausea, vomiting, constipation, disorientation among other things. He was unable to get out of bed and had injections and drips, suffered from anxiety, could not sleep without morphine or other painkillers and the pain medication he used made him drowsy.¹¹⁹ It is clear from the description of his condition that his quality of life had been substantially diminished. He had also tried various alternative treatments, all of which had been unsuccessful.¹²⁰

The applicant relied heavily on his Constitutional rights to show that in fact he should not be forced to continue to suffer but should be allowed to opt for a dignified death. Section 1 of the Constitution provides that South Africa is a state founded on the values of ‘human dignity, the achievement of equality and the advancement of human rights and freedoms.’¹²¹ The applicant successfully relied on the interrelationship between dignity, privacy and freedom and security of the person, contending that these rights mean that the value and worth of every individual should be acknowledged.¹²² Ultimately, the right to dignity is a right which informs all others and should be respected and protected in all circumstances.¹²³

The court went on to state that quality of life should prevail over the sanctity of life principle and it is the values enshrined in the Constitution rather than public opinion or religious beliefs that should

¹¹⁸ *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 4 (GP) at para 3.

¹¹⁹ *Stransham-Ford* supra at para 5.

¹²⁰ *Stransham-Ford* supra at para 7.

¹²¹ S 1(a) of the Constitution of the Republic of South Africa, 1996.

¹²² *Stransham-Ford* supra at para 19-20.

¹²³ *Advance Mining Hydraulics (Pty) Ltd and Others v Botes NO and Others* 2000 (1) SA 815 (T) at 823E – G cited in *Stransham-Ford* supra at para 20.

inform the decision of the court.¹²⁴ Fabricius J went on to state that a person has no duty to live but merely a right to life which essentially they can waive.¹²⁵ A further argument proffered by the applicant was that it is considered humane to euthanize an animal that is in extreme pain because to prolong its life is considered to be cruel and allows for unnecessary suffering.¹²⁶ The question is then why are humans not given the option of death with dignity as well?

The court gave an order to the effect that the applicant could request that a medical practitioner assist him to commit suicide and that such a medical practitioner would not incur criminal sanction for assisting him.¹²⁷ Despite the fact that the applicant died shortly before the judgement was handed down and although it is not binding on any other High Court as it is a judgement by a single judge, it still has persuasive value. It still remains, however, in the absence of legislation that a person must apply for an order allowing them to make use of physician assisted suicide or euthanasia in order for the doctor who assists them to not be held criminally liable.¹²⁸

The abovementioned case law appears to indicate that the common law is moving towards a more lenient approach to euthanasia. *Stransham-Ford*¹²⁹ is the first case, however, where the court actually stated that it would be an unjustifiable infringement on a terminally ill patient's constitutional rights not to allow them to make use of voluntary active euthanasia. Despite this being a landmark decision, it does not change the fact that a terminally ill patient would have to apply to court to get such an order. These sorts of cases are only to be decided on a case by case basis and so this does not change the position for the average South African who cannot afford the expensive legal fees associated with such litigation – even less so for a terminally ill child who would also require assistance to litigate.

2.7 Conclusion

Despite euthanasia being considered to be murder in terms of South African criminal law, it appears that that convictions on this count do not lead to hefty sentences. The courts appear reluctant to punish the actions of a person who wished to put someone else 'out of their misery' and sentences tend to be suspended. At common law level, and with reference to the ethics of the medical profession, it

¹²⁴ *Stransham-Ford* supra at para 25.

¹²⁵ *Stransham-Ford* supra at para 25.

¹²⁶ *Stransham-Ford* supra at para 27 with reference to 2(1)(e) of the Animals Protection Act 71 of 1962 read with ss 5(1) and 8(1)(d) thereof.

¹²⁷ *Stransham-Ford* supra at para 45.

¹²⁸ D J McQuoid-Mason 'Doctor-assisted suicide: What is the present legal position in South Africa?' (2015) 105(7) *SAMJ* 527.

¹²⁹ *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 4 (GP).

appears that passive euthanasia is permissible in circumstances where a patient has no quality of life and no prospect of recovery at all. The difference between active and passive euthanasia is essentially an artificial one so it can logically be argued that if passive euthanasia is not considered to be reprehensible then the same should apply in respect of active euthanasia. The ethical guidelines of the medical profession are centred on consideration of the best interests of the patient, and in respect of children, this is bolstered by the best interests of the child doctrine in s 28(2) of the Constitution. It can be argued that it is in fact in the best interests of a child and any other terminally ill patient to have their suffering ended and die with dignity. This will be discussed in greater detail in the next chapter.

Although the court has taken a more strict approach in respect of convicting the perpetrators in euthanasia cases, it appears that the courts often come to the conclusion that even if a person is assisted in that they are provided with the means to commit suicide, it is their own voluntary act that is a *novus actus* and breaks the chain of events, thus exonerating the one who assisted them from liability. Ultimately, it can be argued that it is the act of the patient swallowing the lethal medication in an instance physician assisted suicide which is the cause of death, not the act of the doctor prescribing the medication. Each case is, however, dependant on the particular circumstances.

The *Stransham-Ford*¹³⁰ case shows a significant development in our law and recognises that a person should have the right to die with dignity. This case raises serious questions in regard to our current law and begs the question whether legislation regarding voluntary active euthanasia should be promulgated in order to allow ordinary people to die with dignity, instead of only those who can afford to apply to court. It is the author's opinion that such legislation should also allow for competent minors to request euthanasia provided they are sufficiently mature to make such a decision as they also enjoy the same rights as adults. This dissertation will consider in subsequent chapters what legislation should be promulgated, what safeguards should be included in such legislation and how the rights of terminally ill minors can also be upheld whilst ensuring minimal abuse.

¹³⁰ *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 4 (GP)*.

CHAPTER THREE: APPLICATION OF BIOETHICAL PRINCIPLES AND HUMAN RIGHTS

3.1 Introduction

As can be seen from the previous chapter, South Africa currently does not permit a person to request euthanasia or physician assisted suicide. To assist another person to die is unlawful and is a criminal offence. This chapter will consider whether the prohibition of voluntary active euthanasia for a patient suffering from a terminal illness is an unjustified infringement of a person's constitutional rights, looking particularly at the rights as they pertain to children. Children enjoy all the rights in terms of the Constitution, such as the right to dignity, privacy, bodily integrity and equality, as well as the rights relating specifically to children in s 28 of the Constitution.¹ As children are seen as vulnerable groups of society, it is necessary to provide them with extra protection. This protection should not, however, be at the expense of rights they are fully competent to exercise. This chapter will consider the bioethical principles protecting human rights, the international framework protecting human rights as well as considering the meaning and extent of the rights enshrined in the Constitution. Analysis of these rights provides a solid basis for the argument that a terminally ill mature minor should be permitted to request euthanasia provided they are sufficiently competent to make such a decision.

3.2 Bioethical principles protecting human rights

Patient autonomy, the principle of beneficence, non-maleficence and justice and fairness are the bioethical principles which form the basis of the protection of human rights in a health care context.² These principles are found in various international legal frameworks including the International Bill of Rights and the African Charter on Human and People's Rights.³ The International Bill of Rights includes the Universal Declaration of Human Rights (UDHR),⁴ International Covenant on Economic, Social and Cultural Rights (ICESCR)⁵ and the International Covenant on Civil and Political Rights

¹ Constitution of the Republic of South Africa, 1996.

² A Dhali and D McQuoid-Mason *Bioethics, Human Rights and Health Law: Principles and Practice* (2011) 38.

³ Organisation of African Unity African Charter of Human and People's Rights (1981)

⁴ United Nations Universal Declaration of Human Rights (1948)

⁵ United Nations International Covenant on Economic, Social and Cultural Rights (1966)

(ICCPR).⁶ These principles are also found in the South African Bill of Rights⁷ and the South African Patients' Rights Charter.⁸ The bioethical principles are often used by doctors as a justification in the argument against allowing euthanasia. However, these principle are ultimately aimed at achieving the best result for a patient, and it is submitted that in a case of a terminally ill child suffering immense pain, the best alternative is often death.

3.2.1 Patient autonomy

This is the bioethical principle that rejects paternalism, to an extent, and acknowledges that patients have a right to make decisions about their own body and what is done to it.⁹ This means that a person can make their own decisions in respect of medical treatment and surgery. The extent to which a child has a right to autonomy will be discussed in depth in the following chapter.

3.2.2 Beneficence

This principle is that a doctor should promote the welfare of patients and should act in a manner which preserves life.¹⁰ This is in line with the right to life as enshrined in the Constitution.¹¹ The principle of beneficence means that a patient who is terminally ill should be encouraged to undergo palliative care instead of ending their life.¹² It is specifically stated above as including the promotion of the welfare of patients. Welfare is something more than mere survival and can be argued to encompass the need for a quality life rather than merely life itself. In support of the argument for euthanasia, this principle may not entail a need to protect life no matter its form, but rather the protection and promotion of *quality* life. In the case of *Stransham-Ford*¹³ it was emphasized that although the right to life is of paramount importance and that life is sacred, the quality of the life should take precedence over the sanctity of life principle.¹⁴ Further, in the case of *Clarke*¹⁵ and the

⁶ United Nations International Covenant on Civil and Political Rights(1966)

⁷ S 2 Constitution of the Republic of South Africa, 1996.

⁸ Department of Health *South African Patients' Rights Charter 2007* available at www.justice.gov.za/VC/docs/policy/Patient Rights Charter.pdf, accessed on 20 August 2016.

⁹ JK Mason & GT Laurie *Mason and McCall Smith's Law and Medical Ethics* 8 ed (2011) 10.

¹⁰ D J McQuoid-Mason 'Stransham-Ford v. Minister of Justice and Correctional Services and Others: Can active voluntary euthanasia and doctor-assisted suicide be legally justified and are they consistent with the biomedical ethical principles? Some suggested guidelines for doctors to consider' (2015) 8(2) *SAJBL* 36.

¹¹ S 11 Constitution of the Republic of South Africa, 1996.

¹² D J McQuoid-Mason (note 10 above; 39).

¹³ *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 4 (GP)*

¹⁴ *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 4 (GP)* at para 25; see also D J McQuoid-Mason (note 10 above; 39).

¹⁵ *Clarke v Hurst NO and Others 1992 (4) SA 630 (D)*.

English case of *Airdale*,¹⁶ the courts have acknowledged that life should not be preserved at any cost with no regard to the quality of life.¹⁷ It is therefore argued that in a case where a terminally ill patient has no quality of life, the principle of beneficence might justify ending a patient's life prematurely through euthanasia, if they so request.¹⁸ It is also argued that one of the key aspects of the medical profession, and the principle of beneficence, is compassion. Compassion demands that a patient's choice be respected even if this means that they choose to end their life in order to end their suffering.¹⁹

3.2.3 Non-Maleficence

The principle of non-maleficence means that doctors should not unnecessarily harm patients. Active euthanasia then appears to be contrary to this principle, specifically because it could lead to the abuse of vulnerable members of society.²⁰ There is particularly a concern in respect of children that a child who is terminally ill may be coerced into agreeing to euthanasia if the practice is legally permissible in respect of children. This concern needs to be addressed but it has been suggested that provided there are 'minimum safeguards' in place in respect of the legislation, abuses can be prevented.²¹ The South African Law Commission has in its report²² proposed such safeguards although the draft legislation does not provide that children would be permitted to make use of euthanasia or physician assisted suicide at all. In the case of children, it must be acknowledged that additional safeguards would need to be put in place in order to ensure that children are protected from being coerced into consenting to death. Nevertheless, it is not prudent to simply exclude children completely because of the potential for abuse. Instead children should be provided with a choice but legislation should ensure minimal abuse. This will be discussed in further detail in the proceeding chapters.

If a person is forced to stay alive until they die naturally from the disease or illness from which they are suffering, it is condemning them to a life of 'mere existence' which is considered to be a violation of a person's right to dignity.²³ This can be considered to be a violation of the non-maleficence

¹⁶ *Airedale NHS Trust v. Bland* [1993] 1 All ER 821 (AC).

¹⁷ D J McQuoid-Mason (note 10 above; 39).

¹⁸ *Ibid.*

¹⁹ K Moodley 'The Fabricius decision on the Stransham-Ford case – an enlightened step in the right direction' (2015) 105(6) *SAMJ* 434.

²⁰ D J McQuoid-Mason (note 10 above; 39).

²¹ *Ibid.*

²² South African Law Commission Issue Project 86 *Euthanasia and the Artificial Preservation of Life* (1998).

²³ *S v Makwanyane* 1995 6 BCLR 665 (CC); *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 4 (GP); the right to dignity will be analysed and unpacked later on in this chapter.

principle as well because in such a case it could be argued that harm is being caused to the patient by forcing them to continue to exist with no quality of life.²⁴ Especially in a case where a mature minor wishes to end their life and is unable to but must instead suffer until their death, it can be argued that the infringement of their human rights to dignity, bodily integrity and privacy can be considered a harm. Further discussion on human rights will follow.

3.2.4 Justice and fairness

This is a medical principle intertwined with the right to equality. This principle means that doctors are expected to treat patients equally and not to discriminate against any patient.²⁵ An example of such discrimination taking place would be where there are two patients who are terminally ill, one on a ventilator, and one not yet the doctor is permitted to remove the ventilator and bring about death for the first patient but cannot actively cause the death of the second patient.²⁶ This is because passive euthanasia is legally permissible whereas active euthanasia is not. The patient who is not on a ventilator would only be able to legally end his life if he were to approach a court and get an order allowing for him to acquire the assistance of a doctor to die. In the scenario described, both patients are suffering a loss of dignity and lack quality of life, yet only one of the patients can bring about their death legally. In both cases, the elements of causation and intention are the same and there appears to be no difference between the cases in respect of unlawfulness or moral or ethical considerations.²⁷

In applying this principle in respect of the issue at hand, it can logically be argued that this principle permits active euthanasia to take place in order to treat a patient who is not on life sustaining equipment in the same manner as one who is. Further discussion on the right to equality will follow in this chapter.

3.3 Children's rights

The Constitution is the supreme law of the land and hence should in every matter be given utmost importance, specifically the Bill of Rights enshrined therein.²⁸ Section 2 of the Constitution provides

²⁴ D J McQuoid-Mason (note 10 above; 39).

²⁵ Ibid; see also s 9 of the Constitution.

²⁶ D J McQuoid-Mason (note 10 above; 39).

²⁷ D J McQuoid-Mason 'Doctor-assisted suicide: What is the present legal position in South Africa?' (2015) 105(7) *SAMJ* 526-527; see also D J McQuoid-Mason (note 10 above; 39).

²⁸ Section 2, Constitution of the Republic of South Africa, 1996.

that any law or conduct that is inconsistent with the Constitution is invalid. This can mean that although South African patients may be granted additional rights not mentioned in the Constitution by professional ethical guidelines, their rights may not be limited unless it is justifiable in an open and democratic society as provided for in s 36 of the Constitution.²⁹ Generally, rights should be construed broadly rather than narrowly and thereafter it can be decided whether the right should be limited, rather than automatically depriving individuals of fundamental human rights.³⁰ The words ‘law and conduct’ include professional ethical rules such as those contained in the Health Professions Council of South Africa (“HPCSA”)³¹ rules and guidelines for all medical practitioners. The HPCSA imposes rules on doctors that may provide more rights for patients than stipulated in the Constitution but it is impermissible for the rights of patients to be diminished by medical practitioners (such as the right to dignity and the right to bodily integrity) unless it can be shown by the council that such a limitation of the rights in question is justifiable in an open and democratic society (s 36).³²

Our Constitution provides for the rights of every individual in South Africa but extra, special provision is made for children in terms of s 28 of the Constitution. Children are provided with special protection because they are seen as vulnerable groups of society given that generally children are solely dependent on parents and are also still developing. It is for this reason that extra legislation has been put in place in order to protect children.³³ In the case of *Bhe*³⁴ at par 52, Langa J stated that not only do the rights expressly mentioned in s 28 extend to children but also all the other rights in the Constitution. Although s 28 mentions specific rights that pertain to children, the right to equality, dignity, bodily and psychological integrity and the right to individual autonomy extend to children as well. It is important to note that in terms of s28(2) of the Constitution, the best interests of the child should always be of paramount importance in every decision taken that relates to the child. In addition to the rights provided for in s 28 of the Constitution, the Children’s Act³⁵ sets out specifically the law relating to children.

²⁹ D J McQuoid-Mason (note 10 above; 35).

³⁰ *Teddy Bear Clinic for Abused Children and another v Minister of Justice and Constitutional Development and another (Justice Alliance of South Africa and others as amici curiae) 2013 (12) BCLR 1429 (CC)* at para 41.

³¹ Health Professions Council of South Africa *Guidelines on Ethical Rules* available at <http://www.hpcs.co.za/conduct/Ethics>, accessed on April 14 2016.

³² D J McQuoid-Mason (note 10 above; 35).

³³ RB Bernard & MC Buthelezi ‘A critical reflection on the South African law of the child’ (2014) 35(2) *Obiter* 345.

³⁴ *Bhe v Magistrate, Khayelitsha (Commission for Gender Equality as Amicus Curiae); Shibi v Sithole; South African Human Rights Commission v President of South Africa 2005 (1) SA 580 (CC)*.

³⁵ Children’s Act 38 of 2005.

Children's rights can be categorised into 2 separate categories, both of which require consideration in order to decide whether particular decisions can be made by minors. Boezaart suggests that the first theme relates to protection of children given that children are completely dependent on others in most instances because they are considered to lack capacity; the second theme relates to autonomy of children and what that entails.³⁶ It is therefore necessary to decide how far the need for protection of children extends and where their right to autonomy begins. This chapter will analyse these themes in order to show that a terminally ill mature minor should have a right to decide to die and that such over protection of such children does more harm than good in the context of euthanasia.

In line with the first of the abovementioned themes, many rights are limited in respect of children such as the right to vote. The reason for this is that it is considered to be a decision that requires a degree of maturity that perhaps a minor does not have or it is considered that a minor cannot make an educated decision such as that. The legislature had to draw certain lines in respect of specific decisions and actions in many cases, whether a child is competent or not cannot be decided on a case by case basis simply because there are too many children to decide upon. For instance, for a court or other authority to decide if every minor was competent to enter into a contract or not is impossible. This rationale is different when applied in respect of children making end of life decisions, however. The number of children with terminal diseases who may want to make use of euthanasia is surely not large and so it could be potentially decided on a case by case basis whether or not a child is sufficiently mature to make an end of life decision or not, just as it is possible to establish whether a child is sufficiently mature to consent to medical treatment or surgery.³⁷

There is increasing support for the view that children's rights should be considered equal to adult's rights and that it is only when there is a good reason to do so that a child's right should be limited. In the case of *S v M*,³⁸ the majority stated that children should be seen as individual rights bearers and not merely extensions of their parents. Furthermore, children should not be seen merely as dependents but rather as equal bearers of rights.³⁹ If a right has been limited, it is then necessary to consider whether limiting the right is in order to protect the child or because of their lack of development at that age.⁴⁰ Whether there is a legitimate reason for limiting the child's right is determined according to whether the limitation is reasonable and justifiable in an open and democratic

³⁶ T Boezaart *Child Law in South Africa* (2009) 275.

³⁷ S 129 Children's Act 38 of 2005.

³⁸ *S v M* 2008 (3) SA 232 (CC).

³⁹ A Moyo 'Child participation under South African law: Beyond the convention on the rights of the child' (2005) 31(1) *South African Journal on Human Rights* 174.

⁴⁰ *Teddy Bear Clinic for Abused Children and another v Minister of Justice and Constitutional Development and another* (Justice Alliance of South Africa and others as amici curiae) 2013 (12) BCLR 1429 (CC) at para 39.

society.⁴¹ In respect of the rights at stake in relation to prohibiting euthanasia for mature minors, it can indeed be argued that limitation of such rights is not justified in an open and democratic society and that, should legislation in respect of euthanasia be promulgated, children should be afforded the same rights as adults as they are considered to be equal rights bearers.

3.4 International legal framework protecting children's rights

South Africa is party to certain international conventions aimed at protecting and enhancing the rights of children. These include the United Nations Convention on the Rights of the Child, the African Charter on Human and People's Rights and the African Charter on the Rights and Welfare of the Child. South Africa has ratified these conventions in order to show its commitment for human rights and specifically the protection of children's rights.⁴²

Besides our own Constitution providing that the best interests of the child are always of paramount importance, Article 20 of the African Charter on the Rights and Welfare of the Child⁴³ also provides that the best interests of the child should always be taken into consideration and that the parents are responsible for ensuring this. In addition, the state has a responsibility to support and assist parents in their task.⁴⁴ This can be interpreted as a responsibility on the state to implement legislation which promotes the best interests of the child because this would be a step that assists and supports parents in doing the same. If it can be shown that legislation allowing for children to make use of euthanasia is in fact in the best interests of the child, then it would ostensibly be the responsibility of the state to implement such legislation. The best interests of the child will be discussed in greater depth in the following chapter.

Article 12 of the United Nations Convention on the Rights of the Child provides that: ‘

⁴¹ *Teddy Bear Clinic for Abused Children and another supra* at para 39

⁴² C Nicholson and A Politis ‘Life and death lottery: Tipping the scales in favour of the child's best interests’ (2001) 34 *De Jure* 594.

⁴³ Organization of African Unity (OAU), *African Charter on the Rights and Welfare of the Child*, 11 July 1990, CAB/LEG/24.9/49 (1990), available at <http://www.refworld.org/docid/3ae6b38c18.html>, accessed 24 September 2016.

⁴⁴ C Nicholson (note 42 above; 594).

'Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child. The views of the child being given due weight in accordance with the age and maturity of the child.'⁴⁵

The Convention also provides that a child should have access to the 'best available standards of healthcare,' the right to information, the right not to be subjected to cruel inhuman or degrading treatment and also the right to privacy.⁴⁶ These rights will be discussed in greater detail below so as to show that refusing to allow terminally ill children to make use of euthanasia is in fact an unjustifiable infringement on these rights.

The Declaration of Human Rights in Article 1 also provides that children must be recognised as human beings with rights like any other and specifically entitled to the rights of freedom, equality and dignity which are the most fundamental of human rights.⁴⁷ This means that in a health care environment, practitioners are expected to treat children in the same manner as adults, providing them with equal respect for dignity and life which could also include allowing a terminally ill mature minor to request euthanasia.⁴⁸

3.5 Analysis of rights

Below each of the rights pertaining to the request for euthanasia will be discussed in detail in order to ascertain whether such rights are being unjustifiably infringed if euthanasia is not permitted for mature minors who are competent to make such a decision. As can be seen below, by prohibiting voluntary active euthanasia, certain rights are being unjustifiably infringed and prohibiting voluntary active euthanasia for terminally ill mature minors actually does more harm than good by compelling such a child to continue to suffer until they die naturally.

⁴⁵ Convention on the Rights of the Child adopted by the General Assembly of the United Nations on 20 November 1989; Article 12.

⁴⁶ MDL Levy et al 'Informed consent/assent in children. Statement of the Ethics Working Group of the Confederation of European Specialists in Paediatrics (CESP)' (2003) 169(2) *European Journal of Pediatrics* 630.

⁴⁷ Ibid.

⁴⁸ Ibid.

3.5.1 Dignity

Section 1 of the Constitution provides the following:

“the Republic of South Africa is one, sovereign, democratic State founded on the following values: (a) *Human dignity*, the achievement of equality and their advancement of human rights and freedoms.”⁴⁹

Not only is the right to dignity mentioned in s 1 of the Constitution but is further emphasised in s 7:

“(1) This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom. (2) The State must respect, protect, promote and fulfil the rights in the Bill of Rights.”⁵⁰

Section 10 of the Constitution provides directly that every person has the right to dignity.⁵¹ This is an inherent right that attaches to all people simply because they are human and thus extends to both adults and children alike. The right to dignity is a right which is fundamental in the interpretation of all other rights in the Constitution.⁵² In the case of *S v Makwanyane*, O’Regan J stated that the right to life is substantially diminished without the right to dignity and that the right to dignity corresponds with an acknowledgement of human worth.⁵³ The right to dignity is fundamental to our legal system and is a cornerstone of the Constitution.⁵⁴ It is not a right that should ever be limited, as it is a right which ‘requires us to acknowledge the value and worth of all individuals as members of society.’⁵⁵ A minor child, simply because he/she is a human, should be afforded the right to dignity. The right to dignity also applies in respect of death and it is provided for in the HPCSA guidelines that the process of dying should be a dignified one.⁵⁶

⁴⁹ S 1, Constitution of the Republic of South Africa, 1996.

⁵⁰ S 7, Constitution of the Republic of South Africa, 1996.

⁵¹ S 10, Constitution of the Republic of South Africa, 1996: ‘Everyone has inherent dignity and the right to have their dignity respected and protected’

⁵² See D J McQuoid-Mason (note 10 above; 36); *Advance Mining Hydraulics (Pty) Ltd v Botes NO 2000 (1) SA 815 TPD* at 823; G Van der Walt & EK Du Plessis “‘I don’t know how I want to go but I do know that I want to be the one who decides’-the right to die-the high court of South Africa rules in Robert James Stransham-Ford and Minister of Justice and Correctional Services; The Minister of Health Professional Council of South Africa and the National Director of Public Prosecution (3 June 2015): cases’ 2016 36(3) *Obiter* 808.

⁵³ *S v Makwanyane 1995 6 BCLR 665 (CC)* at para 327 – 328.

⁵⁴ S 1, Constitution of the Republic of South Africa, 1996

⁵⁵ *National Coalition for Gay and Lesbian Equality v Minister of Justice 1999 (1) SA 6 (CC)* at 29

⁵⁶ Health Professions Council of South Africa Booklet 12: *Guidelines for the Withholding and Withdrawing of Treatment* (2008) available at <http://www.hpcs.co.za/conduct/Ethics>, accessed on April 14 2016.

Fundamental to the right to dignity is the right to decide what happens to one's body – For instance, whether one wishes to refuse or consent to treatment.⁵⁷ This means that should a person decide that their life is no longer worthwhile and they wish to end their pain and suffering, such a decision should be respected, and to do so would be to uphold the person's right to dignity.⁵⁸

The right to dignity could also be seen, to an extent, as a subjective right.⁵⁹ This means that a person can decide himself/herself what he/she considers to be a dignified life and what is not. If a terminally ill patient considers his/her life to be an undignified one, then their subjective right to dignity is being infringed. It is often suggested that children often will not regard the right to dignity in the same manner as an adult. However, mature minors and surely even younger children would regard certain ways of living as being an undignified existence. For instance, a child who cannot use the toilet or wash herself but has to be helped with everything would surely consider that to be an undignified existence. In such an instance, the child in question should have the opportunity to make use of euthanasia, provided of course that all the other requirements are met.⁶⁰ Terminally ill patients often argue that suffering until death cannot be considered a dignified way of life. The right to dignity means that a person should be permitted to make the decision to die in a manner that they consider to be dignified as opposed to having to suffer. What it is essential to understand is that the option of requesting euthanasia should merely be offered to children who are sufficiently competent to make such a decision. This does not mean that every child that is terminally ill should be euthanized.

The court in the case of *Stransham-Ford*⁶¹ considered the right to dignity in some depth and it was decided that the life that the applicant was living at the time, that is, suffering in his final stages of cancer, could not be considered a dignified existence. In considering the quality of life that a terminal patient endures in their final months before death, Fabricius J concluded that there was no dignity in a life lived in severe pain, being constantly medicated and being unaware of one's surroundings and loved ones, being confused and also not being able to take care of one's own hygiene.⁶² Furthermore, the court considered that in many cases, a terminal patient lives the last part of their life in a hospice

⁵⁷ C Ngwenya 'Health-care decision making and the competent minor: the limits of self-determination' (1996) *Acta Juridica* 146.

⁵⁸ A Dhai 'An introduction to informed consent: ethico-legal requirements' (2008) 63(1) *SADJ: Journal of the South African Dental Association* 018

⁵⁹ In the case of *S v M (Centre for Child Law as Amicus Curiae)* 2008 (3) SA 232 (CC), the Constitutional Court stated that '[e]very child has his or her own dignity' at para 18.

⁶⁰ See chapter 5 for the types of requirements that are provided for in foreign legislation.

⁶¹ *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 4 (GP); see also discussion in N Manyathi-Jele 'Judge's ruling in assisted suicide case divides South Africa: news' (2015) 553 *De Rebus* 4-5.

⁶² *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 4 (GP) at para 10.

or hospital, away from home and often all alone. Such a patient may die without even being aware of their loved ones saying goodbye because of being in a dissociative state as a result of a combination of their medication and disease. Ultimately the court, having considered the type of life such a patient is forced to endure, decided in favour of the applicant on the basis that there was no dignity in continuing to live such a life. A mature minor suffering from a similar terminal illness to the applicant in that case, could also easily argue that their right to dignity is being unjustifiably infringed and that they should be given the option to request death.

In the case of *Baxter*,⁶³ the judge in arriving at the decision that prohibiting physician assisted suicide was an unjustifiable infringement on a terminally ill patient's rights, pointed out that if a terminally ill patient is not able to acquire assistance from their physician to end their life, then they may have to resort to other undignified means to end their suffering.⁶⁴ This would mean, for instance, hanging oneself. Such measures are an even greater violation of a person's right to dignity and cause unnecessary suffering to both the patient and their family.⁶⁵

A child who is suffering from severe pain and is told that he/she has no prospect of recovery might also see suicide as a way out. The issue becomes even more complex in respect of children because children are often far less likely to be able to acquire the means to carry out a full proof method of committing suicide. This means a child may be more likely to fail in a suicide attempt because he may not have sufficient knowledge or resources to accomplish a successful suicide. This will often result in an even more painful existence for a child who may be further injured by the failed attempt, whereas an option to make use of euthanasia would mean that such a child could die a dignified death. Furthermore, a minor is usually solely dependent on his/her parents. This means that in most instances, a minor is not even capable of acquiring the means to commit suicide. An adult, on the other hand, even if he/she cannot make use of euthanasia, is generally capable of acquiring the means to end their suffering by committing suicide. This essentially means that children are forced to suffer with no alternative, whereas adults are in a much better position to be able to end their suffering. In considering this, it is even more necessary that death with dignity legislation should be considered in respect of children, perhaps even more so than adults for the abovementioned reason. Legislation allowing for euthanasia will mean that the decision to die can be regulated by medical practitioners instead of patients having to resort to "more drastic, painful and inhumane ways of ending [their] suffering."⁶⁶

⁶³ *Baxter v Montana* [2009] MT 449

⁶⁴ *Baxter v Montana* [2009] MT 449 at 19

⁶⁵ *Baxter v Montana* [2009] MT 449 at 19

⁶⁶ S Bhamjee 'Is the right to die with dignity constitutionally guaranteed? *Baxter v Montana* and other developments in patient autonomy and physician assisted suicide' (2010) 31 (2) *Obiter* 350.

The question of the right to dignity specifically in respect of children was considered in the *Teddy Bear Clinic*⁶⁷ case. In that case the court looked at s 15 and s 16 of the Sexual Offences Act.⁶⁸ Section 15 provided that any person who engaged in sexual intercourse with a child would be guilty of an offence, even if there was consent and both parties were children. The legislation essentially criminalized all sexual acts between adolescents (12 – 15 year olds). Section 16(1) of the Act provided that any person who committed an act of sexual violation against a child and even if the child consented to the act, shall be guilty of the offence of sexual violation. S 16(2) provided that both parties to the act must be charged with contravention of s 16(1) of the Act.

The Constitutional Court held that both s 15 and s 16 of the Act were invalid as they violated the rights of adolescents – namely their right to dignity and privacy – and to do so was not in the best interests of the child. The court stated that children enjoy all the fundamental rights in the Constitution, although some of the rights listed, for instance the right to vote, is only applicable to adults. Although some rights are limited in respect of children, the court held that there should be no limitation on the right to dignity and privacy in respect of children.⁶⁹

The court in that case places specific emphasis on a child’s right to dignity and privacy, stating that those rights are of fundamental importance and should not be limited. In respect of the right to dignity, the court considered legislation prohibiting sexual activity between 2 consenting adolescents to be an unjustifiable infringement on their right to dignity. The decision to have sex is a very personal one and obviously not one which the court considered should be readily encroached on by the state. Restricting the decision to end one’s suffering if a person is terminally ill could also be considered an encroachment on a very personal aspect of a minor’s life and not something that should be prohibited by the state. In taking this argument further and applying the reasoning in the *Teddy Bear* case, it could further be argued that to prohibit voluntary active euthanasia for mature minors would also be an unjustifiable violation of their right to dignity. Of course, the decision to die should be regulated by legislation to minimise abuse, but complete prohibition of the practice would be a violation of a terminally ill minor’s right to dignity.

3.5.2 The right to life

The right to life and the right to dignity are intertwined and cannot be easily separated. The right to life is more than just a right to mere ‘existence’ and it is suggested that the Constitution, although it

⁶⁷*Teddy Bear Clinic for Abused Children and another v Minister of Justice and Constitutional Development and another (Justice Alliance of South Africa and others as amici curiae) 2013 (12) BCLR 1429 (CC).*

⁶⁸ Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007

⁶⁹ *Teddy Bear Clinic for Abused Children and another supra* at para 38.

protects the right to life, it does not protect the ‘right to an existence that undermines a person’s right to dignity.’⁷⁰ The following was stated in the *Makwanyane*⁷¹ case:

“The right to life, thus understood, incorporates the right to dignity. So the rights to human dignity and life are entwined. The right to life is more than existence it is the right to be treated as a human being with dignity: without dignity, human life is substantially diminished.”

This means that if one is not living a dignified existence, one’s right to life is also being infringed upon. In order to fulfil the right to life, given that it is interlinked with the right to dignity, the quality of life lived also needs to be assessed. A person who has a poor quality of life and undignified existence also, essentially, can argue that their right to life is being infringed upon as well. As was stated in the *Stransham-Ford*⁷² case, the right to life ‘cannot mean that an individual is obliged to live, no matter what the quality of his life is.’⁷³ To suggest that the life must be preserved at all costs would be to misunderstand the right altogether. A mature minor who is suffering from a terminal illness will usually have a poor quality of life as their death nears. This means that their life is reduced to ‘mere existence’ and an existence which is undignified given that many people who suffer in their final stages of life are unable to wash themselves, complete basic tasks, are often highly medicated and unable to recognise family members and are suffering immense pain. This warrants the need for an option to end such a life if the patient so decides and in so doing, legislation will provide a person with the ability to end their life with dignity instead of preserving life at all costs.

Those opposed to euthanasia argue that life is sacred and should not be interfered with. This idea stems from the religious/spiritual belief that life is sacred and that it is only God that can decide when it ends. This suggests that the state should not be able to allow for a person to request death because it would interfere with the sanctity of life doctrine. However, Dworkin argues that a life of indignity may actually be more of a violation of the sanctity of life than ending that life.⁷⁴

⁷⁰ D J McQuoid-Mason (note 10 above; 35); principle articulated in the cases of *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 4 (GP) and *S v Makwanyane* 1995 6 BCLR 665 (CC).

⁷¹ *S v Makwanyane* 1995 6 BCLR 665 (CC).

⁷² *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 4 (GP).

⁷³ *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 4 (GP) at para 42.

⁷⁴ S Chesterman ‘Last Rights: Euthanasia, the sanctity of life, and the law in the Netherlands and the Northern Territory of Australia’ (1998) 47 *International & Comparative Law Quarterly* 366.

In considering the concept of quality of life, it is determined by whether or not a person's life is worthwhile to some extent in order to be meaningful.⁷⁵ It is argued that if one is suffering from a terminal illness, it is often the case that one no longer has any quality of life which translates to a meaningless existence. Philosophers such as Glover and Harris submit that it is necessary to consider what quality of life a person has when considering end of life decisions – it is the person's ability to have a pleasurable existence that denotes value or quality of life.⁷⁶ The quality of a person's life is also subjective and is determined subjectively, just as a person's belief that their dignity is being infringed upon can also be considered to be a subjective judgment.⁷⁷ This essentially means that a person should be able to make their own decision that their life is no longer worth living. If a person is suffering in constant pain, such an existence cannot be considered to be a pleasurable one. By extension, this then means that such a person has no quality of life either. In such a case, provided a person is sufficiently competent to make such a decision, that person should be permitted to request death.

One of the main aspects of the right to life is the right to be free from interferences that threaten life.⁷⁸ Every person has a right to act and make choices and the act of a person does not necessarily have to be to their benefit and it does not matter if other people think that the act in question is not for the actor's good.⁷⁹ In this sense, it is immaterial if other people think that a person should not continue living because he has a poor quality of life. Ultimately it is the choice of the man and if he wishes to continue living, no other person can interfere with his right to do so.⁸⁰

Although many people consider life to be sacred and it is often argued from a philosophical point of view that life is always preferable to death even if one is suffering, this should be a decision made by the individual himself. Bearing in mind that euthanasia is for the benefit of the individual, in some circumstances, a person is suffering a greater evil being alive than dead as in some situations life is so unbearable that it is better for the person to be dead.⁸¹ It is suggested that certain "minimum basic goods" that are supposedly required for a good life are: not being worked beyond one's capacity,

⁷⁵ L Jordaan 'The legal validity of an advance refusal of medical treatment in South African law (part 1)' 2011 44(1) *De Jure* 46; As opposed to believing that life is not inherently a good as is suggested by Herring in terms of the "sanctity of life" principle.

⁷⁶ M Stauch et al *Text, Cases & Materials on Medical Law* 3 ed (2006) 633.

⁷⁷ L Jordaan (note 75 above; 45-46).

⁷⁸ P Foot 'Euthanasia' (1977) 6(2) *Philosophy and Public Affairs* 99.

⁷⁹ P Foot (note 78 above; 100).

⁸⁰ *Ibid.*

⁸¹ P Foot (note 78 above; 88).

having the support of family or community, is more or less able to feed oneself, one has hopes for the future, one has a place to lie down and rest at night.⁸² If a person is in extreme pain, struggles to eat without being nauseous and has no friends or family near, it could be argued that that person does not have an ordinary human life in the sense discussed above.⁸³ In such a case the person should therefore be permitted to make the decision to end their life in a dignified manner.

It is argued that if a person expresses his wish to be euthanized, in killing him, his right to life is not infringed. A person should be able to waive his right to life or to remove the duty of non-interference from others; hence another can end his life without reprehension. It can be argued that permission given by a person is sufficient to remove the duty of non-interference from other people.⁸⁴ This means that a minor, too, can decide to waive their right to life if they are suffering from a terminal disease that has rendered their quality of life poor and their existence meaningless.

3.5.3 The right to bodily integrity

S 12(2) of the Constitution provides the following:

‘Everyone has the right to bodily and psychological integrity, which includes the right -

(a) to make decisions concerning reproduction;

(b) to security in and control over their body

(c) not to be subjected to medical or scientific experiments without their informed consent.’

This right means everyone has control over their own body and what is done with it and supposes that a person is in the best position to make decision about their own body and that such decision making should not be interfered with as far as possible.⁸⁵ This means that even if it is the opinion of others that your decision in respect of your body is not in your best interest, they are in no position to intervene.⁸⁶

⁸² P Foot (note 78 above; 95-96).

⁸³ Ibid.

⁸⁴ P Foot (note 78 above; 105).

⁸⁵In *Ferreira v Levin and Others* 1996 (1) SA 984 (CC) at para 251 the court held that the state should not interfere with a person’s choices in respect of their own body but must create conditions in which such choices may be made; see also E Du Plessis et al ‘The constitutional rights of children to bodily integrity and autonomy’ 2014 35(1) *Obiter* 4.

⁸⁶ E Du Plessis et al ‘The constitutional rights of children to bodily integrity and autonomy’ 2014 35(1) *Obiter* 4.

This right is often cited in respect of health care and the medical environment and is strongly linked to the right to autonomy. This right allows a person to refuse medical treatment if they wish to do so. In terms of the common law, a person who has the legal capacity to make decisions can decide to refuse treatment, even if such treatment is life-sustaining.⁸⁷ The right to refuse treatment comes from the right to self-determination which encompasses the right to bodily integrity in terms of s 12 of the Constitution and is also linked to the doctrine of consent which acknowledges a person's right to autonomy and to make decisions that affect them.⁸⁸ The South African Guidelines for Good Practice in the Health Care Professions provides that a physician must respect a patient's right to self-determination.⁸⁹ Of course the right to autonomy in respect of children is slightly different because it is acknowledged that a child's right to autonomy may be limited to an extent in order to protect them from making decision which they do not fully understand.

S 12(1) is also a noteworthy section. It provides that 'Everyone has the right to freedom and security of the person which includes the right - (e) not to be treated or punished in a cruel, inhuman or degrading way.' It is often argued that to prevent a person from making use of euthanasia or physician assisted suicide is essentially a means of treating them in a cruel, inhuman and degrading way because it is forcing them to suffer and to endure a life where, for instance, they cannot take care of their own personal hygiene and this can definitely be considered degrading. Rachels argues that there are instances where it may be "more humane," albeit morally reprehensible, to kill a person than to allow him to die slowly.⁹⁰

Euthanasia offers patients a humane way out of suffering instead of forcing a person to continue to suffer until they die naturally.⁹¹ As was considered by the judge in the *Stransham-Ford* case,⁹² humans consider it humane to euthanize animals that are suffering as provided for in s 2(1)(e) of the Animals Protection Act 71 of 1962 read with ss 5(1) and 8(1)(d).⁹³ It is actually considered to be cruel to allow an animal to suffer if it is diseased, severely injured or in a condition such that to keep it alive would cause it unnecessary suffering. Not only is keeping such an animal alive considered to be cruel,

⁸⁷ L Jordaan (note 75 above; 35).

⁸⁸ *Castell v Greef 1994 4 SA 408 (C)* at 420J and 422H-J.

⁸⁹ Regulation 2.3.5 of the South African Guidelines for Good Practice in the Health Care Professions.

⁹⁰ P Foot (note 78 above; 103).

⁹¹ S Bhamjee 'Is the right to die with dignity constitutionally guaranteed? Baxter v Montana and other developments in patient autonomy and physician assisted suicide' (2010) 31 (2) *Obiter* 352.

⁹² *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 4 (GP)*.

⁹³ *Stransham-Ford supra* at para 27

it is also a crime.⁹⁴ Why this thinking is not translated to humans can be considered nonsensical. If it is considered cruel to allow an animal to continue to suffer, surely it is cruel to allow a human to do the same. People can make their own decisions and a decision to request euthanasia would need to be a voluntary one.⁹⁵ Furthermore, the decision would need to be one which is made by a competent and sufficiently mature individual. Subjecting a person to suffering with no alternative can surely be considered inhumane and degrading treatment which could even be thought to be akin to torture.

3.5.4 The right to privacy

The right to privacy is also closely linked to the right to dignity and autonomy in that it entails a right to make decisions about one's body without state interference.⁹⁶ The *Bernstein* case defined the right to privacy as the "inner sanctum of personhood" which includes "family life, sexual preference and home environment, which is shielded from erosion by conflicting rights of the community."⁹⁷ In the *National Coalition* case, the court stated that the right to privacy includes the right to 'a sphere of private intimacy and autonomy.'⁹⁸

In applying the abovementioned definitions of privacy, the court in the *Teddy Bear case*⁹⁹ held that for the state to interfere with adolescent's private sexual relationships was an intrusion into a "deeply personal sphere" of their lives¹⁰⁰ which was impermissible. It was stated that "Privacy fosters human dignity insofar as it is premised on, and protects, an individual's entitlement to a sphere of private intimacy and autonomy."¹⁰¹ This decision relates specifically to adolescents and the principles can therefore be applied in respect of mature minors' decision to be euthanized. Such a decision can also similarly be considered to be a decision that falls within a deeply private sphere of a child's life.

⁹⁴ *Stransham-Ford supra* at para 27

⁹⁵ Involuntary euthanasia falls outside the scope of this dissertation.

⁹⁶ L Jordaan (note 75 above; 43).

⁹⁷ *Bernstein and others v Bester and others* NNO 1996 (4) BCLR 449 at para 67 as referred to in *Teddy Bear Clinic for Abused Children and another v Minister of Justice and Constitutional Development and another (Justice Alliance of South Africa and others as amici curiae)* 2013 (12) BCLR 1429 (CC) at para 59.

⁹⁸ *National Coalition for Gay and Lesbian Equality and another v Minister of Justice and others [1998] ZACC 1 5; 1999 (1) SA 6 (CC)* at para 32; referred to in *Teddy Bear Clinic for Abused Children and another v Minister of Justice and Constitutional Development and another (Justice Alliance of South Africa and others as amici curiae)* 2013 (12) BCLR 1429 (CC) at para 59.

⁹⁹ *Teddy Bear Clinic for Abused Children and another supra*.

¹⁰⁰ *Teddy Bear Clinic for Abused Children and another supra* at para 60.

¹⁰¹ *Teddy Bear Clinic for Abused Children and another supra* at para 64.

In respect of end of life decision making, it could similarly be argued that for the state to prevent a mature adolescent from making a decision to die would be an unjustifiable infringement on his/her right to privacy. A decision to die is one of the most personal and private decisions a person can make and it can be argued that such a decision should be permissible provided certain safeguards are in place but that, given the right to privacy is also so closely linked to the right to dignity, that the state, by prohibiting a child from making an end of life decision, is forcing such a child to endure unbearable suffering until natural death and this is interfering with a deeply personal sphere of their life.

3.5.5 The right to equality

As was discussed in the previous chapter, passive euthanasia is permissible in terms of the common law yet voluntary active euthanasia is not. This means that if a person is suffering from a terminal illness and is on life sustaining machines or treatment may request that the machines be removed or the treatment be ceased and will then die a relatively quick death. However, another person who is suffering from a terminal illness but who is not on life sustaining machines, cannot end their life in any way because active euthanasia is not permissible, unless they commit suicide.¹⁰² It is argued that this could in fact constitute an unjustifiable infringement on the right to equality and would amount to unfair discrimination. In the American case of *Quill v Vacco*,¹⁰³ the court stated that the New York law¹⁰⁴ does not treat terminally ill patients equally in that

“those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.”¹⁰⁵

¹⁰² Once again, the argument is that a person should be allowed to die with dignity. Most suicides are violent and unpleasant for family members who discover the body. Furthermore, a person who is terminally ill but is physically incapable of committing suicide would then be unable to end her life, even though a terminally ill patient who is able bodied would be able to. In addition, a child is usually in an even weaker position given that they are generally solely reliant on their parents. Most children are unable to acquire the means to commit suicide even if they wanted to and so must continue to suffer with no other option. Suicide is not a viable ‘way out’ of life. A person needs to be able to approach a doctor who can then assist them to die in a dignified manner.

¹⁰³ *Quill v Vacco* 521 US 793 (1997) at 801.

¹⁰⁴ This principle is the same in respect of South African law and could also therefore be seen as discrimination given that a patient on life support is able to end their life prematurely whereas another terminally ill patient not on life support cannot approach a doctor for assistance in hastening death.

¹⁰⁵ *Quill v Vacco supra* at 729.

In terms of the discrimination enquiry, if the discrimination is not based on a ground listed in section 9 of the Constitution, then discrimination may still occur if it is on an analogous ground: it is 'based on attributes or characteristics which have the potential to impair the fundamental dignity of persons as human beings, or to affect them seriously in a comparably serious manner.'¹⁰⁶ Further, it is considered to be an infringement of a person's right to equality if they are treated as 'less deserving of respect' or their fundamental human dignity is undermined.¹⁰⁷ It can be argued that for the law to allow for passive euthanasia to take place in respect of a terminally ill patient who is on life sustaining treatment but to not extend a similar right to die in the form of voluntary active euthanasia to another terminally ill patient, can be seen as an impairment of their right to dignity in a serious manner (See 3.5.1. of this chapter). Following from this, to disallow voluntary active euthanasia can be seen as an unjustifiable infringement on a person's right to equality.

Even though it might be established that there is unequal treatment of people, it is further necessary to decide whether this unequal treatment is rationally connected to a legitimate interest of the state.¹⁰⁸ In the case of *Cuzan* the court considered that perhaps the state's interest is less when 'the potential for life diminishes.'¹⁰⁹ Surely this would mean that the state has less of an interest in sustaining life where it will end soon anyway. If this is the case, then there should be no prohibition of euthanasia but rather legislation allowing individuals to request euthanasia in a regulated manner. In the case of *Quill v Vacco*, the court concluded that in fact the law prohibiting a physician from prescribing lethal medication for a terminally ill patient to take is not rationally connected to a legitimate state interest.¹¹⁰ This reasoning could also be applied in South Africa where it can be argued that the prohibition of voluntary active euthanasia merely interferes with a very private decision of a terminally ill patient and is not rationally connected to a legitimate government interest. This means that it can be considered to be an unjustifiable infringement on the right to equality.

It can also be argued that children are faced with discrimination on the basis of age in respect of legislation in other jurisdictions that permit some form of euthanasia but only for people over the age of 18. The South African Constitution specifically states in s 9 that no person may be discriminated against on the basis of age. The fact that there is also no legislation currently allowing minors to request euthanasia means that the only way a child would possibly be able to make such an end of life

¹⁰⁶ *Harksen v Lane NO 1998 (1) SA 300 (CC)* at 29.

¹⁰⁷ I Currie & J De Waal *The Bill of Rights Handbook 6th ed* (2013) 223.

¹⁰⁸ Krause 'Going gently into that good night: The constitutionality of consent in cases of euthanasia' (2012) 33(1) *Obiter* 60.

¹⁰⁹ *Cruzan v Director, Missouri Health 497 US 261, 110 S Ct 284, 111 L Ed 2d 224 (1990) 730*; discussed in S Krause 'Going gently into that good night: The constitutionality of consent in cases of euthanasia' (2012) 33(1) *Obiter* 60.

¹¹⁰ *Quill v Vacco supra* at 731

decision would be to approach a court as was done by Mr Stransham-Ford.¹¹¹ This would require a child to have assistance and financial support. This makes court generally not practically accessible for most children and for a child who is further suffering from a terminal illness, this task is near impossible. It is submitted that in the case of euthanasia, the limitation of a child's autonomy (See 3.5.3 above) in respect of end of life decisions is not justifiable as it merely dictates for how long a child must suffer instead of allowing that child to die with dignity.

3.5.6 The right to healthcare

In order to establish the meaning of health care, it is first necessary to define health. It is difficult to define health exactly but many definitions in law tend to indicate that health is more than a mere absence of disease but also includes a sense of well-being. The World Health Organisation defines health as a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'¹¹² This is a broader social model rather than treating the body as a machine which malfunctions when ill.¹¹³

The Universal Declaration of Human Rights (UDHR) states that 'everyone has the right to a standard of living adequate for the health *and well-being* of himself and his family, including food, clothing, housing and medical care and necessary social services.'¹¹⁴

It is suggested that health is 'a dynamic state of wellbeing characterised by physical, mental and social potential, which satisfies the demands of a life commensurate with age, culture, and personal responsibility.'¹¹⁵ A person who does not experience wellbeing can be treated either biologically or an improvement of the 'potential' is required. Alternatively, it is often necessary to merely adapt or adjust the demands on a person.¹¹⁶

The above tend to show that health includes more than merely the absence of sickness or disease. The use of the word wellbeing tends to indicate something more – a degree of happiness. LW Sumner's authentic happiness theory, for instance, suggests that wellbeing entails authentic happiness wherein a

¹¹¹ *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 4 (GP)*.

¹¹² World Health Organisation, *The Constitution* (Geneva: WHO, 1948).

¹¹³ J Montgomery *Health Care Law* 2ed (2003) 24-25.

¹¹⁴ The Universal Declaration of Human Rights (UDHR) 1948 General Assembly resolution 217(III) A

¹¹⁵ J Bircher 'Towards a dynamic definition of health and disease' (2005) 8(3) *Medicine, Health Care and Philosophy* 335.

¹¹⁶ *Ibid.*

person is informed about the conditions of their life and they are also able to maintain autonomy instead of being oppressed or manipulated by society.¹¹⁷

The degree of satisfaction that a person has with his/her life is also used as a measure of the wellbeing of an individual.¹¹⁸ There are many aspects to the concept of wellbeing but many authors indicate that autonomy, a sense of self determination and feeling as if one is living a life of purpose and meaning are all important in achieving wellbeing.¹¹⁹ A substantive theory of wellbeing for instance provides that happiness is a necessary, essential or perhaps even the only element of wellbeing.¹²⁰ The formal theory of wellbeing proposed by Sumner provides that happiness is what makes something good for an individual and therefore happiness is necessary to achieve wellbeing: wellbeing only being achieved when something is good for the individual.¹²¹

It appears that wellbeing, which is essential to general health includes a degree of happiness, self determination and a sense of purpose. A patient suffering from a terminal illness in most cases does not fulfil any of the above criteria for wellbeing. Furthermore, in most cases a patient suffering from a terminal illness does not consider their life to be meaningful nor can they describe their life as a happy one. This means that by forcing such a person to stay alive, that person's wellbeing suffers. Anything that does not promote wellbeing cannot be healthcare. Conversely, it could then be argued that something which ends suffering could in turn be considered a promotion of wellbeing and by extension, a form of healthcare. If this is true, then euthanasia can be considered healthcare.

In the case of *Airedale NHS Trust v Bland*¹²² Lord Keith stated that although there is a general duty on medical practitioners to keep patients alive, that duty does not extend to a situation where 'a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance' of the treatment. Lord Wilkinson stated that doctors are only obliged to sustain life where it is in the best interests of the patient to be kept alive. Health care professionals have an obligation to ensure the welfare of their patients to the greatest extent possible; this is linked

¹¹⁷ D Haybron 'Philosophy and the science of subjective well-being' in M Eid & R Larsen (eds) *The science of Subjective well-being* (2008) 7.

¹¹⁸ Ibid.

¹¹⁹ C Ryff 'Psychological well-being in adult life' (1995) 4(4) *Current Directions in Psychological Science* 99.

¹²⁰ R Rodogno 'Happiness and well-being: Shifting the focus of the current debate' (2014) 33(4) *South African Journal of Philosophy* 434.

¹²¹ Ibid.

¹²² *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 880-83; See also J Montgomery *Health Care Law* 2ed (2003) 462.

to the bioethical principle of beneficence.¹²³ This is also encompassed in s 28(1)(c) of the Constitution which provides that children have the right to basic health care services.

The right to healthcare is centred around the patient's best interests¹²⁴ and if in cases where the patient is incapacitated it is permissible for the doctor to make a decision with regards to withholding treatment because such is in the best interests of the patient then surely a doctor should also act in allowing a terminally ill patient, adult or child, to end their life if it is in their best interests? If a doctor is the provider of healthcare when they withhold treatment in the interests of a patient, is it not then possible to also classify voluntary active euthanasia as healthcare?

The relief of pain and suffering is considered to be healthcare specifically known as palliative care. Palliative care is aimed at reducing a person's suffering but not necessarily to prolong their life. A doctor may administer pain medication to a terminally ill patient knowing that this medication may have the effect of shortening the patient's life. This is known as the doctrine of double effect: the primary motive of the doctor is a good one and this is seen to outweigh the adverse, and known, effect of the medication ie shortening the life of the patient. In the case of *R v Adams*,¹²⁵ the court stated that where a doctor cannot do anything more to improve the health of a patient, he may do what is necessary to relieve pain and suffering of the patient even if what he does 'might incidentally shorten life by hours or even longer.' Some consider forms of palliative care to be a form of euthanasia because the treatments involved often make subsequent death a foreseeable event. Palliative care deals only with physical and not mental pain and is therefore not an option for those who are dependent on life-sustaining machines.¹²⁶

The HPCSA ethical guidelines on withdrawal or withholding of treatment specifically state that if specialised care is ceased, a health care institution is obliged to provide appropriate palliative care.¹²⁷ Similarly, in the Patients' Rights Charter, it provides that palliative care must be provided for patients suffering from an incurable or terminal illness.¹²⁸ If palliative care and the administration of pain

¹²³ Beauchamp TL and Childress JF *Principles of Biomedical Ethics* 3rd ed (1989) 67-386 cited in D J McQuoid-Mason (note 10 above; 36).

¹²⁴ J Montgomery *Health Care Law* 2ed (2003) 463

¹²⁵ *R v Adams* [1957] *Crim. LR* 365; see also J Montgomery *Health Care Law* 2ed (2003) 464.

¹²⁶ R Ogden 'The right to die: A policy proposal for euthanasia and aid in dying,' (1994) 20(1) *Canadian Public Policy/Analyse de Politiques* 12.

¹²⁷ Health Professions Council of South Africa *Guidelines on Ethical Rules, Guideline 9.3 of Booklet 12: Guidelines withholding and withdrawing treatment*, available from <http://www.hpcsa.co.za/conduct/Ethics>, accessed on April 14 2016.

¹²⁸ Department of Health *South African Patients' Rights Charter* 2007 available at www.justice.gov.za/VC/docs/policy/Patient_Rights_Charter.pdf, accessed on 20 August 2016.

medication, even that which shortens life, is considered to be health care, then it should follow that euthanasia is also a form of health care because it is a method of ending pain and is in the best interests of the patient. It could in fact be argued that euthanasia is merely a form of ending a patient's suffering eternally and if every person has the right to healthcare which includes the right to receive medication to relieve pain and suffering, then every terminally ill person also has the right to receive medication to end their life.

If euthanasia can be considered healthcare, this right should also be extended to children. It is true that not all rights are automatically extended to everyone, however, some rights should more readily be extended to children because they are considered to be vulnerable members of society. It could be argued that in the case of a patient suffering from a terminal illness, a child who is utterly desperate to end his/her life because they can no longer cope with the pain and suffering is less able to acquire the means necessary to commit suicide as opposed to an adult in that same situation. This furthers the argument that euthanasia should be permissible for children in such a position instead of condemning them to final months of pain and suffering.

The Constitution provides that reasonable steps should be taken by the state towards progressive realisation of socio-economic rights. It should also be understood that such rights can only be achieved when taking into account the availability of resources. However, as can be seen in the *Grootboom* case,¹²⁹ when socio economic rights of children are involved, there is a greater duty on the state to fulfil those rights because such rights are also stated in s 28 of the Constitution relating specifically to children. Section 28 of the Constitution does not include internal limitations as with other socio-economic rights in the Constitution where it is stated that such rights are subject to availability of resources and that there is only a duty on the state to progressively realise those rights. The rights envisaged in s 28 can therefore be considered to be 'unqualified and immediate' given that there is no internal limitation provided for in this section.¹³⁰ In respect of healthcare, this means that the state has, arguably, a greater duty towards children to make provision for this right, subject only to reasonable and justifiable limitation of which euthanasia cannot be considered one. The reason that there exists a greater protection of rights in respect of children is because children are considered to be a vulnerable group of society and therefore require more protection.

If the argument proffered above that euthanasia can in fact be classified as healthcare holds true, then given the greater protection and provision of rights in respect of children, it can be argued that in fact children have a greater claim to the right to die than adults do. To condemn a child to a life of pain

¹²⁹ *Government of the Republic of South Africa and Others v Grootboom and Others* 2000 (11) BCLR 1169 (CC)

¹³⁰ *Centre for Child Law and vs MEC for Education, Gauteng* 2008 (1) SA 223 (T) at 227I-J; see also Boezaart (note 36 above; 302)

and suffering and to decline them the choice of ending such a life is akin to a deliberate decrease in a child's health and wellbeing and surely such cannot be permissible where the right to healthcare is a right which should promote or protect wellbeing. Death can very often be seen as preferable to suffering and the decline in the welfare of a terminally ill individual who is forced to continue living.

3.6 Conclusion

Children should be seen as equal rights bearers to 11 adults specifically in instances involving the right to dignity which is the right that informs all others and is the cornerstone of our democracy. The right to request euthanasia, or the right to die, is a right which should be afforded to a terminally ill minor provided that he is sufficiently mature and competent to make such a decision. To prohibit voluntary active euthanasia not only infringes a patient's Constitutional rights, as was shown in the case of *Stransham-Ford*,¹³¹ but can also be seen to be contrary to bioethical principles in healthcare. As shown above, euthanasia can in fact be seen as healthcare. Children have a right to healthcare both in respect of s 27 and 28(c) and it can therefore be argued that terminally ill mature minors in fact have a right to euthanasia in terms of the Constitution. The intention of limiting children's rights in many respects is to protect children from making decisions they do not fully understand. Further discussion on maturity and competence will follow the proceeding chapter. In respect of prohibiting voluntary active euthanasia, however, the prohibition is not a justifiable limitation of rights if the terminally ill minor in question is sufficiently competent to make the decision to die.

¹³¹ *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 4 (GP)*.

CHAPTER FOUR: CHILD AUTONOMY

4.1. Introduction

This chapter will consider the legislation in place specific to children in relation to decision making as well as the common law and legislation in respect of a child's right to autonomy. It was established in the previous chapter that the Constitution provides for the right to bodily integrity, privacy, dignity and equality which all relate to children as well. The right to bodily integrity, privacy and dignity are intertwined and are key in determining how far a child's right to autonomy extends. Certain rights are limited in terms of children in order to protect them from decisions they do not have sufficient capacity or maturity to make. The question is then, what about mature minors? It was submitted in the previous chapter that certain rights would be infringed if voluntary active euthanasia was not permitted but this chapter will focus more specifically on a child's right to autonomy in order to show that a terminally ill mature minor's rights are being unjustifiably infringed by the prohibition of voluntary active euthanasia for such a patient.

4.2. Legislation

4.2.1. Children's Act

Section 129 of the Children's Act¹ provides the following:

- (2) A child may consent to his or her own medical treatment or to the medical treatment of his or her child if-
 - (a) the child is over the age of 12 years; and
 - (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.
- (3) A child may consent to the performance of a surgical operation on him or her or his or her child if-
 - (a) the child is over the age of 12 years; and
 - (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and

¹ Children's Act 38 of 2005.

(c) the child is duly assisted by his or her parent or guardian.

The requirements in s 129 acknowledge that age is not a requirement that alone can determine competence; maturity and mental capacity should also be assessed in order to determine whether consent given by a minor is informed consent.² Given that the legislation specifically states that a child over the age of 12 may consent to treatment and to surgery (with the assistance of his/her parent or guardian) provided he/she is sufficiently mature and has the mental capacity to understand the implications of the treatment, it could be argued that such a child could also refuse treatment or a surgical operation if the same criteria are met. This impliedly provides an age at which a child can also refuse medical treatment or a surgical operation.³ Medical treatment as stated in the Act is wide enough to also encompass life sustaining treatment such as chemotherapy and this could also be refused by a child over the age of 12 who is competent to consent to treatment in terms of the Act.⁴ Essentially, if a person has the legal capacity to consent to something, they also have the capacity to refuse it.⁵ There appears to be no logical reason why a higher standard of competence should be required for the refusal of treatment in comparison with consenting to it.⁶ The right to bodily integrity in terms of s 12 of the Constitution means that the South African courts are unlikely to override, at the request of the parents, the decision of a child to refuse life-sustaining medical treatment, provided the child is competent to refuse such treatment.⁷ The National Health Act also provides that a health care provider must explain to a patient that they have the right to refuse treatment and must further explain the implications, risks and obligations of the refusal.⁸ The concept of refusal of treatment or surgery could be extended to passive euthanasia: A child dying of a terminal illness who is on life-sustaining machines could request that the machines be switched off. Jurisprudence on the topic of euthanasia tends to indicate that active and passive euthanasia are morally no different (See chapter 2). The law appears to be anomalous in this regard as refusal of treatment which results in death is permissible. If a child is permitted to refuse treatment in line with the Children's Act, then it could be argued that such a child should also be permitted to request euthanasia.

² D McQuoid-Mason 'Provisions for consent by children to medical treatment and surgical operations, and duties to report child and aged persons abuse: 1 April 2010' (2010) 100(10) *SAMJ* 646.

³ J Devereaux et al 'Can children withhold consent to treatment?' (1993) 306 (1890) *BMJ* 1459.

⁴ E Du Plessis et al 'The constitutional rights of children to bodily integrity and autonomy' 2014 35(1) *Obiter* 14.

⁵ D McQuoid-Mason (note 2 above; 646).

⁶ J Fortin *Children's Rights and the Developing Law* 3 ed (2009) 153.

⁷ D McQuoid-Mason 'The National Health Act and refusal of consent to health services by children' (2006) 96(6) *SAMJ* 531.

⁸ Section 6(1) of the National Health Act No. 61 of 2003.

In respect of consent to medical treatment, it is necessary to ascertain whether a child is sufficiently mature enough to understand the nature of the medical treatment in question. In order to assess maturity, the reasoning ability of the child, the understanding that the child has in regard to the decision to be made as well as the voluntariness of the consent need to be assessed.⁹ The requirement of voluntariness is like any other in law – The consent must be informed and given without coercion of any kind. What is important to consider is the child’s reasoning ability – That is, the ability to reason logically and make a decision – and also the child’s understanding of the decision to be made.¹⁰ Factors such as age, intelligence, cognitive functioning and emotional functioning are to be considered in determining a child’s ability to reason and to make a decision.¹¹ Hence, a child who is very young is often considered to be immature and cannot sufficiently reason, therefore being unable to make a decision in respect of his or her own medical treatment. The factors above are used in an enquiry as to the maturity of a child. The abovementioned factors provide guidance as to how maturity and competence can be assessed in children. In the case of a decision to die, it would be prudent for legislation on the matter to provide for assessment by a psychologist as well as a physician.

Legislators felt that it would be possible for an assessment of maturity and mental capacity of children over the age of 12 to be carried out in order to decide whether such children could consent to medical treatment or medical surgery (if duly assisted by their parent or guardian). If such an assessment is deemed to be possible to carry out in respect of s 129, then it would surely also be possible for a medical practitioner and psychologist to assess the maturity and mental capacity of a terminally ill child who wishes to make use of euthanasia. If legislation were to be promulgated in respect of euthanasia and which allowed for children to make use of the practice, similar wording as is found in the Children’s Act could be used in that legislation. Such would act as a safeguard to ensure that children who are permitted to make use of the legislation are sufficiently mature to understand the implications of their decision. It would give children with sufficient mental capacity the right to exercise autonomy over their own body and also the opportunity of a dignified death rather than discriminating against them merely on the basis of age, regardless of maturity and mental capacity.

There is increasing support amongst authors for an approach that does not apply a rigid age limit, especially in instances when a decision or action is extremely important. There is a great deal of criticism for a system that determines competence strictly according to age, especially in highly

⁹ RB Bernard & MC Buthelezi ‘A critical reflection on the South African law of the child’ (2014) 35(2) *Obiter* 352.

¹⁰ *Ibid.*

¹¹ *Ibid.*

personal matters that arise in the realm of health care.¹² Research has shown that children are often able to make difficult decisions in regard to medical treatment and there are many instances in which a child may exceed adults in intelligence and discretion and so it is merely societal perceptions that dictate the difference between adults and children rather than actual differences in decision making abilities.¹³ It appears little respect is given to a child's right to autonomy even if they have the same mental ability to understand the consequences of decisions yet if they were an adult their right to make an autonomous decision would be treated with importance.¹⁴ There is increasing support for the notion of a 'mature minor' and the legislation of many countries reflects the belief that there are instances where a minor may be sufficiently competent to make their own decision, although a child's competence needs to be decided on a case by case basis.¹⁵ This reasoning supports the view that in a matter as personal and important as the decision to die, a mature minor should not be excluded from legislation merely because of age despite being sufficiently competent to make such a decision.

In addition to s 129 of the Children's Act, s 31 of the Act also provides that in all decisions which affect a child, the child should be consulted in the decision making process, considering the maturity level of that child. Section 10 of the Children's Act also provides that a child of sufficient maturity, age and stage of development must be able to participate in any matter relating to them. This includes matters of health care. The purpose of such legislation is to ensure that parents do not abuse their parental responsibility rights.¹⁶ It is also necessary to acknowledge that children, if they are of sufficient maturity, should be able to make their own decisions, perhaps with the guidance of their parents. The law should not remove a child's autonomy entirely from them. The United Nations Convention on the Rights of the Child¹⁷ also provides in article 12 that a child should be given the opportunity to express his/her views and to have such views taken into account depending on the age and maturity of the child. These provisions simply bolster the view that, provided a child is sufficiently mature, he should be allowed to make his own decision, particularly in decisions which are very important and are of a highly personal nature.

¹² MDL Levy et al 'Informed consent/assent in children. Statement of the Ethics Working Group of the Confederation of European Specialists in Paediatrics (CESP)' (2003) 169(2) *European Journal of Pediatrics* 631.

¹³ J Fortin (note 6 above; 87).

¹⁴ L Hagger *The Child as Vulnerable Patient* (2009) 44.

¹⁵ MDL Levy et al (note 12 above; 631).

¹⁶ RB Bernard & MC Buthelezi (note9 above; 352).

¹⁷ Convention on the Rights of the Child GA res 44/25 UN doc A/44/49 (1989) (entered into force 2 September 1990).

There are other areas of the Children's Act where children are permitted to make decisions about their own bodies and often parental consent is not even required. These provisions give children 'absolute freedom to make personal decisions.'¹⁸

- (1) Virginity testing can only be performed on a child over the age of 16 if the child has consented to the testing in the prescribed manner and has been provided with counselling in relation to the testing.¹⁹ Furthermore, the results of the virginity test may only be disclosed with the child's consent.²⁰
- (2) The circumcision of male children may only be performed to a child over the age of 16 provided he has consented to the procedure in the prescribed manner and has been provided with counselling.²¹ The only instance where circumcision may be performed on a child younger than 16 years is if it is performed for religious reasons in the manner prescribed or if it is for medical reasons and is recommended by a medical practitioner.²²
- (3) A child over the age of 12 may be provided with contraception on request and no consent from the child's parent or guardian is required.²³

These abovementioned provisions presuppose that a child may be competent to make certain decisions and reach a level at which they are capable of using their own discretion to make decisions which affect them.²⁴ The above provisions show a willingness of the legislature to acknowledge children's right to autonomy and their ability to make certain decisions that personally affect them. Of course the decision to die is the most important decision a person can ever make and therefore it is of the utmost importance that a child's maturity and competence be correctly assessed. What the abovementioned legislation shows, however, is that very personal decisions in relation to a child's body should be decided by that child. The decision by a terminally ill child to die is a decision which is also highly significance because refusing a child this choice condemns that child to a life of suffering and indignity until their natural death. It is therefore imperative that legislation be promulgated in order to promote the best interests of the child which in most instances, would be to allow a terminally ill mature minor to die.

¹⁸ A Moyo 'Child participation under South African law: Beyond the convention on the rights of the child' (2005) 31(1) *South African Journal on Human Rights* 182.

¹⁹ Children's Act 38 of 2005, s 12(5)(a) & (b).

²⁰ Children's Act 38 of 2005, s 12(6).

²¹ Children's Act 38 of 2005, s 12(9)(a) & (b).

²² Children's Act 38 of 2005, s 12(8)(a) & (b).

²³ S 134 of Children's Act 38 of 2005.

²⁴ A Moyo (note 18 above; 182).

4.2.2. Choice on Termination of Pregnancy Act²⁵

This legislation is the only other law in South Africa which allows for a child to make her own decision regarding her body. According to this legislation, a child of any age may terminate her pregnancy without parental consent or control. The medical practitioner or midwife who performs the abortion must advise a female minor to consult with her parents, guardian, family members or friends before taking the decision to abort but the medical practitioner/midwife may not refuse to carry out the abortion on the basis that family were not consulted.²⁶ Despite the fact that the legislation does not prescribe a strict age limit at which a child can terminate her pregnancy, it is still the task of the medical practitioner to ensure that the child is capable of giving informed consent.²⁷ If the child does not understand the risks, benefits, social and other implications of the termination of her pregnancy, then the consent given cannot be considered informed consent. This means that the level of maturity of a girl child who wishes to terminate her pregnancy also needs assessment in order to ensure that consent to the procedure is valid consent. This piece of legislation is another indication that the legislature considers it possible for maturity and competence of children to be assessed by medical practitioners and further, that children should be provided with the opportunity to make decisions about their own bodies.

This legislation was challenged in the *Christian Lawyers Association*²⁸ case on the basis that a girl under the age of 18 was not sufficiently competent to decide whether having an abortion is in her best interests or not without the guidance of her parents. The court stated that the legislation in question is based on the notion of informed consent and that no woman, regardless of her age, would be permitted to terminate her pregnancy if her consent to an abortion was not deemed to be informed consent. There are 3 legs to informed consent:²⁹

- (1) Knowledge – A woman who terminates her pregnancy must have full knowledge of the nature and extent of the risk and harm involved in the procedure.
- (2) Appreciation – The woman must be able to appreciate the risk of harm or understand the nature and extent of the harm.
- (3) Consent – The woman must subjectively consent to the nature and extent of the harm and all the consequences that may arise from the procedure.

²⁵ Choice on Termination of Pregnancy Act 92 of 1996.

²⁶ Section 5(3) Choice on Termination of Pregnancy Act 92 of 1996.

²⁷ D McQuoid- Mason (note 7 above; 530-2).

²⁸ *Christian Lawyers' Association v National Minister of Health 2004 (10) 1086 BCLR (T)*.

²⁹ *Christian Lawyers' Association supra* at 1093.

The court stated that it is constitutionally permissible for a child to be able to abort a foetus without parental consent because the legislation 'is flexible to recognise and accommodate the individual position of a girl child based on her intellectual, psychological and emotional make up and actual majority.'³⁰

Essentially, this means that only a woman with the requisite mental capacity and understanding will be able to give informed consent, provided of course that she has full knowledge of the risk involved. This means that a child that is particularly young and immature will not fulfil the requirements for informed consent and will not be able to make the decision in any event.³¹ The legislation acknowledges that some children may be able to consent because they have sufficient emotional and intellectual capacity to understand fully to what they are consenting. The Act requires each individual to be assessed on a case-by-case basis by a medical practitioner to decide if she is sufficiently competent to make an informed decision to terminate her pregnancy without the assistance of her parents or guardian.³²

This legislation, as with the Children's Act, acknowledges that it is possible to assess the maturity and competence of a child to make a decision about their own body and that the child's decision should be respected if they are sufficiently mature. If the Choice on Termination of Pregnancy Act provides that a girl of any age can make the decision to terminate her pregnancy, provided that her consent is informed consent, then the same should be the case in respect of the decision to make use of euthanasia. It would obviously be necessary to assess each individual child on a case-by-case basis in order to establish whether consent to death is informed or not. The fact that a medical practitioner needs to assess a patient for mental and intellectual competence before they are permitted to make an end of life decision, would need to be incorporated into legislation to ensure that it is only minors who actually understand their decision who are permitted to make such a choice.

4.3. Child autonomy

The right to autonomy involves respect for an individual's ability to make their own decisions. This encompasses a decision making process where the individual is assisted in making decisions and their

³⁰ *Christian Lawyers' Association supra* at 1105.

³¹ *Christian Lawyers' Association supra* at 1093.

³² *Christian Lawyers' Association supra* at 1094.

choices are thereafter respected.³³ Patient autonomy is considered to be one of the ‘basic ethical principles’ relating to medical practitioners and is considered in the WMA Resolution on Euthanasia.³⁴ The WMA Declaration on Terminal Illness³⁵ also provides that patients should be allowed to make their own decision towards the end of their lives and such a decision should be respected although this does not mean that a medical practitioner is permitted to assist them in committing suicide.³⁶ In order for a person to be able to exercise their autonomy, they need to be capable of making decisions which entails the ability to process and understand information related to the decision in question. This ability is acquired with age and maturity – Something which is different for every person.³⁷ People who have cared for children who have chronic, debilitating conditions, however, often remark that these children have a higher level of maturity and are the only ones who fully understand their condition. In such situations, it may be the legitimate wish of the child to stop having life-saving treatment or to be euthanatized.³⁸ In order to decide whether a person is capable of making a decision and understanding its implications, it is necessary for their maturity to be assessed and this is where a consideration of age comes into play. To assess every child’s maturity based entirely on their age is not a fair judgement to make. To do so would mean that children who are sufficiently competent as adults are not allowed to make decisions merely because they are under the age of 18.

The Hippocratic Oath provides that a medical practitioner should always promote and advance the best interests of the patient but in line with the Universal Declaration of Human Rights and the World Medical Association guidelines; the medical profession is required to respect a patient’s autonomy and right to self determination.³⁹ If a person is considered to be a rational moral being capable of acting in their own interests, a medical practitioner is required to respect such a person’s wishes and desires. Not to do so would be treating them as ‘less than human.’⁴⁰ This would mean that a minor’s wishes should also be respected provided the child is considered to be capable of acting in his own

³³ H Fisher ‘Assent to participate in healthcare research’ (2013) 26(3) *Current Allergy & Clinical Immunology* 147.

³⁴ World Medical Association *Resolution on Euthanasia* 2002 available at www.wma.net/en/30publications/10policies/e13b/, accessed on 29 September 2016.

³⁵ World Medical Association *Declaration of Venice on Terminal Illness* 2002 available at <http://www.wma.net/en/30publications/10policies/i2/>, accessed on 29 September 2016.

³⁶ *Ibid.*

³⁷ H Fisher (note 33 above; 147).

³⁸ L Hagger (note 14 above; 6).

³⁹ A Du Plessis ‘An introduction to informed consent: ethico-legal requirements’ (2008) 63(1) *SADJ: Journal of the South African Dental Association* 018.

⁴⁰ A Dhali ‘An introduction to informed consent: ethico-legal requirements’ (2008) 63(1) *SADJ: Journal of the South African Dental Association* 018.

best interests. Chapter 3 of this dissertation provided a strong basis for the argument that disallowing voluntary active euthanasia is unconstitutional so if it can be shown that a terminally ill child is a sufficiently rational being, such a child should be permitted to request euthanasia.

The right to autonomy is closely linked to the right to freedom. Although not expressly stated as such in the Constitution, the right to autonomy also includes the right to privacy and freedom, both of which are rights that are guaranteed to children. In some instances it may be argued that it is necessary to recognise a child's right to autonomy because it shows a respect for the child's right to self-determination and promotes respect for a child's dignity as a human subject rather than an object.⁴¹ In respect of health care there is a presumption that the person involved is the best person to make a decision in respect of their own body because they are the best judge of their present situation.⁴² Generally, however, a minor's competence cannot be presumed and must rather be proved.⁴³ Provided a child can be shown to be competent, that child should be permitted to make a decision as important as the decision to end their own pain and suffering.

Recognizing that children should have a right to autonomy and to make their own decisions does not mean that there are no serious risks attached to this. Some children are not emotionally or intellectually sufficiently mature to make adult decisions and the law still needs to protect these individuals.⁴⁴ A child's right to autonomy is often restricted in order to protect that child from making decisions they do not really understand. It is argued by many authors that children should not be given the same freedoms as adults because they are different from adults in that they are still developing, have less knowledge and skills and they are often dependent on adults.⁴⁵ Children are often not yet capable of rational thought and should therefore be treated differently from adults for their own protection.⁴⁶ It is generally accepted that particularly pre-adolescents have insufficient social experience and have not developed adequate intellect to be able to make decisions that have a major impact on their lives.⁴⁷ Adolescents, however, have often developed cognitive abilities that may be on par with young adults. It can therefore be argued that setting a rigid age limit at 18 often does not take

⁴¹ C Ngwenya 'Health-care decision making and the competent minor: the limits of self-determination' (1996) *Acta Juridica* 133.

⁴² C Ngwenya (note 41 above; 136).

⁴³ C Ngwenya (note 41 above; 137).

⁴⁴ E Du Plessis et al (note 4 above; 6).

⁴⁵ H Kruger 'Traces of Gillick in South African jurisprudence: two variations on a theme' 2005 46(1) *Codicillus* 3.

⁴⁶ H Kruger (note 45 above; 6).

⁴⁷ C Ngwenya (note 41 above; 138).

into account that every individual is different.⁴⁸ The concept of competence of a minor is not only associated with age but also rationality, mental ability and also the child's own personal experiences.⁴⁹ For instance, a child that is suffering from a terminal disease such a leukaemia is in the best position to make an informed decision in respect of treatment because he/she has firsthand experience of the disease. It is, however, important to note that such experience only goes so far in determining competence and that other factors should also be considered. A young child may, for instance, have a good understanding of death but may not understand what the effect of death on their families will be.⁵⁰ It could then be argued that such a child could not be considered sufficiently mature but rather lacking in competence to make a decision to end their own life through the use of euthanasia. It is certainly necessary that the law protect minors that are not sufficiently competent to make a decision about death, however, if an adult is permitted to make a decision to die currently in terms of the Constitution, a child capable of rational thought and understanding the consequences of their actions, should also be permitted to make such a decision.

It is understandable that setting a rigid age limit at which children gain majority and can enjoy more freedom is a practical way of establishing control. It is impossible for a child's individual maturity level to be assessed in respect of every decision in order to establish whether that child can understand the consequences of the decision. However, in respect of the decision to make use of euthanasia, such a decision is the most important one a person can make. In a case where a child is suffering from a terminal illness and is in incredible pain, such a decision should not only be allowed when the child reaches the arbitrary age of 18. A child of 17 years and 9 month might have sufficient maturity to make an end of life decision yet in most countries where Death with Dignity legislation exists, such a child is forced to suffer until they reach the age of 18. Foreign legislation will be considered in greater detail in the proceeding chapter but what is important to note at this stage is that such legislation has safeguards in place to ensure that a terminally ill patient is sufficiently competent to make an end of life decision. It could therefore be argued that if such an assessment can be carried out on an adult, a similar mental assessment could quite easily be carried out on a child as well in order to decide whether the minor is sufficiently competent to make the decision to opt for euthanasia.

⁴⁸ H Kruger (note 45 above; 3).

⁴⁹ MDL Levy et al (note 12 above; 631).

⁵⁰ Ibid.

4.4. Determining competence

Determining competence of a child involves an assessment of the child's maturity in order to ascertain whether the child can in fact make the decision in question. In respect of medical decisions, the degree of understanding a child has could be decided upon by 'getting them to paraphrase their knowledge of the proposed treatment or procedure, their appreciation of the consequences of the proposed treatment or procedure, and their willingness to accept all the harm or risks involved in such treatment or procedure.'⁵¹ In order for a medical practitioner to establish whether a child is sufficiently competent, the following need to be shown:⁵² (1) The child can understand the information that they are provided with in respect of their condition. This also means that the doctor needs explain the information in an age-appropriate manner that the child can understand; (2) The child must believe and understand that the information in question applies to them specifically; (3) The child must be able to use the information provided to make a decision. Such decision must be made freely and voluntarily; (4) The child must then show the ability to make the particular choice. The idea of competence to make a decision involves more than just the child. It is also necessary to assess the relationships between child, parents and doctor as well as the surrounding circumstances. Furthermore, especially in a case of a child who is terminally ill, debilitating pain may reduce the child's competence to an extent where such a child can no longer be considered competent to make a decision anymore.⁵³ This problem also arises in respect of terminally ill adult patients. The above, however, provides solid guidelines as to how competence can indeed be established and shows that such should and can be done in respect of establishing whether a child is sufficiently competent to make an end of life decision.

One of the key cases cited in respect of child autonomy in health care and assessment of maturity is the case of *Gillick*.⁵⁴ In this case, a mother argued that the health care authority did not have the right to provide contraceptive advice and treatment to her daughter under the age of 16 without her consenting to it. The court did not find in favour of the mother and stated that the parental rights were in place in order to benefit the child but that they should not extend beyond what is necessary to fulfil their duties towards the child.⁵⁵ This decision is an important one because the court concluded that a

⁵¹DJ McQuoid-Mason & MA Dada 'The National Health Act: some implications for family practice' (2008) 24(1) *Continuing Medical Education* 13.

⁵² MDL Levy et al (note 12 above; 631).

⁵³ *Ibid.*

⁵⁴ *Gillick v West Norfolk and Wisbech Area Health Authority [1985] (1985) 3 All ER 402.*

⁵⁵ *Gillick supra* at 410.

child's wishes should be given due weight.⁵⁶ It was decided that a 16-year-old child has the requisite capacity and understanding to make a decision on a matter that affects him.⁵⁷

The decision in *Gillick*⁵⁸ meant that if a child who is sufficiently mature to understand the implications of their decision consents to treatment, even if their parent or guardian does not consent, the child's wishes should be respected. A child's decision will only be overridden if the child is not considered to be sufficiently mature enough to understand the ramifications of their decision and are therefore not 'Gillick competent.' Such a test of maturity could also be carried out in order to decide whether a child is sufficiently competent to request death.

It is of utmost importance to establish whether the consent of a child can be considered valid in that the child is sufficiently mature to understand the decision in question. In respect of adults, competency is also considered in establishing validity of consent. For instance, if a person is mentally ill, they will not be able to give valid consent. Similarly, competency of children to consent can also be established. A number of factors need to be considered in order to establish the capacity of a child to consent. The factors listed below are better suited to cases of consent to medical treatment or refusal thereof, but similar principles will also apply in respect of a decision to make use of euthanasia.⁵⁹

- (1) Reasoning – A child must be able to reason in order to make a choice. The ability to reason is influenced by factors such as 'age, intelligence, cognitive functioning and emotional functioning.'⁶⁰
- (2) Understanding – This relates to the child's understanding and knowledge of the problem. For instance, a child suffering from leukaemia has the best understanding of his/her own condition and also the treatment involved if he/she has previously been treated. If a child can give an informed opinion, it should be taken seriously. Part of being able to make an informed decision is also being exposed to all the relevant information. It is therefore necessary to ensure that a child is provided with all the necessary information in order to make the decision. In respect of an end-of-life decision, the implications need to be fully explained to a child and such a child needs to be assessed to determine whether or not that child is sufficiently mature to take the decision.

⁵⁶ H Fisher (note 33 above; 147).

⁵⁷ *Gillick supra* at 422.

⁵⁸ *Gillick supra*.

⁵⁹ S King 'Ethical issues in treating children' (2011) 24(4) *Current Allergy & Clinical Immunology* 218.

⁶⁰ *Ibid*.

- (3) Voluntariness – As with any consent given, the consent is not valid if the party consenting has been coerced or intimidated in any way.
- (4) The nature of the decision to be made – In respect of decisions regarding medical treatment, the benefits of the treatment are weighed up against its risks. Depending on the risk of harm associated with the procedure, different standards may apply. In a case where there is a high risk of harm occurring, it would be necessary to be extra careful in ensuring that the child is sufficiently mature to consent to the treatment. In the case of euthanasia, such a decision is fatal and is the most important decision anyone could make in their life. It is therefore necessary that the child is assessed properly for competency in order to establish whether he/she in fact has sufficient maturity to be able to reason and see the ramifications of making such a decision.

Of course nobody can be considered fully competent to make a decision if they have not been provided with all the relevant information pertaining to the decision. In respect of information associated with the making of an informed decision, a couple of general guidelines need to be considered. Firstly, the quality of the information given to the child must be such that the child is able to understand the information fully.⁶¹ This means that it must be explained to the child in an age appropriate manner and in a language that the child understands. Culture and language may be problematic in respect of doctors having to provide information to a patient.⁶² Secondly, the minimum quantity of information to be provided is that which is necessary for a reasonable child to make an informed decision and there is a duty on the medical professional to answer all questions posed to him/her. If a child is not provided with sufficient information to make a decision, then the decision made is not considered to be an informed one and consent is not real.

In respect of euthanasia, the above requirement would mean that a doctor would need to give the child all the information relevant to the process of dying in a manner that the child can fully understand and consent to. It would also mean an explanation of the implications of choosing to make use of euthanasia. The magnitude of a decision to die cannot be emphasised enough and therefore it is preferable that the decision made should be one which is made collectively by medical professionals, the parents (and possibly family of the child) and the child herself who is suffering from a terminal disease. Provided that the consent is valid in respect of the factors mentioned above and due consideration of the child's ability to competently make a decision is given, which should be assessed by a child psychologist, then such a child should be permitted to request euthanasia.

⁶¹ MDL Levy et al (note 12 above; 631).

⁶² A Dhai 'Informed consent – 2008'(2008) 1(1) South African Journal of Bioethics and the Law 28.

It should be acknowledged that establishing the maturity and competence of a child is by no means an easy task. It is especially difficult if the child is a first-time patient of the practitioner and there has been scant time to establish a doctor-patient relationship.⁶³ It is often argued that if there is little guidance for health care professionals with regards to establishing maturity and competence, then it may result in differential treatment of children.⁶⁴ It would be advisable that those in the health care industry should receive training and support in order to help them to accurately measure a child's level of maturity and whether or not they are sufficiently mature to make the decision.⁶⁵ At the least, medical practitioners should apply the 'principle of equity' in that they do not hold children to a higher threshold of competence as adults.⁶⁶ The principles mentioned above in this chapter do provide quite extensive guidance, however, to practitioners in terms of factors to consider when assessing competence and maturity. In respect of allowing a child to make such a big decision as the one to die, mistakes are irreversible. It is therefore necessary to ensure that legislation provides that a panel of medical staff should be involved in deciding on the maturity level and competence of the child in order to minimise the chance of error. Given that the assessment of maturity and competence also involves an analysis of a child's cognitive development in general, it would be advisable that a child psychologist also indicate that he/she believes that the child is in fact sufficiently mature and competent to opt for euthanasia.

4.5. Best interests of the child principle

In respect of treatment, the choice to die and indeed many other decisions that are taken in respect of a child, the 'best interests of the child' are always of paramount importance.⁶⁷ In addition to the provision in the Constitution, s 9 of the Children's Act also provides that "in all matters concerning the care, protection and well-being of a child the standard that the child's best interest is of paramount importance, must be applied."⁶⁸ What is in contention is whether it is indeed in the best interests of a child to die, should they request euthanasia. Certain factors are taken into account when determining the best interests of the child including the child's "age and cognitive level, his or her physical,

⁶³ A Dhali 'An introduction to informed consent: ethico-legal requirements' (2008) 63(1) *SADJ: Journal of the South African Dental Association* 019.

⁶⁴ T Boezaart (ed) *Child Law in South Africa* (2009) 213.

⁶⁵ P Mahery 'Consent laws influencing children's access to health care services' (2016) *South African Health Review* 171.

⁶⁶ T Boezaart (note 64 above; 213).

⁶⁷ S 28(2), Constitution of the Republic of South Africa, 1996.

⁶⁸ S 9, Children's Act 38 of 2005.

emotional and educational needs and desires, as well as his or her cultural belief system and social environment.”⁶⁹ It is necessary to acknowledge that emotional, medical and all welfare issues in respect of the child help to determine what is in the child’s best interests and these best interests ensures the best outcome for a child, not necessarily the most reasonable outcome.⁷⁰ The wishes of a child will be overridden when their decision is considered not to be in their best interests and they are not sufficiently mature to make such a decision. In the case of *Re M*,⁷¹ the mother of 15 year old child consented to the child having a heart transplant but the child refused to have the operation. The court in that case overruled the child’s decision. Similarly, in the case of *Re W*,⁷² the court did not permit a 16 year old from refusing life sustaining treatment for anorexia. The reason why these decisions were reached is because it was considered to be in the child’s best interest in both circumstances to receive the requisite treatment. The abovementioned cases, however, do not involve terminally ill children who have no prospect of recovery. It cannot be considered to be in the child’s best interests to continue to suffer until death and live a poor quality life. In such a case, it can easily be argued that euthanasia is an alternative which is in the best interests of the child.

Of course, a child should always be viewed as being part of a family and so the views of the parents and perhaps family need to also be taken into account.⁷³ Especially in the case of euthanasia, it is most definitely a decision that requires considerable input from other parties because it is ultimately the biggest decision a person can make – To end their own life. It should be understood that children cannot be completely isolated from their parents and that it is often true that a parent is in the best position to understand the best interests of their own child and to make a decision in that respect. In the case of *Re C (HIV test)*,⁷⁴ Wilson J stated that the views of parents were definitely important and that regardless of what the underlying reasons for their views are, they are in a good position to decide on the welfare of their child. Parental consent should perhaps be a prerequisite before any request of euthanasia is carried out. The question then often arises though – What if a parent refuses to give consent for the child to end their own life and yet the child continues to suffer? In such a situation it would then be possible for the child to approach a court and gain an order which overrides the parent’s lack of consent if the child is considered to be sufficiently mature to make the decision and it is in the best interests of the child for his wishes to be carried out.

⁶⁹Knapp van Bogaert, D & G Ogujbanjo ‘Ethics and medicine: revisiting the Children’s Act and the implications for healthcare practitioners’ 2013 55(1) *South African Family Practice* S 3.

⁷⁰ S Elliston *The Best Interests of the Child in Healthcare* (2007) 19.

⁷¹ *Re M (Child: Refusal of Medical Treatment)* [1999] 52 BMLR 124.

⁷² *Re W (A Minor) (Medical Treatment: Court’s Jurisdiction)* [1992] 3 WLR 758.

⁷³ S King (note 59 above; 218).

⁷⁴ *Re C (HIV Test)* [1999] 2 FLR 1004).

Despite parents playing a key role in the decision making of their child, the best interests of the child are always of paramount importance regardless of the wishes of the parents. In cases where parental consent is required for a child to undergo a medical procedure, there have been a number of cases where a court has ordered that, for instance, a child receive a blood transfusion where the parents had refused to consent to the procedure on religious grounds.⁷⁵ However, there appears to be little or no jurisprudence on what would happen if a child refuses treatment. In the foreign case of *A.C v Manitoba*,⁷⁶ the child's decision to refuse treatment was overridden as it was considered to be in the best interests of the child to get treatment. However, given the provisions of the Children's Act that a child must consent to a procedure, it could follow that a child is also permitted to refuse a medical procedure and be able to argue successfully based on his/her rights to bodily integrity in terms of the Constitution, and that it is in their best interests to die. If the child is permitted to refuse treatment then it should also follow that such a child should be able to request active euthanasia (See discussion on the artificial difference between active and passive euthanasia in chapter 2).

There are instances already in society where doctors will recommend that treatment not be given to a person if their diagnosis is such that there is no prospect of recovery. Infants who suffer from mental or physical defects are also frequently deliberately left to die. The question in such cases is whether the decision is for the benefit of the child or whether it is the parents/family that the doctor has in mind when the decision is made. It is often genuinely for the benefit of the child in cases of severe disability where life-prolonging treatment is not given. The rationale behind a decision to do the above is to save the child from a life of immeasurable suffering.⁷⁷ If this is considered to be morally permissible, then surely it could be considered to be in the best interests of a child to grant a request for euthanasia if the child is terminally ill in order to prevent unnecessary suffering.

⁷⁵ E Du Plessis et al (note 4 above; 11); see also *Hay v B 2003 (3) SA 492 (W)*.

⁷⁶ *A.C. v Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181: In this case a 14 year old child who was a Jehovah's witness and needed a blood transfusion in order to survive, refused treatment on religious grounds. The Director of Child and Family Services applied to court for an order directing the blood products to be administered to the child. The order was granted and on appeal, the court upheld the judgement of the trial court. The court stated that it was in the best interests of the child to receive the blood transfusion and therefore it was justifiable to restrict the child's autonomy despite being a "mature" minor. The minority judgement, however, suggested that any child should be permitted to make such a decision provided that they are sufficiently competent and mature. Furthermore, simply because society considers a decision to be a bad one does not mean a person's freedom to make that choice should be restricted; *Re R (a minor) (wardship: consent to treatment) [1992] Fam 11*: Court of Appeal provided that a 15 year old suffering from increasingly paranoid and disturbing behaviour could not refuse treatment to control keep the condition under control; *Re W (a minor) (medical treatment: court's jurisdiction) [1993] Fam 64*: Court of Appeal authorized compulsory treatment of 16 year old who suffered from anorexia.

⁷⁷ P Foot 'Euthanasia' (1977) 6(2) *Philosophy and Public Affairs* 109-110.

S 7 of the Children's Act⁷⁸ sets out criterion for determining what the best interests of the child are. Section 7 is a closed list which means that the court cannot apply its own factors outside of this list. This has been severely criticised on the basis that it is a "pre-determined formula."⁷⁹ In the case of *s v M*, the Constitutional Court held that to apply a pre-determined list is not actually in the best interests of the child.⁸⁰ It is preferable that the court considers all relevant factors applicable to the case in order to determine the best interests of the child.⁸¹ It is necessary to determine whether something is in the best interests of a child on a case by case basis and law must be flexible to allow for the best interests to be decided according to the facts at hand.⁸²

Competent adults are generally able to make decisions which may even be considered irrational or to their detriment.⁸³ A child who makes the same decision, even if they are sufficiently competent to make such a decision, will not be treated in the same manner. The child's decision will be scrutinised and it will be considered whether that decision is a rational one or not and in the child's best interests. The emphasis on rationality tends to promote the prolonging of a child's life, regardless of its quality and this overshadows the child's right to autonomy.⁸⁴ This is understandable given that the law is expected to protect children from making bad decisions, but what are the best interests of a child when it comes to a terminally ill child who is suffering? Surely if such a child can understand their choice to die, they should not be denied that choice merely because of their age. In any event, it can be argued that it is a violation of that child's rights and therefore it is in fact in that child's best interests to respect their decision. There is also a case for euthanasia of a terminally ill child being in their best interests because their quality of life is poor and they are suffering. In many instances, a newborn who is deformed for instance will be left to die by doctors because it is considered not to be in the best interests of that child to live a life of suffering. In a case where a mature minor actually requests euthanasia because of the immense pain they are in, it can surely be seen to be in their best interests for the request to be carried out in order to end their suffering.

⁷⁸ Children's Act 38 of 2005.

⁷⁹ E Du Plessis et al (note 4 above; 16).

⁸⁰ *S v M (Centre for Child Law as Amicus Curiae) 2008 (3) SA 232 (CC)* at para 24; the court stated that it is necessary to consider the rights and needs of each child in a certain circumstance in order to decide what is in the best interests of that particular child.

⁸¹ See *McCall v McCall (1994) 2 All SA 212 (C)* which provides that all other relevant factors should be considered in order to ascertain what the best interests of the child are.

⁸² See *C and others v Department of Health and Social Development, Gauteng and others 2012 (2) SA 208 (CC)* and *Centre for Child Law v Minister of Justice and Constitutional Development and others 2009 (6) SA 632 (CC)*.

⁸³ L Hagger (note 14 above; 45).

⁸⁴ *Ibid.*

The Belgian legislation permits a child to request euthanasia provided the child has decisional capacity to make that decision, meaning that the child must be sufficiently mature to understand their request for death.⁸⁵ The Dutch legislation, similarly, allows for children over the age of 12 to request euthanasia.⁸⁶ The legislation provides certain safeguards in respect of children which are expected to minimise abuse of the practice. This legislation acknowledges a child's right to autonomy while still ensuring maximum protection. Euthanasia is always seen as a last resort but legislation in these foreign jurisdictions provides a child with the option to request death when suffering is unbearable and the minor wishes to die with dignity, provided he or she is sufficiently mature to make the decision to die. This will be discussed in further detail in the following chapter.

4.6. Conclusion

Legal framework should reflect both adults and children's' rights in respect of death. As advocated throughout this dissertation, legislation should be promulgated in order to allow terminally ill patients to request euthanasia and should also allow for mature minors to make use of the practice provided they are sufficiently competent to make such a decision. The Children's Act already reflects the willingness of legislators to allow mature minors to make their own decisions about their body. Both the Children's Act and the National Health Act impliedly allow for a mature minor to refuse medical treatment which essentially means that passive euthanasia is permissible for such a minor and following from this should also allow for active euthanasia given that the distinction between the two forms is essentially artificial. The legislation also provides that maturity and competence need to be ascertained before a child can consent to or refuse medical treatment and such is decided on a case by case basis. A similar approach could be employed in respect of euthanasia and assessing whether a minor is competent to make the decision to die. The final factor to consider in respect of children is the best interests of the child. A solid argument can be made for the notion that a life of pain and suffering is not a quality life and to force a child to continue to suffer is not in that child's best interests. Ultimately, it is in the best interests of a mature minor to make a decision in respect of their own body provided they understand the decision sufficiently. In disallowing a request for euthanasia, such a minor's rights are being unjustifiably infringed which can never be in a child's best interests.

⁸⁵ The Belgian Act on Euthanasia of May, 28th 2002 § 8 (D Kidd translation from *Ethical Perspectives* (2002) 9 (2-3) 182-188).

⁸⁶ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002.

CHAPTER FIVE: FOREIGN LEGISLATION AND THE SOUTH AFRICAN PROPOSAL

5.1 Introduction

This chapter will contemplate the legislation in respect of euthanasia in two other jurisdictions: Belgium and the Netherlands. The reason why these specific countries have been chosen is because they allow children to make an end of life decision, that is, to request euthanasia, provided they are sufficiently mature and competent to make such a decision. Dutch law is of specific importance in relation to South African law given that South African law is based on Roman-Dutch law. The Belgian euthanasia law was extended in 2002 to allow for minor's to request euthanasia if they are suffering from a terminal illness in respect of which there is no prospect of recovery and the minor in question is suffering great pain. The legislation places no age limit on a patient who can request euthanasia although certain additional safeguards have been adopted in order to protect children. The legislation in the Netherlands provides that only children over the age of 12 may request euthanasia and consent of their parents is required up to the age of 16. Both of these jurisdictions, therefore, show a willingness to acknowledge the need for a child who is terminally ill to make the decision to die and that such a child's right to autonomy should be respected. In addition to the Dutch and Belgian legislation, this chapter will also consider the South African Law Commission Draft Bill which proposes euthanasia legislation for implementation in South Africa. Provided that procedural safeguards are put in place to ensure minimal abuse of the practice, legislation which promotes a mature minor's right to choose death should they meet the requirements should indeed be implemented.

5.2 Belgium

The Belgian euthanasia law had been in place for over a decade before it was decided by the legislators that the law should be extended to allow for children to also make use of the law. The Belgian law on euthanasia came into effect in 2002 but it was only in 2014 that the law was extended to allow for a person of any age to request euthanasia.¹ This was in line with concerns that there were

¹ M Friedel 'Does the Belgian law legalising euthanasia for minors really address the needs of life-limited children' (2014) 20(6) *Int J Palliat Nurs* 265.

also minors who were suffering from terminal illnesses and had no option to die.² The legislation was promulgated with the view and acknowledgement that despite modern pain relief medication, children may still suffer pain and distress and should in some instances be permitted to end their life in accordance with the legislation.³

Prior to the enactment of the Belgian legislation, a survey conducted revealed that 69% of physicians who dealt with Belgian children were in favour of allowing minors to request euthanasia as well.⁴ The survey also revealed that 60% of the physicians surveyed, thought that parental consent should be required in terms of a minor making an end of life decision.⁵ The study carried out showed that physicians also believed that it was possible for the decision making competence of a child to be correctly assessed so that only those children who are sufficiently mature to make an end of life decision would be permitted to do so.⁶ A similar acceptance by physicians of euthanasia for minors was also found and it is believed that this acceptance stems from there appearing to be no significant abuses of the euthanasia law that was in place prior to the extension of the law to include minors.⁷ This information in respect of physician's attitudes is interesting to note given that physicians are trained to heal and often have a negative attitude towards the practice of euthanasia. The acceptance of euthanasia by the majority of doctors indicates that there is a strong feeling that euthanasia should be permitted in certain circumstances where there is no prospect of the child recovering and where such a child is suffering pain unnecessarily.

5.2.1 Legislative safeguards

The Belgian legislation stipulates additional safeguards in respect of children who request euthanasia in order to try and minimise abuse. A terminally ill child who wants to request euthanasia must make an explicit voluntary request free of coercion on a number of occasions.⁸ The request must also be in writing and the child in question must be suffering from a terminal disease with no prospect of

² B Carter 'Why palliative care for children is preferable to euthanasia' (2016) 33(1) *American Journal of Hospice and Palliative Medicine* 5.

³ Ibid.

⁴ G Poussett et al 'Attitudes and practices of physicians regarding physician-assisted dying in minors' (2010) 182139 *Archives of Disease in Childhood* 3.

⁵ Ibid.

⁶ G Poussett et al (note 4 above; 5).

⁷ G Poussett et al (note 4 above; 4).

⁸ B Carter (note 2 above; 5).

recovery.⁹ In addition, the law makes provision for a multidisciplinary team which assesses the competence of the child in order to ensure that the child has decisional capacity and that euthanasia appears to be the best option for the child in the circumstances.¹⁰ The multidisciplinary team consists not only of medical doctors but also of a child psychologist or psychiatrist that can make an accurate assessment of the child's decision making capacity.¹¹ It is prescribed that in addition to parental consent, three separate doctors would also need to agree with the decision to allow the request for euthanasia to be carried out.¹² The fact that it is a prerequisite that the child be of sufficient capacity to make the end of life decision means that patients who are mentally ill or very young are automatically excluded from being able to make a decision to die.¹³ The doctor must also explain the alternatives available to the patient, for instance the possibility of palliative care.¹⁴ These safeguards are intended to minimise abuse and to ensure that euthanasia is only permitted in circumstances where the requirements are fulfilled.

In addition to the safeguards mentioned above specifically relating to children, the legislation also provides that a physician must ensure that the consent given is not coerced consent and that the request for euthanasia is given repeatedly.¹⁵ The physician must also explain the patient's condition to him/her and be sure that there appears to be no alternative treatment for the patient in the circumstances.¹⁶ The physician must be sure that the patient is in a state of constant and unbearable suffering and must consult with another physician who must agree on the degree of suffering the patient is in and must also agree that the patient's condition is incurable.¹⁷ In the event that the physician believes that the patient will not die very soon, he is expected to consult with a second physician or a psychiatrist or specialist in the illness from which the patient is suffering and to inform

⁹ M Friedel (note 1 above; 265).

¹⁰ B Carter (note 2 above; 5).

¹¹ M Friedel (note 1 above; 265).

¹² I Feliciano 'Belgium's euthanasia law gives terminally ill children the right to die' (2015) *PBS Newshour Online* available at <http://www.pbs.org/newshour/bb/belgium-terminally-ill-children-right-die/>, accessed on 14 October 2016.

¹³ B Dan et al 'Self-requested euthanasia for children in Belgium' (2014) 383(9918) *The Lancet* 671.

¹⁴ Ibid.

¹⁵ The Belgian Act on Euthanasia of May, 28th 2002 § 3(1) (D Kidd translation from *Ethical Perspectives* (2002) 9 (2-3) 182-188). The provisions of the 2002 Belgian Act in relation to an adult patient's request for euthanasia have not been altered. Instead, the legislation was simply extended in 2014 to allow for children to request euthanasia. With this change in legislation, additional safeguards (as mentioned above) were also adopted in order to provide further protection for children.

¹⁶ The Belgian Act on Euthanasia of May, 28th 2002 (D Kidd translation from *Ethical Perspectives* (2002) 9 (2-3) 182-188); § 3(2)(1).

¹⁷ The Belgian Act on Euthanasia supra; § 3(2)(3).

this practitioner of the patient's condition and the second practitioner must confer with the first that the patient is suffering unbearable and constant pain.¹⁸ The request for euthanasia must be in writing and must be signed by the patient. In addition, there must be at least one month between the request being made and the act of euthanasia being performed by the practitioner.¹⁹ The extent of these safeguards indicates that the intention behind the legislation is only to provide the option of death in instances firstly, where a patient has a disease that is incurable and the prognosis has been confirmed and secondly, where the patient is suffering. It must be emphasised that euthanasia is intended to be a last resort rather than simply as a result of a decision made on a whim.

The Belgian legislation is progressive in that it recognises a person's right to autonomy and to make a decision to die, regardless of age. Rather than the law stipulating the age at which a person is sufficiently mature to request euthanasia, the legislature has instead opted for an approach that allows for any person, regardless of age, to make such a decision provided that the abovementioned requirements stipulated in the legislation are fulfilled.²⁰ The requirements stated in the legislation essentially provide that a person must fully understand the decision they are making and this will exclude young children anyway because a child who is insufficiently mature to understand the seriousness of the decision to die will be excluded from requesting euthanasia. The extensive safeguards adopted in the legislation also provide for some form of psychological assessment of the patient in order to ensure that the patient is sufficiently competent and mature to make the decision to die. This means that the legislation provides only that a child who is sufficiently mature and has decisional capacity to make the decision to die can make such a decision and will not be forced to suffer unbearable pain until the occurrence of their natural death.

The Belgian Euthanasia Act also makes provision for the establishment of the Federal Control and Evaluation Commission which is a body that investigates instances of euthanasia reported.²¹ If it appears that the procedures and conditions in respect of euthanasia that are stipulated in the Act are not adhered to then the commission will hand the case over the public prosecutor having jurisdiction in the area where the transgression occurred.²² The legislation, therefore, creates a process whereby the decision of a physician can be questioned and those who transgress the provisions of the legislation will be prosecuted and penal sanction will follow.

¹⁸ The Belgian Act on Euthanasia supra; § 3(3)(1).

¹⁹ The Belgian Act on Euthanasia supra; § 4.

²⁰ A Laskin et al 'Beyond autonomy? A Transnational comparison of end-of-life decision making by mature minors' (2014) 18 *Mich. St. UJ Med. & L* 143.

²¹ The Belgian Act on Euthanasia supra; Chapter 4; § 6.

²² The Belgian Act on Euthanasia supra; § 8.

The Belgian legislation provides that parents must agree to their child's decision to request euthanasia and prior to the decision making, the parents must obviously be consulted.²³ The provision requiring parental consent has been included in the legislation in order to provide additional protection for children and to ensure that the decision taken is the correct one. It is often suggested that the involvement of parents is crucial in the decision making process as parents are generally in a good position to be able to understand their child's needs and provide valuable insight. It is, however, argued that in fact the inclusion of parental consent in the legislation simply means that the parent's perception of what is hopeless and unbearable suffering is adopted, the result of which is not a true reflection of the child's perception and there is even further chance that a child may be influenced by their parents. This, to an extent, is a legitimate criticism. However, the multidisciplinary team involved in granting the request for euthanasia should in fact ensure that the decision made by the child is that of the child herself and not merely the decision of her parents. This is why it is particularly necessary that a child psychologist sit on the multidisciplinary team in order to assess the child's decision making capacity and to ensure that the decision is in fact what the child wants, bearing in mind that ultimately the best interests of the child are of utmost importance.²⁴

5.2.2 Criticisms and counter-arguments

There are always concerns that the decriminalisation of euthanasia will result in many more cases of patient euthanasia, often in circumstances where vulnerable members of society are coerced into consenting to death as an alternative to palliative care.²⁵ This is known as the 'slippery slope' argument but studies in Belgium and the Netherlands do not confirm the slippery slope hypothesis.²⁶ There may in fact be more reported cases of euthanasia in both countries but this is merely because it is now legal and so more cases have been reported where previously they were kept undercover by physicians who feared prosecution.

Furthermore, the precise conditions that are stipulated in the legislation are to an extent criticised. The legislation provides that a child must be in a state of "constant and unbearable suffering" and their medical condition must be "futile" in that the patient is suffering from an incurable illness or disease.²⁷ This is the same standard that is adopted in respect of adults requesting euthanasia. This

²³ M Friedel (note 1 above; 265).

²⁴ See Chapter 3 for the discussion on the best interests of the child standard.

²⁵ B Dan et al (note 13 above; 671).

²⁶ Ibid.

²⁷ The Belgian Act on Euthanasia *supra*; § 3(1).

standard is criticised and considered to be problematic because it is difficult to define what exactly the phrase “constant and unbearable suffering” actually means. There is no objective standard to ascertain whether a person would be able to fall within this category.²⁸ It is further argued that even if a patient can in fact identify the extent of their pain and suffering, such a patient suffering from a terminal illness may not be able or competent to voice this.²⁹ In opposition to the abovementioned criticism of the legislation, it is submitted that “constant and unbearable suffering” is something which can subjectively be determined and voiced by a patient. If a patient is in a situation of constant suffering and voices this, it could be considered as sufficient to fulfil the criteria in terms of the legislation. Furthermore, although perhaps medics cannot determine the precise subjective suffering of a patient, there are ways to monitor and determine pain from a physiological point of view as the body will react in certain specific ways when in severe pain. From a physician’s knowledge and understanding of pain management for terminally ill patients, such a physician could be in a position to make an educated judgement with regards to whether or not a patient is suffering unbearably or not. This, in conjunction with the patient’s request, should be sufficient to fulfil the criterion in terms of legislation.

Many authors agree that the alternative of palliative care should always be offered and explained to a patient prior to their request for euthanasia being granted.³⁰ The physician must explain the patient’s diagnosis to them and present the patient with alternative therapeutic measures as well as the possibility of palliative care.³¹ The problem is that in many countries, and indeed South Africa, palliative care is often not seen as a very viable option because it is not sufficiently understood and is not adequately funded.³² In many instances it is also argued that palliative care does not go far enough in relieving pain and suffering and that there comes a stage where a child can be in such a desperate position that he or she would want to request death if it is legal in order to end his or her unbearable suffering.³³ Friedal argues that instead of the law in Belgium allowing for minors’ requests for euthanasia to be carried out, the palliative care law should be extended to allow for children to also receive high quality palliative care and for there to be more discussion and policy centred on improving the psychological, mental and physical aspects of palliative care for both the child and his

²⁸ B Carter (note 2 above; 6).

²⁹ Ibid.

³⁰ M Friedel (note 1 above; 267).

³¹ R Cohen-Almagor ‘Belgian euthanasia law: a critical analysis’ (2009) 35(7) *Journal of Medical Ethics* 437.

³² M Friedel (note 1 above; 266).

³³ J Van Der Werff Ten Bosch ‘Belgium’s euthanasia law gives terminally ill children the right to die’ (2015) *PBS Newshour Online* available at <http://www.pbs.org/newshour/bb/belgium-terminally-ill-children-right-die/>, accessed on 14 October 2016.

or her family.³⁴ Similarly, Siegel also argues that adequate palliative care should be provided for children instead of euthanasia, although that author acknowledges that quality palliative care is not available in many countries.³⁵

The above approach is not one that is particularly viable in a developing country such as South Africa where medical facilities are already under resourced. Palliative care can indeed be seen as preferable in some cases, although in an underdeveloped country such as South Africa, medical resources are more readily allocated to patients who have a prospect of recovery rather than those who are terminally ill.³⁶ This means that many South Africans who are terminally ill may not even have access to any form of pain relief or palliative care simply because hospitals are under resourced. In such instances, a patient may have to suffer until death without a proper pain management regime. Where this is the case, such a patient should be provided with the opportunity to request euthanasia and end their suffering should they wish to do so. Legislative provisions merely provide patients with an alternative option; they do not advocate the practice as a solution in all cases. In every case of a request for euthanasia, all the requirements listed in the legislation must be fulfilled and so if a patient is coerced into requesting euthanasia such a request should in any event not be granted.

The Belgian euthanasia legislation is further criticised by Siegel on the basis that it does not take into account that adults make a decision to die for different reasons to children.³⁷ For instance, adults may fear a loss of dignity and control and do not want to be a burden on family members, which it is argued are not the same reasons that a child would opt for euthanasia.³⁸ Siegel argues that children do not have the requisite knowledge or intellectual ability to be able to choose euthanasia categorically over palliative care.³⁹ Although it can easily be agreed that a young child may lack the competence and decisional capacity to make an end of life decision, the difference between a 17 year old and 18 year old is surely minimal. A child or adult would need to be assessed individually when a request for euthanasia is made and therefore even an adult who is particularly immature would not be able to make an end of life decision just as a 16 or 17 year old child may certainly be sufficiently mature and competent to make an end of life decision. The Belgian Euthanasia Act, prior to amendment in 2014,

³⁴ M Friedel (note 1 above; 266).

³⁵ A Siegel et al 'Pediatric euthanasia in Belgium: Disturbing developments' (2014) 311(19) *Jama* E2.

³⁶ In the case of *Soobramoney v Minister of Health, KwaZulu-Natal 1998 (1) SA 765 (CC)*, the court held that the state's obligations to provide health care are only to the extent that they have available resources. It is necessary to allocate resources wisely. This means that the state is unlikely to allocate medical resources to patients who are dying of terminal diseases as opposed to those who have a prospect of recovery.

³⁷ A Siegel et al (note 35 above; E1).

³⁸ *Ibid.*

³⁹ *Ibid.*

provided that any person requesting euthanasia must be found to have the ‘capacity of discernment’ before such a request could legally be granted.⁴⁰ A similar approach would then be used in assessing the competency of children who request euthanasia rather than strictly applying age restrictions which do not necessarily correspond with the competency of a child to make an end of life decision.⁴¹ If a terminally ill child requesting euthanasia is found to be sufficiently mature for ‘discernment’ then such a child’s request should be granted.⁴² As the decision is such an important one, each individual needs to be assessed on a case by case basis in order to ensure that that particular person is sufficiently competent to make the decision. Regardless of whether the individual in question is an adult or child, the assessment should still be conducted with meticulousness.

The Belgian law is also criticised on the basis that the type of drugs that should be used for euthanasia are not stipulated in the legislation which may have different effects on patients and may in fact not result in a peaceful death for some.⁴³ It is suggested that the type of drugs to be used by a physician who carries out a request for euthanasia should be stipulated in the medical professionals’ ethical guidelines publication if not in legislation.⁴⁴ It has also been argued that the law provides too much room for abuse in that the legislation even allows for a person with a mental condition to request euthanasia.⁴⁵ This dissertation does not extend to the consideration of euthanasia in case of mental illness. It is preferable for euthanasia to only be permissible in instances where a patient is suffering from a physical illness which is easily identifiable by a physician.

One of the main arguments against euthanasia legislation is the so-called ‘slippery slope’ argument which presupposes that enactment of legislation will result in an increase in cases of euthanasia and the law will be relaxed even further to allow for other vulnerable groups to make use of the practice as well.⁴⁶ For instance, it appears that in the Netherlands, the law has been substantially relaxed to the extent that patients are now being euthanized for psychiatric disorders instead of merely physical

⁴⁰ The Belgian Act on Euthanasia *supra*; 3 § 1.

⁴¹ J Samanta ‘Children and euthanasia: Belgium’s controversial new law’ (2015) *Diversity & Equality in Health and Care* available at <http://diversityhealthcare.imedpub.com/children-and-euthanasia-belgiums-controversial-new-law.php?aid=3729>, accessed on 14 October 2016.

⁴² *Ibid.*

⁴³ R Cohen-Almagor (note 31 above; 438).

⁴⁴ For instance in South Africa, such information about the drugs to be used would be published in the Health Professions Council of South Africa’s ethical guidelines booklet.

⁴⁵ R Cohen-Almagor (note 31 above; 438); section 3 of the legislation specifically provides that a patient may request euthanasia if they are suffering from some condition which means that they are suffering either mentally or physically from unbearable pain suffering from some incurable medical condition.

⁴⁶ J Samanta (note 41 above).

ailments.⁴⁷ This is why it is necessary that the legislation be well drafted and provides adequate safeguards to ensure minimal abuse. It is also imperative that those who transgress the law be prosecuted and convicted. As was shown in chapter two of this dissertation, in instances where a physician assisted a patient to die, the physician is generally handed a suspended sentence. The implementation of euthanasia legislation should provide that those who transgress the provisions therein are held criminally liable for their actions and the courts should thereafter follow with a punitive sentence.

In opposition to the above slippery slope argument, it has been said that countries which have enacted euthanasia law have fewer instances of euthanasia without the consent of the patient as opposed to those countries whose laws allow for a person to legally request euthanasia.⁴⁸ Many doctors in Belgium have suggested that in fact the enactment of the new euthanasia laws in that country have not increased the number of patients dying as a result of euthanasia but rather that physicians have instead been able to carry out legal mercy killings as opposed to doing such illegally.⁴⁹ It is argued that the ‘slippery slope’ argument is confirmed with reference to the substantial increase in the number of patients in Belgium who have opted for euthanasia to cause death.⁵⁰ This does not, however, necessarily mean that there is abuse of the practice, although many people tend to jump to this conclusion automatically. Instead it may simply mean that more people are exercising their rights and deciding to be euthanized when they are terminally ill. It also means that these deaths are reported and recorded whereas prior to legislation, if a person was euthanized it was illegal and the true cause of death was not reported. The study referred to in the Chambaere article, indicates that along with an increase in the requests for euthanasia, there also appears to be more willingness on the part of physicians to comply with the statutory provisions of the Euthanasia Act.⁵¹

Since the extension of the Belgian law to include children as well, there has only been one case of a terminally ill minor being euthanized.⁵² The fact that in 2 years there has only been one case shows that there are actually very few cases of terminally ill children who wish to make use of the euthanasia

⁴⁷ JV Larsen ‘Legal assisted suicide in South Africa’ (2015) 105(7) *SAMJ* 513-514.

⁴⁸ R Cohen-Almagor (note 31 above; 436).

⁴⁹ R Cohen-Almagor (note 31 above; 438).

⁵⁰ K Chambaere et al ‘Recent trends in euthanasia and other end-of-life practices in Belgium’ (2015) 372(12) *New England Journal of Medicine* 1179: There has been an increase of 1.9% to 4.6% in the number of deaths as a result of euthanasia between the years 2007 and 2013.

⁵¹ K Chambaere et al (note 50 above; 1180).

⁵² The minor child is believed to have been 17 years old and ‘critically ill’ (D Chazan ‘Terminally ill child becomes first euthanized minor in Belgium’ *Telegraph Online* 17 September 2016, available at <http://www.telegraph.co.uk/news/2016/09/17/terminally-ill-child-becomes-first-euthanised-minor-in-belgium/>, accessed on 5 October 2016).

legislation. It also shows that the so called ‘slippery slope’ argument is a fallacy. Nevertheless, this does not mean that children should not also be permitted to die with dignity and end their suffering if they wish to do so.⁵³ The decision of a patient to die with dignity when one is terminally ill is of such importance that it is not one which should be allowed only for adults.

5.3 Netherlands

In terms of the law in the Netherlands, euthanasia is the practice of a physician administering medication to the patient, at the request of the patient, with the intention of causing death.⁵⁴ The legislation provides that the physician attending to the patient who requests death must be sure that the consent given is ‘voluntary and well considered.’⁵⁵ The patient’s suffering must be ‘lasting and unbearable’ and there must appear to be no alternative to the patient in the circumstances.⁵⁶ In order to try and minimise abuse, the Act further provides that the physician must inform the patient of all the medical alternatives available to him so that he can then make an informed decision and further, an independent doctor must be consulted before the request can be granted.⁵⁷ These safeguards are virtually identical to those provided for in the Belgian legislation discussed above. The common thread running through the legislation is that it is always necessary that more than one physician agree to grant the request for euthanasia and that these physicians must ensure that the patient is suffering from a terminal illness and is in unbearable pain. It is essential that these doctors ensure that the patient’s situation is futile. Furthermore, it is essential to ascertain that the patient’s request for euthanasia is given voluntarily and that it is in fact the wish of the patient to die.

⁵³ Professor Wim Distelmans, the head of Belgium’s Federal Control and Evaluation Committee on Euthanasia, acknowledged that there are very few minors that are even eligible for euthanasia but that this does not mean that those who are eligible should be prohibited from dying with dignity (D Chazan ‘Terminally ill child becomes first euthanized minor in Belgium’ Telegraph Online 17 September 2016, available at <http://www.telegraph.co.uk/news/2016/09/17/terminally-ill-child-becomes-first-euthanised-minor-in-belgium/>, accessed on 5 October 2016).

⁵⁴ A Van der Heide et al ‘End-of-life practices in the Netherlands under the Euthanasia Act’ (2007) 356(19) *New England Journal of Medicine* 1958.

⁵⁵ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 Article 2 1(a).

⁵⁶ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 Article 2 1(b) and (d).

⁵⁷ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 Article 2 1(c) and (e).

5.3.1 Dutch legislative safeguards

In the Netherlands, the Euthanasia Act⁵⁸ provides that a minor over the age of 12 can request physician assistance to die or request euthanasia but only with the consent of his/her parents.⁵⁹ A child over the age of 16 does not require the consent of his/her parents but does require parental assistance.⁶⁰ In both events above, the minor's ability to understand his interests must always be assessed before the decision to die can be granted.⁶¹ The legislation specifically stipulates that a minor must have 'reasonable understanding of his interests' in order for that child to be considered competent and for their request for euthanasia to be granted.⁶² This indicates an assessment of a child's competence to make such a decision before allowing for the request to be granted.

The Dutch legislation places a strong emphasis on family involvement in the decision to die. This is can be seen specifically in respect of the legislation as it relates to minors. Unlike the Belgian legislation, the Dutch legislation provides that a minor between the age of 12 and 16 must attain parental consent before the request for euthanasia may be granted. Despite it being imperative the decision made by the patient is ultimately a voluntary one, it is suggested that it is important that the decision to opt for euthanasia should be extensively discussed with the patient and/or family or relatives.⁶³ It is also implied that a similar approach should be adopted in respect of palliative care measures such as palliative sedation.⁶⁴ Although the law on euthanasia should provide patients with the option to die, it should never allow for people to be euthanized without their explicit and uncoerced consent. To allow for such would be unethical and unlawful.⁶⁵ The Dutch legislation attempts to provide safeguards in order to minimise abuse and to prevent the vulnerable from being coerced into consenting to death while at the same time allowing for people to make an end of life decision and to die with dignity.

Following the enactment of euthanasia legislation, there always appears to be concern that the number of deaths in the country will increase unnecessarily as a result of the practice being legally permitted. Studies show that after the enactment of the Dutch euthanasia legislation, however, there was a

⁵⁸ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002

⁵⁹ G Poussett (note 4 above; 1).

⁶⁰ Ibid.

⁶¹ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 Article 2 (3) and (4).

⁶² Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 Article 2 (3) and (4).

⁶³ B Farham 'End-of-life practices in the Netherlands' (2012) 30(8) *CME* 271.

⁶⁴ Ibid.

⁶⁵ Ibid.

decrease in the number of deaths resulting from euthanasia or physician assisted dying, mainly attributed to greater reliance on end-of-life care such as palliative care and continuous deep sedation.⁶⁶ Studies have also shown that there does not appear to be abuse of the vulnerable in euthanasia cases.⁶⁷

The Dutch legislation, in a similar way to the Belgian Euthanasia Act, also provides for the establishment of a review committee.⁶⁸ The committee analyses the terminations of life on request and investigates instances where it appears that the attending physician has not taken due care in terms of the Act.⁶⁹ In a case where it is suspected that the physician has not followed the prerequisite due care requirements, the case may be handed over to the public prosecutor for criminal prosecution of the physician.⁷⁰ The committee also has the function of reporting cases in which life has been terminated on request by the patient in terms of the Act.⁷¹ This is a particularly necessary feature of the legislation as it makes provision for penal sanction should the requirements as stipulated in the legislation not be fulfilled and a request be granted nevertheless.

5.4 Proposed South African legislation

As considered previously in this dissertation, specifically in chapter 2, South African law does not permit any form of voluntary active euthanasia at common law level and there is currently no legislation enacted in order to allow for or regulate the practice. The South African Law Commission drafted a report and proposed legislation regulating the practice of voluntary active euthanasia in a report titled '*Euthanasia and the Artificial Preservation of Life*.'⁷²

The draft Bill 'To regulate end of life decisions and to provide for matters incidental thereto'⁷³ provides for three different legal options in respect of the practice of voluntary active euthanasia. The options can be summarised as follows:

Option 1 – No legislation is enacted. This would mean that there simply needs to be a confirmation of the current legal position in respect of euthanasia in that the practice is considered to be unlawful and

⁶⁶ A Van der Heide et al (note 54 above; 1957, 1962).

⁶⁷ B Farham (note 63 above; 271).

⁶⁸ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 Chapter 3.

⁶⁹ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 Chapter 3.

⁷⁰ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 Chapter 3, Article 10.

⁷¹ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 Article 17.

⁷² South African Law Commission Issue Project 86 *Euthanasia and the Artificial Preservation of Life* (1998).

⁷³ South African Law Commission Issue Project 86 supra 224.

instead, those who are suffering from terminal illnesses should instead receive palliative care until their natural death.⁷⁴

Option 2 – If a patient requests that a doctor assist him or her in ending his or her suffering by either providing or administering some form of lethal substance which will result in the patient’s death, the medical practitioner should assist the patient as requested provided certain requirements are met:⁷⁵

- ‘(a) the patient is suffering from a terminal or intractable and unbearable illness;
- (b) the patient is over the age of 18 years and mentally competent;
- (c) the patient has been adequately informed in regard to the illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;
- (d) the request of the patient is based on a free and considered decision;
- (e) the request has been repeated without self-contradiction by the patient on two separate occasions at least seven days apart, the last of which is no more than 72 hours before the medical practitioner gives effect to the request;
- (f) the patient, or a person acting on the patient's behalf in accordance with subsection (6), has signed a completed certificate of request asking the medical practitioner to assist the patient to end the patient's life;
- (g) the medical practitioner has witnessed the patient's signature on the certificate of request or that of the person who signed on behalf of the patient;
- (h) an interpreter fluent in the language used by the patient is present in order to facilitate communication when decisions regarding the treatment of the patient are made where the medical practitioner as contemplated in this section does not share or understand the first language of the patient;
- (i) ending the life of the patient or assisting the patient to end his or her life is the only way for the patient to be released from his or her suffering.’

⁷⁴ South African Law Commission Issue Project 86 supra 143.

⁷⁵ South African Law Commission Issue Project 86 supra 228 5(1).

The legislation further requires that an independent medical practitioner should also be consulted before a request can be given effect to.⁷⁶ The draft legislation provides further that only a medical practitioner can carry out the request in question.⁷⁷ One of the requirements listed above that must be fulfilled in order for a request to die to be affected is that the patient must sign a certificate of request which is a document signed by the patient requesting that a medical practitioner assist them to die.⁷⁸ The draft legislation acknowledges that a patient may change his or her mind with regard to requesting death and in such an instance where a patient changes his or her mind, the certificate of request shall be destroyed by the medical practitioner.⁷⁹ The whole of s 7 in fact, provides for the right of a patient to rescind his or her request after he or she has made it. This is one of the safeguards that protect patients as the request must be entirely voluntary and the patient is at liberty to rescind that request should he or she change his or her mind about the request to die.

Option 3 - This option provides for the establishment of a panel or committee which would either grant or refuse a request for assistance to die made by a patient. The committee consists of the following members:

- a) two medical practitioners other than the practitioner attending to the patient;
- b) one lawyer;
- c) one member sharing the home language of the patient;
- d) one member from the multi-disciplinary team; and
- e) one family member.⁸⁰

The committee will decide whether a request will be granted, provided that they are satisfied that the request is made voluntarily and with proper consideration, the patient is in fact terminally ill and that the only way they can be released from their suffering is through euthanasia.⁸¹ Such a decision must be made by the committee within 3 weeks of the date on which the request for euthanasia is received by the committee.⁸² Following the granting of a euthanasia request, the committee must report to the

⁷⁶ South African Law Commission Issue Project 86 supra 229 5(2).

⁷⁷ South African Law Commission Issue Project 86 supra 230 5(4).

⁷⁸ South African Law Commission Issue Project 86 supra 229 5(1)(f).

⁷⁹ South African Law Commission Issue Project 86 supra 230 7(a).

⁸⁰ South African Law Commission Issue Project 86 supra 231.

⁸¹ South African Law Commission Issue Project 86 supra 231 5(2).

⁸² South African Law Commission Issue Project 86 supra 232 5(3).

Director-General of Health with particulars of the patient, medical practitioner carrying out the request, place, date and reasons for the request as well as particulars of the members of the committee involved in the granting of the request.⁸³ The draft bill further includes provisions relating to the advance directives but this falls outside the scope of this dissertation.

It is submitted that option one listed above unnecessarily infringes on a patient's right to die with dignity and to be able to make choices regarding their own bodies. The provisions listed under option two of the draft legislation, however, are prudent and well drafted. It is, however, submitted that the legislation should also provide for mature minors to be able to request death and to have such a request granted, as is provided for in the Belgian and Dutch legislation. In such an instance, the child's mental capacity and competence to make an end of life decision would need to be assessed. This is certainly a conceivable assessment given that the legislation requires that a person be mentally competent in any event in order to have their request for euthanasia granted. The legislation should further include additional safeguards in respect of children. This should include assessment by a child psychologist in order to ensure that the child is competent to make the decision and understands the decision he or she is making. Furthermore, a child under the age of 18 who requests euthanasia should also require parental consent in line with the provisions of the Belgian Euthanasia legislation. This is because it is generally accepted that a parent is in a good position to understand their child's condition. Consent should be given by either the parents or guardians of the child and if the child does not have parents or guardians, such a child should be permitted to attain consent from the High Court in lieu of parental consent.

In all instances, it is of utmost importance that the patient's condition and alternatives be explained to him or her in his or her home language in a manner that he or she can understand. This may mean the assistance of an interpreter and in all instances it is necessary that measures are taken to ensure that the patient is fully aware of his or her condition and the alternatives available to him or her so that the decision made by the patient is a well informed one. It must be restated that euthanasia should always be considered a course of last resort and not a decision made on a whim. It should be a well considered, voluntary decision which is made in order to end suffering when a patient's condition is considered to be futile. This is why safeguards regulating the practice of euthanasia are of utmost importance in order to minimise abuse while at the same time ensuring that those patients who are suffering unbearably are permitted to die with dignity, provided they are mentally competent and mature to make the decision to die.

Option three of the Draft Bill in conjunction with the conditions listed in option two is perhaps the best way in which abuse can be minimised. This would be in line with the Belgian legislation which

⁸³ South African Law Commission Issue Project 86 supra 232 5(4).

establishes a multidisciplinary team that assesses and grants a request for euthanasia and is arguably preferable to the Dutch legislation which merely provides for assessment by physician and a consulting independent doctor. A multidisciplinary team, specifically in relation to a request made by a child is perhaps a better way of ensuring that the child in question is competent to make the decision and that the consent given is valid consent. If the patient is to submit the request to the panel, along with supporting information, for instance in the case of a child, proof of parental consent, then the panel can decide whether the request is to be granted or not. Given that the committee is comprised of a number of individuals chosen for specific reasons, it may minimise abuse of the practice of euthanasia by refusing requests which do not adequately fulfil the requirements stipulated in the legislation.

5.5 Conclusion

Both the Belgian and Dutch legislation allows for minors to request euthanasia provided that they have the capacity to make that decision. The difference between the law in those countries, however, is that the Belgian legislation places no age limit on the patient who requests death but instead focuses on the decision making capacity of a patient in order to decide whether a request for euthanasia be granted or not. The Dutch legislation, on the other hand, provides that only a child over the age of 12 may request euthanasia and if such a child is between the age of 12 and 16, the child must acquire parental consent before the request be granted. The legislation in the Netherlands, like the Belgian legislation, additionally provides that the minor must have the maturity and capacity to make the decision to die. The legislation proposed by the South African Law Commission in respect of allowing voluntary active euthanasia is well drafted and provides for stringent conditions and requirements, similar to those in the foreign jurisdictions which must be fulfilled in order for a request for euthanasia to be granted. It is submitted that the legislation should provide that a multidisciplinary team to grant requests for euthanasia, as suggested in option 3 of the South African Law Commission report but that the decision should be granted based on the requirements listed in option 2 being sufficiently fulfilled.

It is submitted, however, that the proposed legislation should be extended to allow for mature minors to make use of the practice as well. In order to minimise abuse in respect of children, additional safeguards should be included in the legislation to ensure that minors are adequately protected. Recommendations in this regard will be discussed in the final chapter. It is submitted that a child psychologist should assess a child prior to the granting of a request for euthanasia in order to ensure that the child is sufficiently competent and mature to make the decision to die. In addition, as is included in the Belgian Euthanasia legislation, a child should be required to obtain the consent of his

or her parents in order for the request for euthanasia to be granted. The Dutch legislation places strong emphasis on the need for discussion to be conducted with family members before the decision in question is taken, specifically in child cases. This approach should also be considered in respect of South African law and perhaps doctors should ensure that a patient has consulted with family members prior to making the decision. The fact that since the extension of the Belgian legislation to include children in the right to request death there has only been one child to make use of the legislation shows that in fact the cases in which a child may request death are very few. The decision to die with dignity, however, is such a colossal one, that children should not be ignored in legislation merely on the basis of age.

CHAPTER SIX: RECOMMENDATIONS AND CONCLUSION

6.1 Summary of research

The recent case of *Stransham-Ford*¹ has reopened the euthanasia debate in South Africa. The decision of the court a quo is currently being appealed in the Supreme Court of Appeal.² It is likely that the case will ultimately be heard in the Constitutional Court where the right to die will finally be decided upon judicially. The euthanasia debate is a highly controversial and uncomfortable one but it is something that needs careful consideration. If a terminally ill patient does constitutionally have the right to choose to die, then the need for legislation has to be contemplated as it is not possible for every individual suffering to approach a court. This dissertation intended to confront the even more uncomfortable question of a mature minor's right to die. The Constitution provides that in all matters the best interests of the child are of paramount importance and it is with this background that the question of death must be considered. Ultimately, the goal of the research was to show that it can never be in a child's best interests to force a terminally ill child to suffer against their will until death if they are sufficiently mature to make the decision to die.

South African law permits passive euthanasia and where for instance, a patient is on a ventilator, the doctor will remove the ventilator to bring about death if there appears to be no prospect of recovery and in many cases, family members will recommend this.³ The difference between active and passive euthanasia, however, is essentially an artificial one given that in both instances the intention and outcome is the same and often active euthanasia actually shortens suffering before death as opposed to passive euthanasia where a patient may still continue to suffer for quite some time until death naturally occurs. Making reference specifically to the elements of intention and causation which must both be present to be successful in a prosecution of murder, it was shown in chapter two that these elements are both present in respect of passive euthanasia and therefore the distinction between active and passive euthanasia is ultimately a superficial one. What must be borne in mind is that if the intention of the doctor in causing death is to protect the Constitutional rights of a patient and to honour their request, then the method of bringing about death – either through active or passive euthanasia – should be irrelevant. The goal of chapter two was also to show that consent to death could be a valid defense to wrongfulness because such consent does not encroach on public policy but

¹ *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 4 (GP)*.

² 'SCA to hear assisted suicide case' *eNCA Online* 4 November 2016, available at <http://www.enca.com/south-africa/sca-to-hear-assisted-suicide-case>, accessed on 22 November 2016.

³ See *Clarke v Hurst NO and Others 1992 (4) SA 630 (D)*.

instead allows for the rights of a terminally ill patient to be recognized. Of course competence to consent is always necessary and this is why it would only be in a case where a minor is mature enough to understand their decision that he or she would be permitted to consent to death.

Common arguments in opposition to euthanasia were considered and easily discredited in the penultimate stage of chapter two to show that such arguments do not negate the need to allow terminally ill patients the opportunity to die with dignity and further, mature minors who understand the implications of their decision. Finally, the legal progression in respect of cases considering assisted suicide and euthanasia clearly shows the reluctance of our courts to punish acts of euthanasia which are seen as ‘mercy killing’ to ease the suffering of the patient.⁴ This approach of leniency can be seen to an extent as a shift in the way in which the courts view euthanasia in that it is an acknowledgement that a person should not be severely punished when they are merely acting on the request of a terminally ill patient to end suffering. The most recent case on the matter, the case of *Stransham-Ford*,⁵ confirms that a terminally ill patient may rely on his constitutional rights to dignity, privacy and freedom and security of the person for an order allowing for physician assisted suicide to be granted. Nevertheless, this case is only persuasive in nature. Not every individual is like Mr Stransham-Ford and has the opportunity to approach court for an order and therefore the need for legislation is of paramount importance.

Chapters three and four considered the rights-based research problem in detail, with specific reference to children and their rights. Through an in-depth analysis of bioethical principles and human rights, it was shown that such rights should in a constitutional dispensation such as ours, be upheld and protected. This applies in respect of minors as well. Of course when dealing with the rights of minors to make decisions, specifically a decision as important as the decision to die, there are many factors to be considered. Chapter four showed that a variety of other legislation such as the Children’s Act and the Choice on Termination of Pregnancy Act allow for a child to consent to procedures which affect their own body namely treatment, surgery and abortion. This shows an acknowledgement by the legislature of a child’s right to make decisions about their own body. In terms of the Children’s Act, the child must be sufficiently mature to understand the procedure they are consenting to which shows the legislature’s reluctance to curb a child’s right to autonomy in respect of matter affecting their own bodies. The aim of this chapter was to show that it is both possible and practical to establish the competence and maturity of a minor to make the decision to die and that consequently such a child’s right to dignity and bodily integrity should be promoted by allowing such a child to request death. The

⁴ See the cases of *S v De Bellocq* (1975) 1 All SA 6 (T); *S v Hartmann* 1975 All SA 87 (C); *S v Marengo* (1991) 3 All SA 784 (W) and *S v Smorenburg* 1992 (2) SACR 389 (C) where the court handed down suspended sentences and showed a lenient approach to euthanasia.

⁵ *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 4 (GP).

intention behind this chapter was also to show that a child's right to autonomy should be given due consideration. Ultimately, the best interests of the child are of paramount importance and the goal of this research is to show that it cannot be in a terminally ill child's best interests to be forced to suffer until natural death, provided of course that the child is sufficiently competent to make the decision to die.

The penultimate chapter of this dissertation assessed the legislation in Belgium and the Netherlands in order to show how euthanasia allowing children to consent to death can in fact be well drafted and effective. The fact that since the 2014 amendment to the Belgian legislation to allow for minors to request euthanasia, only one child thus far has made use of the legislation shows that in fact it is unlikely that there will suddenly be a mass of cases where children are euthanized, as feared by the general public. In a situation where a child is suffering incredibly and there is no prospect of recovery, if that child is sufficiently competent to request death, the child should be permitted to do so – legislation saving any children, even if it is a small number, from unnecessary suffering, is necessary legislation. Chapter five considered the safeguards employed in the legislation in these foreign jurisdictions and further considered the draft bill proposed by the South African Law Commission in an attempt to consider how the South African law should be developed in respect of allowing euthanasia.⁶

6.2 Recommendations

6.2.1 Introduction

The case of *Stransham-Ford*⁷ has made jurisprudential progress in respect of the issue of euthanasia in South Africa but does not go nearly far enough. The case merely means that a person who approaches court for an order allowing a physician to assist them to die may be granted such an order and the doctor who assists such a patient would not be criminally prosecuted. The problem is that it still remains that a person must individually approach court for such an order and it is decided on a case by case basis. Not every terminally ill person who wishes to end their life has the resources or wherewithal to approach a court, much less a minor who would require assistance to approach a court as well. The implementation of legislation is the best way to regulate the practice and can ensure minimal abuse by putting in place strict safeguards. This dissertation has advocated throughout for the inclusion of mature minors in the legislation.

⁶ South African Law Commission Issue Project 86 *Euthanasia and the Artificial Preservation of Life* (1998).

⁷ *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 4 (GP)*.

The South African Law Commission proposed in its report, three different options to amend the current legal position on euthanasia.⁸ The third option listed in the Draft Bill, in conjunction with the factors and safeguards listed in the second option of the Draft Bill is perhaps the best way forward. This would establish a panel or committee that would review the request for euthanasia and would then make a decision to grant the request, provided certain conditions, as listed below, are fulfilled. The panel or committee should consist of various members including two medical practitioners – one of which is the medical practitioner attending to the patient, a lawyer, one member who speaks the home language of the patient, a family member and a child psychologist in the case of a child. Of course a request for euthanasia should only be granted provided the safeguards and conditions have been fulfilled.

6.2.2 Safeguards⁹

With the implementation of legislation, it is essential that certain safeguards be put in place and legislation must include requirements that must be fulfilled in order for a person to make use of the legislation. The purpose and intention behind euthanasia is mercy killing and allowing a patient autonomy and freedom of choice. Although terminally ill patients may be considered vulnerable groups, and even more so in the case of terminally ill minors, safeguards in the legislation minimize abuse. Unfortunately, there are already cases of euthanasia happening unlawfully. With the promulgation of legislation, there is more chance of the strict guidelines and rules being followed in order that people are being euthanized at their legitimate request. Having stringent safeguards and conditions will reduce the chance of abuse. The below conditions act as safeguards to try and minimize abuse of the terminally ill while still recognizing their right to freedom of choice.

- i) The type of illness

The patient must be suffering from a terminal illness or disease and suffering from unbearable pain as a result. This dissertation has only considered physical ailments and illnesses and maintains that only illnesses of a physical nature should be considered to have fulfilled the requirement of illness in terms of the legislation. This is something that can be assessed by the doctor and must be confirmed by at least one other independent doctor.

⁸ South African Law Commission Issue Project 86 *Euthanasia and the Artificial Preservation of Life* (1998).

⁹ Many of these safeguards are suggestions of the South African Law Commission in their report Project 86 *Euthanasia and the Artificial Preservation of Life* (1998), although this dissertation amends certain provisions and various other recommendations are made.

ii) Confirmation by an independent doctor

The diagnosis and prognosis in (i) above must be confirmed and verified by an independent doctor before a request can be granted. In addition, it is only a qualified medical practitioner that can (a) diagnose the patient in (i) above and (b) carry out the request for euthanasia if it is granted.

iii) Mental competency

In order for a person to make the decision to die, they must be mentally competent to make the decision. This means that a person suffering from a mental illness would be unable to have a request for euthanasia granted as he or she cannot be considered mentally competent. The preceding chapters have shown that, provided a child is sufficiently competent to request euthanasia, the request should also be granted. A child would therefore need to be assessed for mental competency in the same way an adult would be assessed. This means that very young and immature children would be completely excluded from legislation and would not be able to request death. It is recommended that, especially in the case of a child patient, it should be a requirement that the child be assessed for competency and maturity by a qualified child psychologist who can correctly ascertain whether the child understands the implications of his or her decision to die.

iv) Parental or guardian consent

If a patient is under the age of 18, the patient must obtain the consent of their parent or guardian in order for the request to be granted. S 129 of the Children's Act provides only for parental assistance in respect of the decision to undergo surgery.¹⁰ It is preferable in terms of euthanasia legislation, however, that parental consent be required as opposed to just assistance. Parental consent is a more onerous burden than assistance but given that the decision to die is the most important decision a person can make, it seems necessary that parents actually consent to the death not just assist. If a parent refuses to consent, a child would need to approach court and the court would need to make an order to the effect that the child is sufficiently competent to make the decision and that the parent's lack of consent could be overridden. Similarly, if a child does not have living parents or his or her parents cannot be traced and the child does not have a guardian, then the child can approach the High

¹⁰s 129(3) of the Children's Act 38 of 2005: 'A child may consent to the performance of a surgical operation on him or her.. if – (a) the child is over the age of 12 years; (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and (c) the child is *duly assisted* by his or her parent or guardian.

Court for an order to the effect that the child can request euthanasia notwithstanding the lack of parental consent.

v) Full knowledge of condition, alternatives and manner of death

The patient must be informed fully by the medical practitioner of his or her condition. This includes the diagnosis and the prognosis. The medical practitioner must also discuss all alternatives with the patient: This could involve palliative care, sedation or other treatment options. One of the key components of consent is that the person consenting must have full knowledge of what they are consenting to. This means that it is also imperative that the manner in which the patient will die is explained to him or her. For instance, if the chosen method of death is the administration of a lethal injection, the doctor must explain the process involved and how death will finally occur.

vi) The decision is given freely and voluntarily

In respect of any legal matter, consent is only valid when it is given freely and voluntarily. The same applies to consent to death. It is essential that the consent given is given without coercion of any kind. It is especially necessary in respect of minors to establish that the child in question has in fact made the decision themselves and has not been influenced or coerced by parents or family members. This is also why it is recommended that a child psychologist should be involved in the process in order to ensure that the child does in fact want to die.

vii) Counseling

The decision to die is the most difficult and important decision that a person can make. It would therefore be prudent for legislation to include a provision stating that a person should be counseled before their request for euthanasia can be granted. This would operate in much the same way as counseling is a prerequisite in relation to virginity testing for children.¹¹ During this counseling, it would need to be suggested that the patient discuss their decision to die with their family, although this cannot be forced. The purpose of the counseling is to establish that the patient fully understands what he or she is consenting to and to ensure that the patient is of sound mind and is not merely depressed.

viii) Repeated request to die

The request to be euthanized must be repeated a number of times. There must be a period of at least one week between the requests. It is recommended that there must be two oral requests and at least

¹¹ Children's Act 38 of 2005, s 12(5)(a) & (b).

one formal, written request. This written request will be in the form of a certificate asking the doctor for assistance to die. The signature of the patient needs to have been witnessed by the medical practitioner in order for the certificate to take effect. The final request must be made not more than 72 hours before the medical practitioner gives effect to the request to die.

ix) Rescission of request

The patient can at any point leading up to the execution of the request, rescind the request. The patient would simply need to tell the attendant medical practitioner that he or she no longer wants to be euthanized. In such an instance, the certificate of request must be destroyed by the medical practitioner. This does not prevent the patient from later requesting euthanasia again but then the same criteria and time periods above must be fulfilled again.

x) Language

In all matters leading up to and including the request and decision by the patient to die, it is essential that the patient understands the medical practitioner. It is therefore necessary that there be an interpreter in a case where the medical practitioner does not speak the same language as the patient. In respect of children, it is essential that the medical practitioner explains things to the patient in an age appropriate, simple manner so that the child understands their condition, the alternatives and has full knowledge of what he or she is consenting to.

xi) Euthanasia is the only way to end suffering

Euthanasia should always be seen as a course of last resort, specifically in the case of minors. However, it must be accepted that there are instances where a minor suffers unbearable pain and the only manner of ending that suffering is through euthanasia. It must be acknowledged that palliative care can only go so far in relieving suffering and that there comes a point where pain cannot be relieved effectively. In such an instance where a child then requests euthanasia and fulfills all the conditions listed above, and euthanasia is the only method of relieving the child of his or her suffering, such a request should be granted.

xii) Development of guidelines for practitioners

Should legislation be promulgated allowing for terminally ill patients to make the decision to die, it would be prudent for the Health Professions Council of South Africa to develop guidelines for practitioners in respect of the practice. It would be wise to include the type of drugs that can and cannot be used by a practitioner to bring about death given that one of the criticisms of the Belgian

law is that the type of drugs to bring about death are not stipulated.¹² Perhaps it would be better to include this type of information in the ethical guidelines for medical practitioners as this is strictly a medical issue which legislators may not have the expertise to decide upon.

xiii) Establishment of a review committee and real chance of prosecution

One of the essential aspects of legislation is that there must be some form of sanction attached to it should the conditions of the legislation be transgressed. The Dutch and Belgian legislation establishes review committees and South African legislation should also include a similar structure. This body would be responsible for reviewing any instances where it appears as if there has been malpractice and will hand the case over for prosecution if it appears that the doctor has acted criminally. The committee who grants the request for euthanasia would need to report every instance of a euthanasia request granted to the review committee as the review committee would also have the function of collecting data for statistical purposes.

It is essential that should there be transgressions of the legislation the perpetrators will be criminally punished. The history of case law in respect of assisted suicide and euthanasia, as shown in chapter two, typically shows reluctance by the courts to hand down hefty sentences for people who assist others to die if it is seen as mercy killing. With the implementation of legislation, this attitude would change given that a patient would then be permitted to legally request euthanasia. In instances where the correct procedure is not followed, the courts would need to hand down harsh sentences to the perpetrators.

6.3 Final remarks

The intention of this research was to consider the issue of mature minors requesting their own death in light of the call for euthanasia legislation to be promulgated in South Africa. It cannot be disputed that children enjoy the right to dignity, bodily integrity and privacy in the same way as adults do. It is understandable that in many legal matters rigid age limits must be set if nothing else, for convenience sake. This is a different issue, however, and one which requires serious consideration. This is a unique issue because it revolves around the choice and right to die but it is because this issue is so unique and the decision so important, that it becomes absolutely essential to consider the position of terminally ill mature minors when considering legislation.

¹² R Cohen-Almagor 'Belgian euthanasia law: a critical analysis' (2009) 35(7) *Journal of Medical Ethics* 438.

The case of *Stranham-Ford* showed that a person can in fact rely on his or her constitutional rights to obtain an order that allows one to acquire assistance to die and in such an instance the medical practitioner would not be held criminally liable. However, this case only opens the discussion on euthanasia to the extent that the need for legislation is being reconsidered and this is why it is essential at this time that the position of mature minors also be considered.

This research only went as far as to consider the position of those who are suffering from a physical illness or disease which is terminal in nature and did not consider mental illness. This is perhaps a debate for a further dissertation in which it needs to be decided whether mental illness can be considered a terminal illness and included in euthanasia legislation. There are various other conditions which many may consider to be worthy of ‘mercy killing’ but this is something which needs further research and discussion in the medical, jurisprudential and legal fields and which falls outside the scope of this dissertation.

Ultimately, it should always be the aim of legislators to promote the rights of the terminally ill, especially in the case of minors. When considering the best interests of the child principle, in conjunction with the rights enjoyed by minors in terms of the Constitution, it is submitted that it does more harm than good, and is not in the best interests of a terminally ill mature minor to force that minor to suffer unbearable pain until death and to infringe upon that minor’s rights to dignity, bodily integrity and privacy.

Olly’s situation is not a unique one.¹³ Many children suffer from terminal illnesses and suffer unbearable pain until death. If legislation were to be promulgated, Olly’s situation could be vastly different. Provided he is assessed to be sufficiently mature to understand the implications of his decision and that all the above mentioned conditions are also fulfilled, for instance he is able to get parental consent, then Olly should be permitted to die a dignified death. It can never be in Olly’s best interests to be forced to suffer unbearable pain until his natural death occurs. The law has a duty to protect and promote human rights, including and especially, those of children. Instead of denying Olly the right to die with dignity, his right to autonomy and to make a choice about his own body should be permitted. The right to dignity is not a right that should ever be limited, as it is a right which ‘requires us to acknowledge the value and worth of all individuals as members of society.’¹⁴ To not promote and protect Olly’s rights is to not acknowledge him as a human being worthy of dignity.

¹³ Refer to the analogy of Olly in chapter one.

¹⁴ *National Coalition for Gay and Lesbian Equality v Minister of Justice 1999 (1) SA 6 (CC)* at 29.

7. BIBLIOGRAPHY

7.1 Books

Beauchamp, TL & Childress, JF *Principles of Biomedical Ethics 3 ed* Oxford: Oxford University Press, (1989).

Boezaart, T *Child Law in South Africa* Claremont: Juta & Co, (2009).

Burchell, J *Principles of Criminal Law 5 ed* Claremont: Juta & Co. Ltd, (2016).

Currie, I & De Waal, J *The Bill of Rights Handbook 6th ed* Cape Town: Juta, (2013).

Dhai, A & McQuoid-Mason, D *Bioethics, Human Rights and Health Law: Principles and Practice* Claremont: Juta, (2011).

Elliston, S *The Best Interests of the Child in Healthcare*. Oxon: Routledge-Cavendish, (2007).

Fortin, J *Children's Rights and the Developing Law 3 ed* New York: Cambridge University Press, (2009).

Hagger, L *The Child as Vulnerable Patient* Surrey: Ashgate Publishing Limited, (2009).

Haybron, D 'Philosophy and the science of subjective well-being' in Eid, M & Larsen, R *The Science of Well Being* Guilford Press, (2008).

Harrap's Dictionary of Medicine and Health London: Harrap, (1988).

Mason, JK & Laurie, GT *Mason and McCall Smith's Law and Medical Ethics* New York: Oxford University Press, (2011).

Montgomery, J *Health Care Law 2 ed*. New York: Oxford University Press, (2003).

Singer, P *Applied Ethics* New York: Oxford University Press, (1986).

Snyman, CR *Criminal Law 6 ed* Durban: LexisNexis, (2014).

Stauch, M *Text, Cases & Materials on Medical Law 3 ed* New York: Routledge-Cavendish, (2005).

7.2 Journal articles

- Bernard, RB & Buthelezi, MC 'A critical reflection on the South African law of the child' (2014) 35(2) *Obiter* 345-356.
- Bhamjee, S 'Is the right to die with dignity constitutionally guaranteed? Baxter v Montana and other developments in patient autonomy and physician assisted suicide (2010) 31(2) *Obiter* 333-352.
- Bircher, J 'Towards a dynamic definition of health and disease' (2005) 8(3) *Medicine, Health Care and Philosophy* 335-341.
- Carter, B 'Why palliative care for children is preferable to euthanasia' (2016) 33 (1) *American Journal of Hospice and Palliative Medicine* 5-7.
- Chambaere, K 'Recent trends in euthanasia and other end-of-life practices in Belgium' (2015) 372(12) *New England Journal of Medicine* 1179-1180.
- Chesterman, S 'Last Rights: Euthanasia, the sanctity of life, and the law in the Netherlands and the Northern Territory of Australia' (1998) 47 *International & Comparative Law Quarterly* 362-393.
- Cohen-Almagor, R 'Belgian euthanasia law: a critical analysis' (2009) 35 (7) *Journal of Medical Ethics* 436-439.
- Dan, B. ... et al. 'Self-requested euthanasia for children in Belgium' (2014) 383 (9918) *The Lancet* 671-672.
- Devereaux, J. ... et al. 'Can children withhold consent to treatment?' (1993) 306 (1890) *BMJ* 1459-1461.
- Dhai, A 'An introduction to informed consent: ethico-legal requirements' (2008) 63(1) *SADJ: Journal of the South African Dental Association* 018-020.
- Dhai, A 'Informed consent - 2008' (2008) 1(1) *South African Journal of Bioethics and the Law* 27-30.
- Dhai, A 'Physician-assisted dying and palliative care: Understanding the two' (2015) 8(2) *SAJBL* 2-3.
- Du Plessis, E. ... et al. 'The constitutional rights of children to bodily integrity and autonomy' (2014) 35(1) *Obiter* 1-23.
- Farham, B 'End-of-life practices in the Netherlands' (2012) 30(8) *CME* 271.
- Fisher, H 'Assent to participate in healthcare research' (2013) 26(3) *Current Allergy & Clinical Immunology* 145-150.
- Foot, P 'Euthanasia' (1977) 6(2) *Philosophy and Public Affairs* 85-112.

Friedel, M 'Does the Belgian law legalising euthanasia for minors really address the needs of life-limited children' (2014) 20(6) *Int J Palliat Nurs* 265-7.

Jordaan, J 'The legal validity of an advance refusal of medical treatment in South African law (part 1)' (2011) 44(1) *De Jure* 32-48.

King, S 'Ethical issues in treating children' (2011) 24(4) *Current Allergy & Clinical Immunology* 218-220.

Knapp van Bogaert, D & Ogujbanjo, G 'Ethics and medicine: revisiting the Children's Act and the implications for healthcare practitioners' (2013) 55(1) *South African Family Practice* S2-S5.

Krause, S 'Going gently into that good night: the constitutionality of consent in cases of euthanasia ' (2012) 33(1)*Obiter* 47-71.

Kruger, H 'Traces of Gillick in South African jurisprudence: two variations on a theme' (2005) 46(1) *Codicillus* 1-14.

Larsen, JV 'Legal assisted suicide in South Africa' (2015) 105(7) *SAMJ* 513-514.

Laskin, A 'Beyond autonomy? A Transnational comparison of end-of-life decision making by mature minors' (2014) 18 *Mich. St. UJ Med. & L.* 139-159.

Levy, MDL 'Informed consent/assent in children. Statement of the Ethics Working Group of the Confederation of European Specialists in Paediatrics (CESP)' (2003) 169(2) *European Journal of Pediatric* 629-633.

Mahery, P 'Consent laws influencing children's access to health care services' (2016) *South African Health Review* 167-180.

Manyathi-Jele, N 'Judge's ruling in assisted suicide case divides South Africa: news' (2015) 553 *De Rebus* 4-7.

McQuoid-Mason, DJ & Dada, MA 'The National Health Act: some implications for family practice' (2008) 24(1) *Continuing Medical Education* 12-14.

McQuoid-Mason, DJ 'Doctor-assisted suicide: What is the present legal position in South Africa?' (2015) 105(7) *SAMJ* 526-527.

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) *SAMJ* 102-103.

McQuoid-Mason, DJ 'Provisions for consent by children to medical treatment and surgical operations, and duties to report child and aged persons abuse: 1 April 2010' (2010) 100(10) *SAMJ* 646-648.

McQuoid-Mason, DJ 'Stransham-Ford v. Minister of Justice and Correctional Services and Others: Can active voluntary euthanasia and doctor-assisted suicide be legally justified and are they consistent with the biomedical ethical principles? Some suggested guidelines for doctors to consider' (2015) 8(2) *SAJBL* 34-40.

McQuoid-Mason, D 'The National Health Act and refusal of consent to health services by children'

Moodley, K 'The Fabricius decision on the Stransham-Ford case – an enlightened step in the right direction' (2015) 105(6) *SAMJ* 434-435.

Moyo, A 'Child participation under South African law: Beyond the convention on the rights of the child' (2015) 31(1) *South African Journal on Human Rights* 173-184.

Ngwenya, C 'Health-care decision making and the competent minor: the limits of self-determination' (1996) *Acta Juridica* 132-147.

Nicholson, C & Politis, A 'Life and death lottery: Tipping the scales in favour of the child's best interests' (2001) *De Jure* 594.

Ogden, R 'The right to die: A policy proposal for euthanasia and aid in dying' (1994) 20(1) *Canadian Public Policy/Analyse de Politiques* 1-25.

Poussett, G. ... et al. 'Attitudes and practices of physicians regarding physician-assisted dying in minors' (2010) 182139 *Archives of Disease in Childhood* 1-6.

Rachels, J 'Active and Passive Euthanasia' (1975) 292(2) *New England Journal of Medicine* 78-80.

Rodogno, R 'Happiness and well-being: Shifting the focus of the current debate' (2014) 33(4) *South African Journal of Philosophy* 433-446.

Ryff, C 'Psychological well-being in adult life' (1995) 4(4) *Current Directions in Psychological Science* 99-104.

Siegel, A 'Pediatric euthanasia in Belgium: Disturbing developments' (2014) 311(19) *Jama* E1-E2.

Strode, AE. ... et al. 'Boni mores and consent for child research in South Africa' 2015 8(1) *SAJBL* 22-25.

Van der Heide, A. ... et al. 'End-of-life practices in the Netherlands under the Euthanasia Act' (2007) 356(19) *New England Journal of Medicine* 1957-1965.

Van der Walt, G & Du Plessis, EK ' "I don't know how I want to go but I do know that I want to be the one who decides"-the right to die-the high court of South Africa rules in Robert James Stransham-Ford and Minister of Justice and Correctional Services; The Minister of Health Professional Council

of South Africa and the National Director of Public Prosecution (3 June 2015): cases.' (2016) 36(3) *Obiter* 801-814.

Van Der Werff Ten Bosch, J 'Belgium's euthanasia law gives terminally ill children the right to die' *PBS Newshour Online*, 17 January 2015 available at <http://www.pbs.org/newshour/bb/belgium-terminally-ill-children-right-die/>, accessed on 14 October 2016.

Vracking, AM. ... et al 'Medical end-of-life decisions for children in the Netherlands' (2005) 159(9) *Archives of Pediatric & Adolescent Medicine* 802-809.

7.3 Newspaper articles

Anon 'SCA to hear assisted suicide case' *eNCA Online*, 4 November 2016 available at <http://www.enca.com/south-africa/sca-to-hear-assisted-suicide-case>, accessed on 22 November 2016.

Chazan, D 'Terminally ill child becomes first euthanised minor in Belgium' (2016) *Telegraph Online*, 17 September 2016 available at <http://www.telegraph.co.uk/news/2016/09/17/terminally-ill-child-becomes-first-euthanised-minor-in-belgium>, accessed on 5 October 2016.

Feliciano, I 'Belgium's euthanasia law gives terminally ill children the right to die' *PBS Newshour Online*, 17 January 2015 available at <http://www.pbs.org/newshour/bb/belgium-terminally-ill-children-right-die/>, accessed on 14 October 2016.

Samanta, J 'Children and euthanasia: Belgium's controversial new law' (2015) *Diversity & Equality in Health and Care* available at <http://diversityhealthcare.imedpub.com/children-and-euthanasia-belgiums-controversial-new-law.php?aid=3729>, accessed on 14 October 2016.

7.4 Table of cases

7.4.1 South African cases

Advance Mining Hydraulics (Pty) Ltd and Others v Botes NO and Others 2000 (1) SA 815 (T).

African Dawn Property Finance 2 (Pty) Ltd v. Dreams Travel and Tours CC and Others 2011 (3) SA 511 (SCA).

Bernstein and others v Bester and others NNO 1996 (4) BCLR 449.

Bhe v Magistrate, Khayelitsha (Commission for Gender Equality as Amicus Curiae); Shibi v Sithole; South African Human Rights Commission v President of South Africa 2005 (1) SA 580 (CC).

C and others v Department of Health and Social Development, Gauteng and others 2012 (2) SA 208 (CC).

Castell v Greef 1994 4 SA 408 (C).

Centre for Child Law and v MEC for Education, Gauteng 2008 (1) SA 223 (T).

Centre for Child Law v Minister of Justice and Constitutional Development and others 2009 (6) SA 632 (CC).

Christian Lawyers' Association v National Minister of Health 2004 (10) 1086 BCLR (T).

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

Ex Parte Die Minister van Justisie: In re S v Grotjohn (1970) 2 All SA 491 (A).

Ferreira v Levin and Others 1996 (1) SA 984 (CC).

Government of the Republic of South Africa and Others v Grootboom and Others 2000 (11) BCLR 1169 (CC).

Harksen v Lane NO 1998 (1) SA 300 (CC).

Hay v B 2003 (3) SA 492 (W).

McCall v McCall (1994) 2 All SA 212 (C).

National Coalition for Gay and Lesbian Equality v Minister of Justice 1999 (1) SA 6 (CC).

R v Nbakwa 1956 2 SA 557 (SR).

R v Peverett 1940 AD 213.

R v Dawidow WLD 155 (unreported).

Soobramoney v Minister of Health, KwaZulu-Natal 1998 (1) SA 765 (CC).

S v De Bellocq (1975) 1 All SA 6 (T).

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

S v Hartmann 3 1975 All SA 87 (C).

S v Hibbert (1979) 2 All SA 323 (D).

S v M (Centre for Child Law as Amicus Curiae) 2008 (3) SA 232 (CC).

S v Makwanyane 1995 6 BCLR 665 (CC).

S v Marengo 1991 3 All SA 784 (W).

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

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

Teddy Bear Clinic for Abused Children and another v Minister of Justice and Constitutional Development and another (Justice Alliance of South Africa and others as amici curiae) 2013 (12) BCLR 1429 (CC).

7.4.2 Foreign cases

A.C. v Manitoba (Director of Child and Family Services), 2009 SCC 30, [2009] 2 S.C.R. 181.

Airedale NHS Trust v. Bland [1993] 1 All ER 821 (AC).

Baxter v Montana [2009] MT 449.

Cruzan v Director, Missouri Health 497 US 261, 110 S Ct 284, 111 L Ed 2d 224 (1990) 730.

Gillick v West Norfolk and Wisbech Area Health Authority [1985] (1985) 3 All ER 402.

Quill v Vacco 521 US 793 (1997) 801.

R v Adams [1957] Crim. LR 365.

Re C (HIV Test) [1999] 2 FLR 1004).

Re M (Child: Refusal of Medical Treatment) [1999] 52 BMLR 124.

Re R (a minor) (wardship: consent to treatment) [1992] Fam 11.

Re W (a minor) (medical treatment: court's jurisdiction) [1993] Fam 64.

Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1992] 3 WLR 758.

R v Adams [1957] Crim. LR 365.

State v. Mackrill, 2008 MT 297, 345 Mont. 469, 191.

7.5 Table of statutes

7.5.1 South African Statutes

Animals Protection Act 71 of 1962

s 2

s 5

s 8

Children's Act 38 of 2005

s 9

s 12

s 129

s 134

Choice on Termination of Pregnancy Act 92 of 1996

s 5

Constitution of the Republic of South Africa, 1996

s 1

s 2

s 7

s 9

s 10

s 11

s 12

s 28

Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007

s 15

s 16

National Health Act 61 of 2003

s 6

Nursing Act 50 of 1978

s 16

s 27

s 44

7.5.2 Foreign statutes

The Belgian Act on Euthanasia of May, 28th 2002 (D Kidd translation from *Ethical Perspectives* (2002) 9 (2-3) 182-188)

§3

§4

§4

§6

§8

Oregon Death With Dignity Act 1997

Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002

Article 2

Article 10

Article 17

Chapter 3

7.6 Conventions, charters and resolutions

Convention on the Rights of the Child GA res 44/25 UN doc A/44/49 (1989) (entered into force 2 September 1990).

Organisation of African Unity, *African Charter of Human and People's Rights* (1981).

Organization of African Unity *African Charter on the Rights and Welfare of the Child* (1990).

United Nations International Covenant on Civil and Political Rights(1966).

United Nations International Covenant on Economic, Social and Cultural Rights (1966).

United Nations Universal Declaration of Human Rights (1948).

World Health Organisation, *The Constitution* (Geneva: WHO, 1948).

World Medical Association *Declaration of Venice on Terminal Illness* (2006) available at <http://www.wma.net/en/30publications/10policies/i2/>, accessed on 29 September 2016.

World Medical Association *Resolution on Euthanasia (2002)* available at www.wma.net/en/30publications/10policies/e13b/, accessed on 29 September 2016.

7.7 Commission Paper

South African Law Commission Issue Project 86 *Euthanasia and the Artificial Preservation of Life* (1998).

7.8 Professional Guidelines

South African Department of Health *South African Patients' Rights Charter* 2007 available at www.justice.gov.za/VC/docs/policy/Patient Rights Charter.pdf, accessed on 20 August 2016.

Health Professions Council of South Africa *Guidelines on Ethical Rules* available at <http://www.hpcsa.co.za/conduct/Ethics>, accessed on April 14 2016.

Health Professions Council of South Africa *Guidelines on Ethical Rules, Booklet 12: Guidelines for the Withholding and Withdrawing of Treatment* available at <http://www.hpcsa.co.za/conduct/Ethics>, accessed on 14 April 2016.

