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Death and dying in a constitutional democracy – An analysis of the South African criminal law and a call for law reform.

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2022

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Mummy, how I wish that you were here. I miss you. Today. Again. Always. This thesis is dedicated to you.

Suhayfa Bhamjee

16 July 2022

ACRONYMS

HPCSA	Health Professions Council of South Africa
DDE	Doctrine of double effect
PAE	Physician-administered euthanasia
PAS	Physician-assisted suicide
PE	Passive euthanasia
SALRC	South African Law Reform Commission
SCA	Supreme Court of Appeal
SCC	Supreme Court of Canada
VAE	Voluntary active euthanasia
WMA	World Medical Association

ABSTRACT

Murder is defined as the unlawful and intentional causing of the death of another human being. Suicide is not a crime. In South Africa, the act of assisting another person to commit suicide is prosecutable under the broad category of crimes classified as homicide – murder, attempted murder and culpable homicide; whether the assistance is the direct administration of a fatal drug or through the provision of the means by which to commit suicide. The current formulation of the common law is broad enough to include medically assisted yet consented-to deaths within the definition of the crime of murder. Some jurisdictions have decriminalised the acts of physician-assisted suicide and physician-administered euthanasia (collectively called voluntary active euthanasia -VAE) under specific conditions, notably the nature of the illness and the fact that a patient has requested and given informed consent for such assistance. In South African law, consent is not a defence to a charge of murder and, consequently, does not justify VAE, which is categorized as murder. When the elements of criminal liability are applied to VAE, they prove that the physician who assists a patient acts both causally and intentionally and cannot escape criminal liability because consent is not a defence in these circumstances.

In contrast to VAE, deaths consented to, intended and caused through passive euthanasia practices (e.g. withdrawing treatment or withholding treatment and/or life-sustaining mechanisms and the administration of palliative care and palliative/terminal sedation) have been medicalised. In other words, this form of intentionally causing the death of a patient is seen as a legitimate form of medical treatment, even though it undeniably hastens and causes death. However, for policy reasons is not treated as nor categorised as the crime of murder, provided that the patient has consented to (either personally or through a proxy) such fatal medical treatment.

The question of whether VAE should be de-criminalised was ventilated in 1998 when the South African Law Reform Commission considered arguments for and against decriminalisation of the practice, and a draft bill to that effect was prepared. To date, there has been no progress towards law reform by the Legislature. The case of *Stransham-Ford* reignited the issue. However, for various reasons, the court did not effect any change to the status quo. The Supreme Court of Appeal, however, did indicate that if a proper case was made, it might result in the development of the law to accommodate for a lawful form of medically-assisted dying. However, this would first require a thorough investigation into the reasons why

the practice is unlawful and criminal in the light of the definitional elements of the crime of murder and the policy reasons for such criminalisation. Only once that has been thoroughly canvassed, can the question of the limit placed on autonomy and patient consent be gauged for whether consent could be a defence in the specific and limited circumstance of a VAE scenario. At its core, the focus turns to autonomy in decision making, policy reasons for disregarding autonomy, and whether arguments for and against decriminalisation can be sustained in light of the spirit, purport and objects of the Bill of Rights of the Constitution.

Those in favour of the decriminalisation of VAE argue that the limit on autonomy and consent violates the constitutionally guaranteed rights to dignity, life and privacy. Those who are against it argue that the limit on autonomy is necessary to protect and preserve these very same rights. An analysis of these rights and the arguments can help determine whether reform or retention would be reasonable and justifiable under a Constitutional dispensation. This thesis considers the elements of criminal liability and the purpose for which the act of assisting another to die at their request has been criminalised to the extent that conduct on the part of an assisting physician is prosecutable as the common law crime of murder. The conclusion reached is that in the light of constitutional advancements, particularly in relation to the right to dignity as informed by autonomy, it is possible to decriminalise assisted dying when strictly confined to VAE in the medical context by moving from a position of criminalisation to medicalisation of the practice, as has been the case with passive euthanasia.

This thesis advocates for neither a pro-life nor a pro-death policy but rather a pro-choice one, which would be in accordance with the cornerstone of constitutionalism in a state governed by constitutional democracy.

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CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

Advances in patient care, treatment measures, mechanisms and technologies have resulted in the extension of the lives of patients.¹ While this may be seen as a boon to some, it is a burden to others where the prolongation of life means a diminished quality of life and the perpetuation of intractable pain and suffering. Since the Second World War there has been increased emphasis on patient autonomy and consent as a result of the atrocities and human rights violations suffered by prisoners in Germany under Nazi rule under the auspices of medical treatment.² The result of such recognition has been the protection in some jurisdictions of a

“mentally competent patient’s right to refuse medical treatment or to receive assistance, should he or she so require, in ending his or her unbearable suffering by the administering or supplying of a lethal substance to the patient.”³

However, in South Africa, while a patient can, through exercising patient autonomy, lawfully refuse medical treatment even when such refusal will have the effect of hastening their death, the patient cannot exercise the same autonomy and request that a physician assists them to end their life more directly through physician-assisted suicide or physician-administered euthanasia. Neither suicide nor attempted suicide are crimes in South Africa,⁴ but the act of

¹ South African Law Commission Issue Paper 71 (Project 86) *Euthanasia and the Artificial Preservation of Life* (1998) para 1.6. Further para 1.7:

“Having created a situation in which lives are routinely saved, transformed or prolonged by medical intervention, we can hardly pretend that the process of dying, and that alone, must be ‘left to nature’. Simplistic aphorisms, which might have had more general truth fifty years ago such as ‘while there is life there’s hope’ or ‘killing is killing’ are inadequate to address the present state of medical expertise which is capable of keeping ‘alive’ irreparably sick or damaged patients who in the recent past would not have survived at all.”

See also A le Roux-Kemp ‘A question of life and death’ (2013) *CILSA* 74-89 at 76:

“By the mid-20 century, however, advances in medical technology had rendered this traditional standard inadequate. Advances in science and medical technology, especially with regard to the artificial prolongation of life, spurred on by an interest in organ transplantation, have necessitated that a new death criteria be developed and applied.”

² P Weindling, A von Villiez, A Loewenau & N Farron ‘The victims of unethical experiments and coerced research under National Socialism’ (2016) 40(1) *Endeavour* 1-6.

³ South African Law Commission op cit note 1 p (x). 1

⁴ As regards assisted suicide see *Ex Parte Die Minister van Justisie: In Re S v Grotjohn* 1970 (2) SA 355 (A). As regards active euthanasia see *S v Hartmann* 1975 (3) SA 532 (C), *S v De Bellocq* 1975 (3) SA 538 (T).

instigating, assisting or putting another person in a position to commit suicide is.⁵ Such conduct is prosecutable as the crime of murder.⁶ The ambit of this crime is broad enough to include physician-assisted suicide (PAS) and physician-administered euthanasia (PAE)⁷ and has been confirmed as the position of the law in South Africa.⁸ This view has been adopted and endorsed by the Health Professions council of South Africa which holds that

“euthanasia and doctor-assisted suicide are presently prohibited under South African law, and the courts frequently do not distinguish between the two when it comes to culpability.”⁹

The intended purpose of this thesis is to determine whether the law in South Africa should be reformed and developed to permit medically assisted dying in the form of physician-assisted suicide and physician-administered euthanasia when the request is made by a competent, adult, terminally ill patient.

⁵ This principle was established in *Ex Parte Die Minister van Justisie: In Re S v Grotjohn* 1970 (2) SA 355 (A) and applied in *S v Hibbert* 1979 (4) SA 717 (D). In *Hibbert* at 722 the court held:

“Now in the present case the accused set in motion a chain of events which ended in the deceased pressing the trigger of a fire-arm which she had been given by the accused and thus causing her death. The successive words and actions of the accused were designed to place her in possession of that fire-arm and were accompanied by the obvious hazard that the deceased might be persuaded to inflict upon herself an injury which could result in her death. The accused's conduct fell short only of the final act of pulling the trigger. It seems to me that the act of pulling the trigger to which all other conduct conducted, cannot in any sense be described as independent of the course of conduct. That being so, we conclude that there was, in the proper sense of that expression, no *actus novus interveniens* which broke the chain of causation set in motion and continued by the series of acts of the accused which I have mentioned. The accused must, as we have found, have appreciated that injury and possibly death could result from his actions. That being so there is present the necessary intention to bring home a charge of murder. We find therefore that the accused occasioned the death of the deceased by his conduct; that he had the necessary intention and is therefore guilty as charged of murder.”

The accused in that case was found guilty of murder and sentenced to four years' imprisonment which was wholly suspended for a period of five years. Regarding the lawfulness of active euthanasia see also *R v Davidow* 1955 WLD unreported, *S v De Bellocq* 1975 (3) SA 538 (T), *S v Hartmann* 1975 (3) SA 532 (C), *S v McBride* 1979 (4) SA 313 (W), *S v Marengo* 1990 WLD unreported, *S v Smorenberg* 1992 CPD unreported.

⁶ *Grotjohn* supra note 5 at 364. Applied in *Hibbert* supra note 7. See also G Williams *Intention and Causation in medical non-killing – The impact of criminal law concepts on euthanasia and assisted suicide* (2007) at 1:

“Euthanasia is understood to be the compassionate bringing about of a death where the ‘victim’ is suffering from an incurable and/or painful disease. However, as an intentional killing, euthanasia come within the ‘definition’ of murder and as such is punishable by a mandatory life sentence.”

⁷ In *Minister of Justice and Correctional Services v Estate Late James Stransham-Ford* 2017 (3) SA 152 (SCA) at para 2 the court defined physician-assisted suicide and physician-administered euthanasia as follows, distinguishing the two practices:

“One possibility is that the patient should be permitted to obtain a prescription for lethal drugs that they may use to terminate their own lives. This is commonly referred to as physician assisted suicide (PAS). The other possibility is that the medical practitioner should be permitted at their request to administer such lethal drugs to them. This is referred to as voluntary euthanasia or physician administered euthanasia (PAE).”

⁸ *Grotjohn* supra note 5.

⁹ Health Professions Council of South Africa (HPCSA) *Ethical Guidelines on Palliative Care*: Booklet 17 (2019) at para 9.3.

1.2 DEFINITIONS AND TERMS¹⁰

“Mercy killing”, “dignified death” and “pulling the plug” are some of the less technical understandings that stir when the discussion turns to euthanasia. The other term which also features is murder, and evidences the polarised views regarding the issue. However, as the debate, legally and medically evolves, more precise terms like physician-assisted suicide, physician-administered euthanasia, and voluntary active euthanasia are preferred in distinguishing between justifiably causing death and murder.

1.2.1 Murder

In South Africa, murder is a common law crime and is defined as any conduct which unlawfully and intentionally causes the death of another human being.¹¹ The definition encapsulates the elements which must be proved in order to secure a conviction, notably, there must be some form of voluntary and intended conduct which brought about a prohibited consequence. To find someone guilty of murder, a court must be satisfied that all the elements of criminal liability for the crime of murder have been proven beyond a reasonable doubt and that there is no justification or defence to exclude unlawfulness. The law has rules and principles for evaluating these elements, which provide the template for logical and “scientific”¹² judicial adjudication. With the development of the law through the cases, the courts have set judicial precedent for how the elements are evaluated and the principles apply for the future.¹³ This creates a sense of legal certainty, bringing a scientific¹⁴ basis to the interpretation, application and practice of law. For present purposes, a prosecutor seeking to secure a conviction on a charge of murder would have to prove that a physician caused the death of a patient unlawfully and intentionally.

1.2.1 Euthanasia

¹⁰ The definitions which follow do not appear in alphabetical order, but rather in order of progression of the arguments to be made in drawing analogy and distinction.

¹¹ S V Hoorntje *Snyman's Criminal Law* 7ed (2020) at 387. J Burchell *Principle's of Criminal Law* 5ed (2016) at 577 defines murder as the unlawful killing of another human being.

¹² M C Roos 'Is law Science' (2014) *PER/PELJ* 17(4) 1392-1439 at 1426:

“When a legal academic unlocks new knowledge or creatively re-exposes or reinterprets existing knowledge as described above, the activity will be scientific, as it complies with the criteria of modal abstraction and the creation of new knowledge or the development of existing theory.”

¹³ *Inter alia*: causation and intention.

¹⁴ Roos op cit note 15. See also B Shaer 'Toward a cognitive science of legal interpretation' (2013) *Law and Language*; D Duarte, PM Lopes and J S Sampaio *Legal Interpretation and Scientific Knowledge* (2019).

The word euthanasia finds its roots in two Greek words – *eu* meaning good, and *thanatos* meaning death. Thus, we have come to understand it as a ‘good death’ – painless, merciful, and dignified, albeit a deliberate act or intervention with a definite goal to end a life of intractable suffering. The word euthanasia was first used in a medical context by Francis Bacon¹⁵ in the 17th century to refer to an easy, painless, happy death, during which it was a “physician's responsibility to alleviate the 'physical sufferings' of the body.”¹⁶ The World Medical Association contextualises euthanasia in relation to the role of physicians defining it as conduct involving a

“physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient’s own request.”¹⁷

Carstens and Pearmain observe that euthanasia occurs in various forms: “active euthanasia, passive euthanasia, physician-assisted suicide and voluntary and involuntary euthanasia.”¹⁸

The authors further note that

“In terms of our reported case law, it is clear that apart from voluntary passive euthanasia, in cases of patients who are in a persistent vegetative state,¹⁹ all other forms of euthanasia (that is, voluntary/involuntary active euthanasia,²⁰ involuntary passive euthanasia) and assistance to suicide,²¹ will be unlawful and will render a physician who performed such forms of euthanasia, liable [under any of the common law homicide offences within the South African jurisdiction].”²²

1.2.2 Voluntary, non-voluntary and involuntary

¹⁵ F Bacon *Francis Bacon: The Major Works by Francis Bacon* (edited by Brian Vickers) (2008) 630.

¹⁶ Ibid.

¹⁷ WMA *Declaration on Euthanasia and Physician Assisted Suicide* (2019) available at [WMA Declaration on Euthanasia and Physician-Assisted Suicide – WMA – The World Medical Association](#) accessed on 1 June 2023.

¹⁸ P Carstens & D Pearmain *Foundational Principles of South African Medical Law* 3ed (2007) at 203-204. This definition is broad and includes physician-assisted suicide as a form of euthanasia.

¹⁹ Carstens & Pearmain op cit note 18 at 205 footnote 441, where the authors cite *Clarke v Hurst NO*, thus confirming that the case was a form of voluntary passive euthanasia.

²⁰ Carstens & Pearmain op cit note 18 at 205 footnote 442:

“Cf *S v Hartmann supra* where a physician injected his 87 year-old father, a dying terminal cancer patient who had suffered a great deal of pain, at his request, with an overdose of pentothal, causing his death (clearly a case of voluntary active euthanasia).”

²¹ Carstens & Pearmain op cit note 18 at 205 footnote 443:

“*In re Grotjohn supra*; cf *S v Nkwanyana supra*; ‘Pretty v United Kingdom’ 2002 *Human Rights Law Reports* 194, where the European court of Human Rights refused to give grant (sic) Diane Pretty’s husband immunity from prosecution if he assisted his wife, who was paralysed from the neck downwards, to die.”

²² Carstens & Pearmain op cit note 18 at 205.

Euthanasia in its various forms can be voluntary,²³ non-voluntary²⁴ or involuntary.²⁵ The distinctions depend on whether the patient had made their wishes explicitly known, either in favour of or against the intended conduct, and even whether they were ever able to do so. The patient in *Clarke v Hurst NO*²⁶ had made his wishes and preferences known through his living will (advanced directive), and thus can be said as Carstens and Pearmain do,²⁷ that *Clarke v Hurst NO*,²⁸ involved conduct that is classified as passive voluntary euthanasia.

*Clarke v Hurst NO*²⁹ is distinguishable from *Airedale NHS Trust v Bland*³⁰ which was a case of passive non-voluntary euthanasia. The patient in *Bland* had never made his wishes known. Passive euthanasia is voluntary when a competent dying patient, makes a request for

²³ Carstens & Pearmain op cit note 18 at 204 Footnote 428: “This term (whether denoting voluntary passive or voluntary active euthanasia) is used to describe the causing of the death of a patient with their consent or some form of advanced directive such as a living will.”

²⁴ T Skinner *Decriminalising voluntary active euthanasia through the recognition of fundamental human rights: A comparison of South Africa and Foreign Jurisdictions* (2021) LLM Dissertation, University of Pretoria at 8 footnote 22:

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

²⁵ Carstens & Pearmain op cit note 18 at 204 footnote 429: “This term (whether denoting involuntary passive or involuntary active euthanasia) is used to describe the causing of the death of a patient in opposition to their wishes and is regarded as murder.”

²⁶ *Clarke v Hurst NO* 1992 (4) SA 630 (D).

²⁷ Carstens & Pearmain op cit note 18 at 205.

²⁸ Supra note 26.

²⁹ Ibid.

³⁰ *Airedale NHS Trust v Bland* [1993] 1 All ER 821 where the House of Lords held that medical treatment may be lawfully withheld from a patient with no hope of recovery even if it is known that the result will be that the patient will shortly thereafter die (at 871, 873-4, 876-7): Provided that responsible and competent medical opinion is of the view that it would be in the patient's best interests not to prolong his or her life by continuing with medical treatment which will be futile and will not confer any benefit on the patient (at 861, 866, 868, 870, 872, 876). See also *Stranham-Ford* supra note 7, where the court discusses situations where patients are unable to consent at para 32:

“The only qualification to what appears in the preceding paragraph is that the patient must have the mental and legal capacity to make that decision. This gives rise to problems where a person suffers a catastrophic injury without any prior expression of their views, or is afflicted with a mental handicap that limits their legal capacity or where, as with a child, they lack legal capacity. It is in circumstances such as these that courts may be called upon, usually by family members or the medical authorities, to make decisions as to the legitimacy of the withdrawal of medical treatment or artificial nutrition and hydration. That is what occurred in South Africa in *Clarke v Hurst NO*, in the United Kingdom in *Bland*, and in the United States in *Cruzan* and *Quinlan*. In each of these cases the patient was in a persistent vegetative state and the court authorised the cessation of artificial means of keeping them alive, including the removal of artificial nutrition and hydration.”

the withdrawing or withholding of life-sustaining measures or treatments,³¹ and is accepted as being ethically permissible and justifiable³² even though it hastens death.³³

With the above in mind, for the purposes of this thesis, *PE occurs when death is hastened by withholding and withdrawing life-supporting measures, including the discontinuance of respirator use, ceasing nutrition and hydration, as well as the administration of pain-alleviating medications in palliative care and terminal/palliative sedation scenarios knowing that such treatments can hasten death.* It is voluntary when such a request is made by a competent patient and the patient provided informed consent to the risk of death, or their wishes have been previously been made known, and have been given effect.

³¹ R Young, 'Voluntary Euthanasia' in Zalta, N (ed) *Stanford Encyclopedia of Philosophy* (Summer 2022 edition) available at <https://plato.stanford.edu/entries/euthanasia-voluntary/> accessed on 4 May 2023.

³² R Young, 'Voluntary Euthanasia' in Zalta, N (ed) *Stanford Encyclopedia of Philosophy* (Summer 2022 edition) available at <https://plato.stanford.edu/entries/euthanasia-voluntary/> accessed on 4 May 2023:

"The reason why passive (voluntary) euthanasia is said to be morally permissible is that the patient is simply allowed to die because steps are not taken to preserve or prolong life. This happens, for example, when a dying patient requests the withdrawal or the withholding of measures whose administration would be medically futile, or unacceptably burdensome. By contrast, active (voluntary) euthanasia is said to be morally impermissible because it is claimed to require an unjustifiable intentional act of killing to satisfy the patient's request."

³³ See also D J McQuoid-Mason 'Withholding or withdrawing treatment and palliative treatment hastening death: The real reason why doctors are not held liable for murder' (2014) 104(2) *SAMJ* 102-103 at 102:

"Doctors are generally not liable for murder if they withhold or withdraw treatment or provide palliative treatment that hastens death when the patient has made an advance directive, treatment is futile or the burdens and risks will outweigh the benefits of such treatment. The usual view is that doctors are not liable because they do not intend to kill the patients in such circumstances, and the underlying illness, injury or condition causes the death.

Such acts and omissions are said to constitute passive euthanasia, which is not regarded as murder, rather than active euthanasia. However, the distinction is artificial because what is sometimes called 'passive' euthanasia involves a positive act, e.g. switching off a ventilator or turning down a pacemaker."

³³ J Rachels 'Killing and letting die' in Lawrence Becker & Charlotte Becker (eds) *Encyclopaedia of Ethics* 2 ed (2001), vol. 2, 947-50:

"So what is the difference between causing and allowing? What real difference is marked by those words? The most obvious ways of attempting to draw the distinction won't work. For example, suppose we say it is the difference between action and inaction – when we cause an outcome, we do something, but when we merely allow it to happen, we passively stand by and do nothing. This won't work because, when we allow something to happen, we do perform at least one act: the act of allowing it to happen. The problem is that the distinction between doing something and not doing something is relative to the specification of what is or is not done – if I allow someone to die, I do not save him, but I do let him die."

I Brassington 'What passive euthanasia is' (2020) *BMC Med Ethics* 21:41, available at

<https://doi.org/10.1186/s12910-020-00481-7> . Accessed on 6 January 2022. Brassington considers the term passive euthanasia and notes at page 1 that

"though all passive euthanasia involves the withholding of life-sustaining treatment, there would appear to be some disagreement about whether all such withholding should be seen as passive euthanasia."

Brassington points out the need for conceptual clarity. The author notes in this regard that there are primarily two distinct conceptualisations of what PE is, which causes argumentative discord. Finding a universal definition will make advocacy for the legalisation of specific forms of euthanasia that much more precise.

³³ *Clarke v Hurst NO* supra note 26.

1.2.3 Passive Euthanasia

Carstens and Pearmain³⁴ note that passive euthanasia (PE) occurs when death is hastened by withholding and withdrawing of life-supporting measures, including the discontinuance of respirator use, ceasing nutrition and hydration, as well as the administration of pain-alleviating medications in palliative care scenarios.³⁵ Several authorities³⁶ agree with this categorisation

³⁴ P Carstens & D Pearmain op cit note 18 at 203-204.

³⁵ Carstens & Pearmain ibid at 203-204 at footnote 426:

“This form of euthanasia involves the hastening of the death of a person by withdrawing some form of life-sustaining support and letting nature take its course. Eg: a) removing life support equipment (eg turning off a respirator); or b) stopping of medical procedures, medication, etc; c) stopping food and water allowing the person to dehydrate or starve to death; d) not delivering CPR (cardio-pulmonary resuscitation) and allowing a person whose heart has stopped, to die. Perhaps the most common form of passive euthanasia is to give a patient a large doses (sic) of morphine to control pain, in spite of the likelihood of the pain-killer suppressing respiration and causing death earlier than it would otherwise have happened. An example in South African case law of passive euthanasia in respect of a patient in a persistent vegetative state is *Clarke v Hurst NO*.”

See also Centre for Health Ethics ‘Euthanasia’ *University of Missouri School of Medicine* (2023) available at <https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/euthanasia#:~:text=Types%20of%20euthanasia&text=Passive%20euthanasia%3A%20intentionally%20letting%20a,a%20ventilator%20or%20feeding%20tube>. Accessed on 19 January 2023:

“Passive euthanasia: intentionally letting a patient die by withholding artificial life support such as a ventilator or feeding tube.”

See also WJ Stewart ‘Involuntary Euthanasia’ *West’s Encyclopedia of American Law* (2 ed) (2008) available at <https://law.jrank.org/pages/6596/Euthanasia-Passive-Euthanasia.html> accessed on 19 January 2023:

“Hastening the death of a person by altering some form of support and letting nature take its course is known as passive euthanasia. Examples include such things as turning off respirators, halting medications, discontinuing food and water so as to allowing (sic) a person to dehydrate or starve to death, or failure to resuscitate.”

See also J Omar ‘Clarity, consistency, and community convictions: Understanding the defence of consent in South African criminal law’ (2022) *SACJ* 131 at 141.

W McClelland, EC Goligher ‘Withholding or withdrawing life support versus physician-assisted death: a distinction with a difference?’ (2019) *Curr Opin Anaesthesiol* 32 (2)184-189. There is debate on whether all of the identified forms of passive euthanasia ought to be labelled as such, hinging largely on perceived distinctions between acts/omissions and intention/foresight. See also Williams *Intention and Causation in* at 55:

“In ordinary language, and in this context, the distinction between acts and omissions is the distinction between a person who acts positively to bring about a death and a person who omits to intervene in a course of events in which he could have prevented death. However, the term ‘omission’ has also been legally interpreted to cover the situation where a doctor has to perform what is ostensibly an action in order to withdraw (life-sustaining) treatment from a patient. This facet of the distinction is one created by the courts as a tactic to provide doctors with a defence against a murder charge where death is the certain, or even foreseen consequence of a patient’s death. The distinction is inextricably linked with intention, with causation and with the perceived difference between killing and letting die. This is because if the doctor ‘acts’ he would be deemed to have the intention required to kill (cause the death of) the patient. Conversely, if he has merely omitted to act, the intent to kill is considered absent and he would be regarded as having allowed or permitted the patient to die of his pre-existing illness or injury.”

³⁶ The SALRC op cit note 1 at para 5.114 refers to the English case of *F v West Berkshire Health Authority* [1989] 2 All ER 545 and noted

“medical treatment (which includes artificial feeding) may be withheld if it is in the patient’s best interests not to be treated any further (since such treatment is futile and do not confer any benefit on the patient).”

The SALRC also sought to distinguish active euthanasia from passive euthanasia. At paras 4.108-4.109 the report states that PAS and euthanasia are categorized as forms of active euthanasia, but holds that the withdrawal of life-sustaining measures is a form of passive euthanasia: “the cessation of medical treatment which is sometimes referred to as passive euthanasia.”

and similarly note that PE in these forms can be voluntary, involuntary or non-voluntary. The authors note that

“the most common form of passive euthanasia is to give a patient a large doses (*sic*) of morphine to control pain, in spite of the likelihood of the pain-killer suppressing respiration and causing death earlier than it would otherwise have happened.”³⁷

See also D J McQuoid-Mason ‘Withholding or withdrawing treatment and palliative treatment hastening death: The real reason why doctors are not held liable for murder’ (2014) 104(2) *SAMJ* 102. McQuoid-Mason similarly identifies as passive euthanasia, the

“turning down (of) a pacemaker or switching off a ventilator as both amount to ‘passive’ rather than ‘active’ euthanasia if the prognosis is hopeless...A doctor who turns down a pacemaker causing the death of a patient to be hastened as a result of the underlying illness or injury would therefore be regarded by law as engaging in ‘passive’ rather than ‘active’ euthanasia.”

In response to McQuoid-Mason, Muckart et al note that “Passive euthanasia includes withholding extreme medical measures or removing life support in the presence of futile or non-beneficial treatment.” in DJJ Muckart, G Gopalan, D Hardcastle, E Hodgson ‘Correspondence: Palliative care: Definition of euthanasia’ (2014) 104(4) *SAMJ* 259-260. Available at http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742014000400006#:~:text=The%20term%20passive%20euthanasia%20includes,futile%20or%20non%20beneficial%20treatment. Accessed on 9 January 2023.

C Kotze and JL Roos ‘End-of-life care in South Africa: Important legal developments’ (2022) *S Afr J Psychiat*. 28 available at <https://sajp.org.za/index.php/sajp/article/view/1748/2387>. Accessed on 8 January 2023 at page 2: “Withholding and withdrawing treatment are considered passive euthanasia and remain an unresolved legal issue locally.”

BA Manninen ‘A case for justified non-voluntary active euthanasia: exploring the ethics of the Groningen Protocol’ *J Med Ethics*. 2006 Nov;32(11):643-51. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563300/> accessed on 16 January 2022. Manninen maintains that the withdrawal of nutrition and hydration in order to hasten death is a form of passive euthanasia, which is an essential aspect of terminal sedation:

“An essential aspect of terminal sedation is the cessation of all forms of treatment, nourishment and hydration to hasten death. In other words, terminal sedation is a method of painless passive euthanasia; the practice essentially drugs the patients into unconsciousness until they finally die, rather than giving a lethal injection that would kill them relatively instantly.”

Yu Kam Por ‘Terminating Futile Medical Treatment and Passive Euthanasia: Is there a Difference?’ *Eubios Journal of Asian and International Bioethics* 12 (2002), 137-138 available at <https://www.eubios.info/EJ124/ej124h.htm> accessed on 16 January 2023. The author considers whether there is a difference between withholding treatment in cases of medical futility and passive euthanasia and concludes as follows:

“So I come to the conclusion that the two are substantially the same. They are just different ways of saying the same thing. Such a different way of describing what is being done obscures the value judgment involved. In the case of passive euthanasia, the value judgment that a prolonged life is worse than immediate death is explicitly made. However, in the case of terminating futile treatment, the same value judgment is being made, but not explicitly made. The two different uses of language represent different frames of mind. The shift to the language of terminating futile treatment replaces the patient's perspective with the doctor's perspective. Instead of emphasizing the patient's preference, the doctor's professional judgment is emphasized. I conclude that the use of the concept of terminating futile treatment tends to obscure the issue instead of solving it, and it runs the risk of substituting the patient's autonomy with the doctor's paternalism.”

J McKenney ‘Informed consent and Euthanasia: An international human rights perspective’ (2018) *ICLR* 18(2) at 120:

“Passive euthanasia ‘occurs when the patient dies because the medical professionals either don’t do something necessary to keep the patient alive, or when they stop doing something that is keeping the patient alive.’ Examples of passive euthanasia include withholding food or water from a patient, not administering medicine to a patient or not performing surgery on a patient that would keep the patient from dying.”

³⁷ Carstens & Pearmain op cit note 18 at 203 footnote 426.

Similarly Manninen notes palliative care in the form of terminal sedation is a form of passive euthanasia.³⁸ Dhai and McQuoid-Mason³⁹ refer to the case of *Clarke v Hurst NO*⁴⁰ and note that passive euthanasia includes the practice of withdrawing and withholding life-sustaining medical treatment in cases where further or continued treatment is deemed futile and would not provide any remedial or restorative treatment to the patient.⁴¹

³⁸ BA Manninen “A case for justified non-voluntary active euthanasia: exploring the ethics of the Groningen Protocol” *J Med Ethics* (2006) 32(11) 643-51:

“In the case of terminal sedation, the subject is deliberately rendered unconscious with an overdose of analgesics and sedative drugs to relieve intractable physical pain or mental suffering. An essential aspect of terminal sedation is the cessation of all forms of treatment, nourishment and hydration to hasten death. In other words, terminal sedation is a method of painless passive euthanasia; the practice essentially drugs the patients into unconsciousness until they finally die, rather than giving a lethal injection that would kill them relatively instantly.”

³⁹ A Dhai and D McQuoid Mason *Bioethics, Human Rights and Health Law – Principles and Practice* (2010) Juta.

⁴⁰ Supra note 14.

⁴¹ A Dhai and D McQuoid Mason *Bioethics, Human Rights and Health Law – Principles and Practice* op cit note 39 at 128:

“‘Passive euthanasia’ occurs where a health professional or a member of a patient’s family withdraws treatment or withholds treatment from a patient who is suffering from a terminal injury or illness or one that is so serious that the prospects of recovery are nil. Such treatment may not be regarded as murder (e.g. withdrawing feeding from a persistent vegetative state patient).”

Stransham-Ford supra note 7 at para 2 where the SCA noted that the refusal of life sustaining treatment is in some jurisdictions considered to be a form of passive euthanasia. See also D McQuoid Mason and M Dada *A-Z of Medical Law* (2011) at 186 where the authors note as follows:

“Passive Euthanasia occurs when a person withdraws or withholds treatment from a terminally ill patient or a patient suffering from unbearable pain (e.g. switching off a ventilator or turning down a pacemaker) and the patient dies as a result of nature taking its course (*Clarke v Hurst NO* 1992 (4) SA 630 (D)).”

The authors further class cases of medical futility as examples of passive euthanasia when they state that

“Passive euthanasia is lawful where it involves terminating treatment in hopeless cases after all possible procedures have failed and the patient is allowed to die naturally (i.e. the withdrawal of treatment or nourishment from patients in a persistent vegetative state with no prospects of recovery)(*Clarke v Hurst NO* 1992 (4) SA 630 (D)).”

See also J Omar ‘Clarity, consistency, and community convictions: Understanding the defence of consent in South African criminal law’ (2022) *SACJ* 131 at 141:

“Passive euthanasia involves the hastening of death by the withdrawal of life-sustaining medication or support. This could include the removal of life support, discontinuing surgical procedures, or not resuscitating a patient whose heart has stopped. Where a patient is given medication for pain which also hastens death, this would be considered passive euthanasia.”

DJ McQuoid-Mason ‘Emergency medical treatment and ‘do not resuscitate’ orders: When can they be used?’ (2014) 103(2) *SAMJ* 223-225. Available at <http://www.samj.org.za/index.php/samj/article/view/6672/4990>. Accessed on 6 January 2023:

“DNR orders are a form of passive euthanasia...Distinguishing between active and passive euthanasia may not appear to be logical, as in both the act or omission by the health professionals in denying medical treatment contributes to the patient’s death, but the courts have taken a pragmatic approach in this regard. DNR orders, as in passive euthanasia, aim to prevent prolonging the patient’s death by letting nature take its course when treatment would be useless or ineffective.”

Measures as described by Manninen, McQuoid-Mason and Carstens and Pearmain usually occur when continued treatment is deemed futile. Referring, with approval to the World Medical Association Medical Ethics Manual,⁴² McQuoid-Mason⁴³ notes that:

“a doctor has ‘no obligation to offer a patient futile or non-beneficial treatment’ and describes treatment as ‘medically futile’ when it ‘offers no reasonable hope of recovery or improvement or because the patient is permanently unable to experience any benefit’.”⁴⁴

He proceeds to note that palliative care becomes futile when it no longer serves to reduce a patient’s pain and suffering: “Futile treatment usually means treatment that is ineffectual and inadequate to cure the patient or alleviate their suffering.”⁴⁵

1.2.2 Active Euthanasia⁴⁶

Carstens and Pearmain refer to the definition of murder and hold that active euthanasia “involves unlawfully and intentionally causing of the death of a person through a direct action, in response to a request from that person.”⁴⁷ Draper notes that euthanasia “must be defined as death that results from the intention of one person to kill another person, using the most gentle and easy means possible, that is solely motivated by the best interests of the person who dies.”⁴⁸ According to the World Medical Association “euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient’s own voluntary request.”⁴⁹ McQuoid-Mason and Dada define active euthanasia as “a situation where a person intentionally or actively participates in causing the death of a terminally ill patient to end pain or suffering (eg. administers a fatal injection or dose of medicine).”⁵⁰ These varied definitions for euthanasia

⁴² JR Willams . *Word Medical Association Medical Ethics Manual*. 3rd ed. Ferney-Voltaire Cedex, France: WMA, 2015:46

⁴³ DJ McQuoid-Mason “Should doctors provide futile medical treatment if patients or their proxies are prepared to pay for it?” 2017 *SAMJ* 107(2) 107-109.

⁴⁴ DJ McQuoid-Mason “Should doctors provide futile medical treatment if patients or their proxies are prepared to pay for it?” 2017 *SAMJ* 107(2) at 108.

⁴⁵ DJ McQuoid-Mason “Should doctors provide futile medical treatment if patients or their proxies are prepared to pay for it?” 2017 *SAMJ* 107(2) at 108.

⁴⁶ Carstens & Pearmain op cit note 18 at 204 and 210.

⁴⁷ Carstens & Pearmain op cit note 18 at 203. The authors cite the case of *S v Hartmann* 1975 (3) SA 532 (C) as authority for this definition: “An example in this regard in (sic) *S v Hartmann supra*, where the accused, Dr Hartmann, injected his father who was suffering from cancer, at his father’s request, with an overdose of pentothal.”

⁴⁸ H Draper “Euthanasia”. In: *Chadwick R, editor. Encyclopaedia of applied ethics*, vol. 2. San Diego: Academic; 1998.

⁴⁹ WMA Declaration on euthanasia and physician-assisted suicide adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019. Available at <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/> accessed on 22 January 2023.

⁵⁰ R Preston “Death on demand? An analysis of physician-administered euthanasia in The Netherlands” 2018 *British Medical Bulletin*, Volume 125, Issue 1, March 2018, Pages 145–155 at 145:

bring to the fore issues of intention, causation and unlawfulness, which also present in the definition of the crime of murder.

Although a request made by a patient would suggest that the request was voluntary and consensual, it does not, in South African law absolve the person from liability for their part in causing the patient's death. The conduct of the person is active because a positive act has been perpetrated. In a medically assisted dying scenario, positive conduct could, for example, be where a lethal drug has been directly administered to the patient (physician-administered euthanasia) or supplied to them for self-administration (physician-assisted suicide).

1.2.2.1 Physician-administered euthanasia

In seeking to draw a distinction between euthanasia performed by a person other than a medical professional, the term physician-administered euthanasia (PAE) has been used to indicate *the voluntary and consensual termination of a patient's life through the administration of a lethal substance by a medical professional*.⁵¹ The assistance is rendered by a physician who personally administers the lethal dose to the patient. It differs from physician-assisted suicide in that, in PAE, the final act of administration is done by the physician, who is thus the final actor in the causal nexus. The distinction between physician-assisted suicide and physician-administered euthanasia is further necessitated when we consider patients who qualify for assisted dying but may be physically unable to perform the final act themselves.

1.2.2.2 Physician-assisted suicide

Physician-assisted suicide (PAS) is the voluntary and consensual termination of a patient's life by their own hand, through the use of a lethal substance which has been prescribed or supplied by a physician.⁵² The assistance rendered by a physician is limited to the prescription of, or provision of the lethal substance. Outside of the physician's rooms, assistance could further be

"Physician-administered euthanasia (PAE) describes a situation where a doctor administers a lethal dosage of drugs to a patient, at that patient's request, in order to bring about his or her death."

See also D McQuoid-Mason and M Dada. *A-Z of Medical Law* 2011 at 186. The authors here refer to *S v Hartmann* 1975 (3) SA 532.

⁵¹ WMA Declaration on euthanasia and physician-assisted suicide adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019. Available at <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/> accessed on 22 January 2023.

⁵² WMA Declaration on euthanasia and physician-assisted suicide adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019. Available at <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/> accessed on 22 January 2023:

"Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death."

given by the pharmacist who prepares the dose and then hands it over to the patient. The act of administration of the dose is left to the patient themselves. As the final act of administration or ingestion is done by the patient, it is deemed to be an act of suicide.⁵³ In South Africa such assistance is currently deemed to be unlawful, and physicians are not permitted to offer such assistance to patients who make a request for medical assistance in dying.⁵⁴

1.2.1 Voluntary Active Euthanasia

For the purposes of this thesis, voluntary active euthanasia (VAE) is the term used to collectively account for acts of physician-assisted suicide (PAS) and physician-administered euthanasia (PAE). For the purposes of this thesis VAE refers to *a voluntary and persistent request for medical assistance in dying (MAID) made by a competent adult patient, suffering from a terminal disease for which medical assistance is rendered*. Assistance may be either the provision of the means by which a patient can end their own life through self-administration or ingestion of lawfully prescribed medication with lethal effect, or the direct administration of such medication by a physician or other lawfully designated person.

The subject matter of this thesis focuses on the legalisation of VAE through MAID.

1.3 THE LEGAL FRAMEWORK

In 2015 the applicant in *Stransham-Ford v Minister of Justice and Correctional Services and Others*⁵⁵ brought an application before the High Court to have the decision in *Grotjohn*⁵⁶ clarified and narrowed to exclude VAE performed by a medical practitioner under very specific circumstances.⁵⁷ The applicant sought an order that a medical practitioner could, without fear of criminal prosecution, assist him in an act of VAE. To that end, he sought an order that the common law crime of murder be developed in terms of s 39(2) of the Constitution.⁵⁸ His prayer

⁵³ Discussed in Chapter Three.

⁵⁴ *Grotjohn* supra note 5. See also HPCSA Booklet 18 at para 9.5:

“At present, South African courts have acknowledged that both euthanasia and doctor-assisted suicide are fundamentally incompatible with a practitioner’s role as a healer, and a practitioner guilty of either is regarded as having acted unethically and unlawfully.”

See also McQuoid-Mason and Dada *A-Z of Medical Law* at 405-406:

“There is no law governing suicide but the common law of murder covers situations where a person helps another to take his or her own life. The courts have held that if a person knowingly incites, assists or enables another to commit suicide, such person is guilty of murder (*Ex Parte Minister van Justisie: In re Grotjohn* 1970 (2) SA 355 (A))... Doctors should be aware that they may not actively assist a patient to commit suicide... Actively assisting a patient to commit suicide may result in a charge of murder.”

⁵⁵ *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (4) SA 50 (GP).

⁵⁶ *Grotjohn* supra note 5.

⁵⁷ *Stransham-Ford* (SCA) supra note 7 at para 3.

⁵⁸ Constitution of the Republic of South Africa, 1996.

was for the court to declare that the prohibition created in *Grotjohn* was an unjustifiable limitation of his constitutional right to human dignity.⁵⁹ The High Court⁶⁰ ruled in favour of the applicant, but the decision was overturned on appeal to the Supreme Court of Appeal.⁶¹

1.3.1 *The common law position on voluntary active euthanasia*

The common law position is that neither suicide nor attempted suicide is a crime in South Africa.⁶² This was confirmed by the Appellate Division (AD)⁶³ in *Grotjohn*⁶⁴ where the court found that these crimes had been abrogated by disuse as punishing and prosecuting these acts did not have the desired effects related to criminalisation, prosecution and punishment, namely deterrence, and it further served no purpose regarding retribution as there was no way of enforcing punishments for these offences. The effect of the dictum is that people are at liberty to end their lives if and when they choose to through an act of suicide, and are not prosecuted or punished if an attempt at suicide is unsuccessful. However, the common law position established through *Grotjohn* is that people are prohibited from rendering assistance to those who want to commit suicide, and although neither suicide nor attempted suicide is a crime, a person who assists another to commit suicide can be criminally prosecuted for murder.⁶⁵ What is prosecutable is not the act of suicide, but conduct on the part of any third person who offers assistance in an individual's act of realising their own end,⁶⁶ whether the person renders assistance by for example handing over a shotgun, prescribing lethal medication for self-administration, or handing over a lethal dose of medication.⁶⁷ Unless there is a break in the causal nexus which would render the suicide a completely independent act, or the accused person is shown to lack *mens rea*, or is found to have a defence against unlawfulness (a justification), the person assisting could be guilty of a crime.⁶⁸ While *Grotjohn*⁶⁹ was not dealing with a case of PAS, the result is that for all practical purposes, all instances of intentionally assisting a suicide amounts to murder, even when the assistance is rendered by a

⁵⁹ S 10 of the Constitution 1996.

⁶⁰ *Stransham-Ford* (HC) supra note 55.

⁶¹ *Stransham-Ford* (SCA) supra note 7.

⁶² *Grotjohn* supra note 5 at 363.

⁶³ Now the Supreme Court of Appeal. At the time of the *Grotjohn* decision, the AD was the apex court in South Africa.

⁶⁴ Supra note 5.

⁶⁵ *Grotjohn* supra note 5 at 365.

⁶⁶ *Grotjohn* supra note 5 at 365.

⁶⁷ *Grotjohn* supra note 5 at 365 – the person who “assists, incites or procures the suicide of another may be guilty of an offence.”

⁶⁸ *Grotjohn* note 5 at 355.

⁶⁹ *Grotjohn* supra note 5 at 365.

physician.⁷⁰ As a result, patients cannot get assistance from anyone, not even a physician, to end their lives. The decision in *Hartmann*⁷¹ confirmed that a more active and direct role on the part of an assistor in the form of PAE is also a criminal offence.

Consent is not a defence to murder,⁷² and a question is whether it could be a defence in a VAE scenario.⁷³ Could the *volenti non fit injuria* principle apply to VAE cases?⁷⁴ Regarding the common law crime of murder, *volenti* does not offer an accused a defence against unlawfulness and for present purposes does not absolve them of criminal liability even if a person (patient) has voluntarily and competently requested an assisted death.

The criminal law distinguishes between deaths which are caused lawfully and those which are caused unlawfully.⁷⁵ For policy reasons, deaths caused by PE may be justifiable, for example when hastening a patient's death is in his best interests or when the patient (or their proxy) has consented.⁷⁶ Essentially, in cases where a patient elects to withdraw from further treatment, there is reliance on the principle of patient autonomy which renders the conduct of the physician lawful, and it does not matter that such an exercise of autonomy will hasten the

⁷⁰ Although the Supreme Court of Appeal in *Minister of Justice and Correctional Services v Estate Late James Stransham-Ford* 2017 (3) SA 152 (SCA) at para 53-56 sought to narrow the scope of *Grotjohn*. A point for development would be for a court or the legislature to confirm when PAS is lawful and when it is not. From para 55 and 56 of the judgement it would appear that PAS is lawful but the court seems to be uncertain of the circumstances which make it so. The SCA has simply restated the *Grotjohn* decision in that PAS *might* be lawful or unlawful, depending on the circumstances.

⁷¹ *S v Hartmann* 1975 (3) SA 532 (C).

⁷² P Devlin *The Enforcement of Morals* (1965) 6-7:

“If the law existed for the protection of the individual, there should be no reason why he should avail himself of it if he did not want it. The reason why a man may not consent to the commission of an offence against himself beforehand or forgive it afterwards is because it is an offence against society... A murderer who acts only upon the consent, and maybe the request, of his victim is no menace to others, but he does threaten one of the great moral principles upon which society is based, that is, the sanctity of human life. There is only one explanation of what has hitherto been accepted as the basis of the criminal law and that is that there are certain standards of behaviour or moral principles which society requires to be observed; and the breach of them is an offence not merely against the person who is injured but against society as a whole.”

However, death resulting from medical procedures, withdrawal of treatment or the administration of pain-relieving medication and palliative care are discussed as lawful practices.

“It appears that consent will be a defence to the causing of bodily harm unless the causing of that harm, or risk of harm, is unacceptable according to prevailing moral standards, or is inimical to the public interest” (*Halsbury's Laws of England* 4 ed. (1976), Vol. 11; §23 fn 9).

⁷³ Where assistance is either through PAS or PAE - the assistance can be, in a sense, either direct or indirect, for the question of causation. This is relevant for the discussion which follows here under regarding the current status of PAS and PAE in a causal analysis for liability. Consent is discussed fully in Chapter Four.

⁷⁴ 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* 333 at 347.

⁷⁵ *S v Hartmann* 1975 (3) SA 532; *Clarke v Hurst NO* 1992 (4) SA 630 (D).

⁷⁶ When continued treatment is deemed to be futile in that it is no longer curative, or where a patient (or this proxy) has instructed that treatment be withdrawn or withheld, or where a patient has consented to the provision of palliative care medications which have the risk of accelerating death.

patient's death.⁷⁷ This means that patients with decision-making capacity can voluntarily, autonomously and independently elect (or withdraw from) a course of treatment in appreciation of the risks attendant thereto, even if the risk is the hastening of death. This course of treatment a physician administers (or withdraws)⁷⁸ is not seen as an unlawful causing or hastening of death, despite the physician's knowledge of the effect.⁷⁹ Why the opposite is true for VAE is the focus of this thesis, and necessitates investigation into the reasons and circumstances under which death caused through PE is justifiable. Once this is understood, then we can ask whether it can be relied on to make VAE justifiable.

The law does not distinguish between murder and mercy-killing.⁸⁰ Motive plays no part in determining the criminal liability of an accused person, regardless of whether the motive was compassionate or "evil". In both instances, the motive may have a bearing on sentencing alone, acting either as an aggravating or mitigating factor, provided that the elements for criminal liability have been proven.⁸¹ Sentencing aside, the language used by the courts when pronouncing an accused guilty of murder in a mercy-killing scenario is coloured in empathy, reflected in meting out lenient, non-custodial sentences.⁸² The court in *Hartmann*⁸³ confirmed that whether in the form of deliberate and callous homicide or mercy killing (albeit equally deliberate but motivated by mercy), a conviction of murder always follows when the definitional and elemental requirements for proof thereof had been satisfied, including the consideration of unlawfulness, intention and causation.⁸⁴

⁷⁷ B Sneiderman & D McQuoid-Mason 'Decision-making at the end of life: the termination of life-prolonging treatment, euthanasia (mercy killing), and assisted suicide in Canada and South Africa' (2000) 33(2) *CILSA* 193 at 193:

"The legal implications of decision-making at the end of life arise in two categories of case. One category is the so-called 'letting die' cases that occur in the context of the patient-physician relationship and involve either withdrawal or the withholding of life-prolonging measures. An example former is the removal of a respirator which provides life-support for a patient who cannot breathe on his or her own. An example of the latter is the withholding of antibiotic therapy when the patient contracts pneumonia. In either case, the failure to treat aggressively signifies the decision that life not be prolonged at all costs. As a general rule, the physician has acted lawfully in letting die cases because the patient is deemed to have died of natural causes. There is also a consensus that there is no ethical distinction between withholding and withdrawing treatment."

⁷⁸ *Clarke v Hurst NO* supra note 26.

⁷⁹ See Chapter Four re Intention.

⁸⁰ *S v Hartmann* 1975 (3) SA 532 (C); *S v De Bellocq* 1975 (3) SA 538 (T) – heard six years apart, but reported alongside each other in the South African Law Reports. These cases are discussed fully in subsequent chapters.

⁸¹ *Hartmann* supra note 80; *De Bellocq* supra note 80.

⁸² *Hartmann* supra note 80 at 537. The accused was a medical doctor and the son of the deceased. He was treating his father who was in the end stages of cancer. He administered lethal doses of pentothal and morphine, motivated by compassion and mercy. The court found him guilty of murder, but handed down a lenient sentence. The accused was sentenced to one year's imprisonment, which was wholly suspended till the rising of the court.

⁸³ *Hartmann* supra note 80. This case involved active euthanasia.

⁸⁴ Causation is discussed in Chapter Two.

1.3.1.1 *Ex Parte Die Minister van Justisie: In Re S v Grotjohn*⁸⁵

The case of *Grotjohn*⁸⁶ was heard by the Appellate Division (AD)⁸⁷ in 1970. *Grotjohn* was a special review brought by the Minister of Justice, who sought clarity on the law as a result of the High Court decisions in *Gordon*⁸⁸ and *Grotjohn* (a quo). These cases held that any person who assisted another to commit suicide was not guilty of any offence as the final act (pulling the trigger on the shot gun in *Grotjohn* and consuming a lethal dose of pills in *Gordon*) was at the personal, voluntary and independent hand of the deceased.⁸⁹ These independent acts on the part of the victim broke the causal nexus, and the accused persons could not be found guilty of murder. Moreover, as there was no crime of incitement to commit suicide or aiding and abetting suicide in South African law, they could not be found guilty of any crime for their role in the eventual suicides of the deceased persons.⁹⁰ The decision of the lower courts prompted the Minister of Justice to seek clarity on whether assisted suicide was a crime in South African law, and if so, what crime? The AD confirmed that neither suicide nor attempted suicide were crimes, but that assisting another to commit suicide might be murder, attempted murder or culpable homicide.⁹¹ Which crime the assistor would be prosecuted under depended on the facts and how the general principles and elements of criminal liability are assessed.⁹²

Grotjohn has been understood as being broad enough to bring within its contemplation assisted suicide where assistance is rendered by a physician and the HPCSA has endorsed the position that it is,⁹³ cautioning its members that

⁸⁵ *Grotjohn* supra note 5.

⁸⁶ *Grotjohn* supra note 5.

⁸⁷ Now the Supreme Court of Appeal.

⁸⁸ *S v Gordon* 1962 (4) SA 727 (N).

⁸⁹ *Grotjohn* supra note 5 at page 363:

“In die *Gordon*-saak en in die onderhawige is die beskuldigdes vrygespreek op grond daarvan dat die onderskeie handelings wat die dood veroorsaak het, die oorledenes se vrywillige en 'selfstandige' handelinge was.”

(My translation – In the *Gordon* case and in the case at present the accused persons were found not guilty on the ground that the various acts which caused the death were the deceased's voluntary and 'independent' acts.)

⁹⁰ *Grotjohn* supra note 5 at page 359 where the AD quoted from the judgement handed down by the High Court:

“Waar selfmoord bowendien nie 'n misdaad in ons reg is nie, kan aansetting of aansporing tot selfmoord ook nie 'n misdaad wees nie omdat die wederregtelikelement ontbreek.”

(My translation – Moreover, where suicide is not a crime in our law, abetting or incitement to suicide cannot be a crime either because the element of wrongfulness is missing.)

⁹¹ *Grotjohn* supra note 5 at page 365.

⁹² *Grotjohn* supra note 5 at page 363:

“Uit die omstandigheid dat nóg selfmoord nóg poging tot selfmoord 'n misdaad is, volg dit egter nie dat die antwoord op die eerste gestelde vraag ontkennend moet wees nie.”

(My Translation: However, from the fact that neither suicide nor attempted suicide is a crime, it does not follow that the answer to the first question should not be no.)

⁹³ HPCSA Booklet 17 op cit note 9 at para 9.3.

“At present, South African courts have acknowledged that both euthanasia and doctor-assisted suicide are fundamentally incompatible with a practitioner’s role as a healer, and a practitioner guilty of either is regarded as having acted unethically and unlawfully.”⁹⁴

1.3.1.2 *Minister of Justice and Correctional Services v Estate Late James Stransham-Ford*⁹⁵

The case above sought to clarify the decision in *Grotjohn* through the argument that the common law position established in that case violated a patient’s constitutional rights to dignity⁹⁶ and life.⁹⁷ Robert Stransham-Ford was diagnosed with terminal cancer and was suffering intractably.⁹⁸ With only a few weeks to live, Stransham-Ford brought an urgent application to the High Court⁹⁹ asking for an order that he be allowed to commit suicide with medical assistance, and that the doctor who assisted him would not be acting unlawfully.¹⁰⁰ He claimed in the alternative that if he was, due to the progression of his underlying illness, rendered physically incapable of personally administering the fatal medication to himself, a physician be permitted to administer the said medication to him.¹⁰¹ In both instances, he prayed that the physician who rendered the required assistance, either as PAS or PAE, be exempted from criminal liability for the causative, and intentional role that the physician would have played in bringing about his consented-to death. Based on the constitutional arguments raised by Stransham-Ford, Fabricius J in the case of *Stransham-Ford*¹⁰² granted the order.

However, it later came to the SCA’s attention that Stransham-Ford had passed away two hours before the decision was handed down, which information was not brought to the attention of the High Court.¹⁰³ The decision of the High Court was then taken on appeal to the Supreme Court of Appeal (SCA), where the decision was overturned chiefly for the reason that when Stransham-Ford passed away, the cause of action ceased to exist, rendering the matter moot.¹⁰⁴ The SCA held that there was insufficient evidence before it to make a decision on the

⁹⁴ HPCSA Booklet 17 op cit note 9 at para 9.5.

⁹⁵ *Minister of Justice and Correctional Services v Estate Late James Stransham-Ford* 2017 (3) SA 152 (SCA).

⁹⁶ S10 of the Constitution 1996.

⁹⁷ S11 of the Constitution 1996.

⁹⁸ *Stransham-Ford* (HC) supra note 55 at para 6.

⁹⁹ *Stransham-Ford* (HC) supra note 55.

¹⁰⁰ *Stransham-Ford* (HC) supra note 55 at para 4.

¹⁰¹ *Stransham-Ford* (HC) supra note 55.

¹⁰² This decision was overturned for mootness by the Supreme Court of Appeal in *Minister of Justice and Correctional Services v Estate Late James Stransham-Ford* 2017 (3) SA 152 (SCA).

¹⁰³ *Stransham-Ford* (HC) supra note 55 at para 7.

¹⁰⁴ *Stransham-Ford* (HC) supra note 55 at para 5.

lawfulness of PAS and PAE¹⁰⁵ and noted that if a similar application was made to a court in the future, provided that a full and proper examination of the criminal law and constitutional arguments were made where lawfulness could be argued fully, such a court may be persuaded to find in favour of an applicant. The SCA noted ultimately that if faced with an appropriately and properly made case, it would be within the power of a court to develop the common law. However, the court also noted that the over-arching question of permissibility and lawfulness would best be answered by Parliament through the enactment of suitable legislation, which could properly demarcate safeguards and regulate the practice.¹⁰⁶ The decision of the High Court was overturned in its entirety and is of no precedential effect.¹⁰⁷

1.3.2 *The Constitution of the Republic of South Africa, 1996*

The Constitution of the Republic of South Africa is the supreme law of the land, and the definer of constitutional *mores*. All laws must conform to its principles and can be struck down if they are proven to be a violation of the rights enshrined in the Bill of Rights.¹⁰⁸ The courts continue to endeavour to strike a balance between various competing interests based on an interpretation and balancing of the rights protected by the Constitution and the purposes served by either statute or common law. Those laws which do not serve a legitimate constitutional interest can

¹⁰⁵ Although the issue may have had importance, due to a lack of evidence, the SCA was not able to exercise its powers and decide the issue, at para 22 “the Constitutional Court has reserved itself a discretion, if it is in the interests of justice to do so, to consider and determined matters even though they have become moot.”

See also *Independent Electoral Commission v Langeberg Municipality* 2001 (3) SA 925 (CC) at para 11; *MEC for Education, KwaZulu Natal & Others v Pillay* 2008 (1) SA 474 (CC) at para 32; *Pheko & Others v Ekurhuleni Metropolitan Municipality* 2012 (2) SA 598 (CC) at para 32; and s 16(2)(a) of the Superior Courts Act 10 of 2013.

¹⁰⁶ *Stransham-Ford* (SCA) supra note 7 at para 101:

“When an appropriate case comes before our courts the common law will no doubt evolve in the light of the considerations outlined there and the developments in other countries. It is of course possible that Parliament will, as has occurred in other countries, intervene and pass legislation on the topic. That would be welcome if only because it would give effect to the proper role of Parliament in a society where the doctrine of the separation of powers has application. Lobby groups could then make their voices heard and a proper debate and process of reflection could occur. In general, whilst recognising the role that the Constitution confers upon the courts, it is desirable in my opinion that issues engaging profound moral questions beyond the remit of judges to determine, should be decided by the representatives of the people of the country as a whole.”

¹⁰⁷ *Stransham-Ford* (SCA) supra note 7 at para 27. Although the high court decision was overturned chiefly for mootness, the SCA proceeded to consider the merits of the case so as to dismiss any precedential value that the decision may have. In this regard the SCA noted specifically that:

“For those reasons alone therefore the order made by Fabricius J must be set aside. But that leaves the dilemma that it is a reasoned and reported judgment by the high court and if this court does not at least to some extent, address the merits it may be taken as having some precedential effect. That is of particular concern in the present case, as it has already been treated as reflecting the South African legal position by a court in New Zealand. This compels us to deal with the merits insofar as necessary in order to dispel that view.”

¹⁰⁸ Chapter 2 of the Constitution 1996.

be struck down or developed such that they are brought in line with the values that underpin the Constitution.

In 1995 the Constitutional Court of South Africa handed down a seminal decision in *S v Makwanyane*.¹⁰⁹ Before the court lay the rights to life and dignity¹¹⁰ as contained in the Constitution (Interim)¹¹¹ and whether these rights were unjustifiably violated by the continued recognition of the death penalty¹¹² as a sentencing option for criminals convicted of heinous crimes. In its final summation¹¹³ the court concluded that the “rights to life and dignity were the most important of all human rights and the source of all other personal rights.”¹¹⁴ Laws which violate those rights may be found to be unconstitutional if the violation is not justifiable in terms of s 36 of the Constitution. Ultimately, the court was unanimous in declaring that the death penalty was a cruel, inhuman and degrading punishment and that the purpose served by the death penalty could be achieved through less restrictive means.¹¹⁵

In *Makwanyane* Mahomed J posed the following questions by way of an obiter remark which, given the subject matter of this thesis, identifies the constitutional considerations in the rights analysis regarding VAE and the rights to dignity and life:

“Does the ‘right to life’, within the meaning of section 9,¹¹⁶ preclude the practitioner of scientific medicine from withdrawing the modern mechanisms which mechanically and artificially enable physical breathing in a terminal patient to continue, long beyond the point, when the ‘brain is dead’ and beyond the point when a human being ceases to be ‘human’ although some unfocussed claim to qualify as a ‘being’ is still retained? If not, can such a

¹⁰⁹ *S v Makwanyane* 1995 (3) SA 391 (CC) (death penalty a violation of rights to life and human dignity).

¹¹⁰ Respectively sections 9 and 10 of the Constitution of the Republic of South Africa, Act 200 of 1993 (the Interim Constitution).

¹¹¹ The Interim Constitution, 1993.

¹¹² As per s 277 of the Criminal Procedure Act 51 of 1977 (this provision has since been repealed).

¹¹³ Concurring judgments were penned and handed down by each member of the court.

¹¹⁴ *Makwanyane* supra note 109 at para 144, per Chaskalson P, who continues that:

“...By committing ourselves to a society founded on the recognition of human rights we are required to value these two rights above all others. And this must be demonstrated by the State in everything that it does, including the way it punishes criminals. This is not achieved by objectifying murderers and putting them to death to serve as an example to others in the expectation that they might possibly be deterred thereby.”

Similarly, it will be argued in this thesis that criminalising medically assisted dying will not deter patients from ending their lives. All that continued criminalisation will do is drive the practice underground by forcing patients to seek assistance elsewhere. This was the situation faced by several patients who approached Professor Sean Davison for an assisted death. P Nombembe ‘Right-to-die activist Sean Davison gets three years’ house arrest for murders’ *Times Live*, 19 June 2019, available at <https://www.timeslive.co.za/news/south-africa/2019-06-19-right-to-die-activist-sean-davison-gets-three-years-house-arrest-for-murders/> accessed on 2 January 2021.

¹¹⁵ Within the meaning of section 11(2) of the Interim Constitution. Section 11(2) prohibited “cruel, inhuman or degrading treatment or punishment”. *Makwanyane* supra note 109 at paras 26 and 53.

¹¹⁶ Of the Interim Constitution.

practitioner go beyond the point of passive withdrawal into the area of active intervention?
When? Under what circumstances?”¹¹⁷

These questions help focus the research aims and questions of this thesis.

In *Stransham-Ford*¹¹⁸ the applicant argued that the continued criminalisation of VAE was an unjustifiable limitation of his constitutional rights as identified in *Makwanyane*. Whether the constitutional arguments would support a call for the legalisation of VAE must be considered. Under a constitutional dispensation, which centres on human rights, the discussion turns to a balancing of competing interests: that of the state¹¹⁹ and of the individual patient,¹²⁰ with both interested parties relying on the Constitution as support for their polarised positions. I seek to argue that these competing interests can be balanced, with the interests of both parties being met.

Section 39 of the Constitution¹²¹ directs us to take cognisance and seek guidance from legal systems and developments outside our borders.¹²² Chapter 2, the Bill of Rights of the Constitution was in fact modelled on the Canadian Charter of Rights and Freedoms.¹²³ Save for the trite, and uncontroversial, South African courts have liberally referred to and cited the law of various jurisdictions as a basis for the development of our law. The jurisprudence emanating from these jurisdictions has been the catalyst for legislative interpretation and implementation. Our courts favour jurisprudential insight from Europe, the United Kingdom and the Commonwealth, all the while being cautious and deliberate when applying such to the South African cultural, political and policy dynamic.¹²⁴ These reasons also inform the choice of comparative jurisdictions in the analysis. The use of comparative law and its role as

¹¹⁷ *Makwanyane* supra note 109 at para 263.

¹¹⁸ *Stransham-Ford* (HC) supra note 55.

¹¹⁹ The State’s interest in protecting the weak and vulnerable from abuse.

¹²⁰ The individual patient’s right to life and dignity informed by autonomy.

¹²¹ The Constitution 1996.

¹²² The Constitution 1996.

¹²³ *Canadian Charter of Rights and Freedoms*, s 7, Part 1 of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11. See also H Klug ‘The Canadian Charter, South Africa and the paths of constitutional influence’ in R Albert & D Cameron (eds) *Canada in the World: Comparative Perspectives on the Canadian Constitution* (2017) 371-396. See also D M Davis ‘Constitutional borrowing: The influence of legal culture and local history in the reconstitution of comparative influence: The South African perspective’ (2003) 1(2) *Internat J Constit L* 181-195 and at 191-192:

“...with liberal borrowings from Germany and the United States of America. Understandably, the decisions of the constitutional courts of these countries have played a significant role in the determination of the meaning and scope of the rights contained in the South African Constitution, particularly during the early years of the Court.”

¹²⁴ Justice Madlala in *Makwanyane* supra note 109 at 258 pointed out that there exists a “need to bring traditional African jurisprudence to these matters, **to the extent that such is applicable**” (emphasis added). Ubuntu was explicitly mentioned in the Interim Constitution, but left out of the final Constitution, on the understanding that Ubuntu means Human Dignity. The term Ubuntu was left out so as not to inadvertently foster a particularly singular cultural bias.

persuasive, rather than precedential or authoritative, however, must be mediated and mitigated in the light of the political history of South Africa where appropriate while taking cognisance of the socio-economic position, which may be markedly different in South Africa than it is in jurisdictions where VAE is permissible.¹²⁵ Differing socio-economic circumstances between States may impact whether the law in South Africa can develop to accommodate for the legalisation of VAE where a real concern is whether adequate safeguards against abuse can be implemented. This may prove decisive for whether VAE can be legalised in South Africa, even if the current position is found to infringe constitutionally guaranteed rights.

1.3.3 *South African Law Commission Report: Euthanasia and the Artificial Preservation of Life*¹²⁶

The South African Reform Law Commission (SALRC)¹²⁷ is a creature of statute¹²⁸ and is tasked with investigating and making recommendations for the development, improvement, modernisation or reform of the law.¹²⁹ In 1998, the SALRC released its report titled *Euthanasia and the Artificial Preservation of Life*.¹³⁰ Although mandated initially to investigate the status of living wills, the SALRC broadened its scope and included VE.¹³¹ The SALRC reported on the following:

- “i. The artificial preservation of life after clinical death has set in;
- ii. The preservation of life where the patient is competent to make decisions and
- iii. The preservation of life where the patient is incompetent to make decisions.”¹³²

The SALRC identified the source of the medico-legal conundrum as being related to the prolongation of life where such prolongation inadvertently meant prolonged suffering for terminally ill, competent patients.¹³³ Coupled with that was the notion of patient dignity as reflected in their autonomy and the need to respect such, particularly where a patient identifies that they require and want to receive assistance in ending their own life.¹³⁴ At the time of writing, the SALRC noted that

¹²⁵ *Stransham-Ford* (SCA) supra note 7 at para 99.

¹²⁶ South African Law Commission *Euthanasia and the Artificial Preservation of Life* op cit note 1.

¹²⁷ Previously called the South African Law Commission, now called the South African Law Reform Commission.

¹²⁸ South African Law Reform Commission Act 19 of 1973.

¹²⁹ South African Law Reform Commission Act 19 of 1973, section 4.

¹³⁰ South African Law Commission *Euthanasia and the Artificial Preservation of Life* op cit note 1.

¹³¹ SALRC op cit note 1 at paras 1.2 and 1.3.

¹³² SALRC op cit note 1.

¹³³ SALRC op cit note 1 at para 1.6 and 1.7.

¹³⁴ SALRC op cit note 1 at para 1.8.

“matters concerning the treatment of terminally ill people are at present being dealt with on a fairly *ad hoc* basis, there is some degree of uncertainty in the minds of the general public and medical personnel about the legal position of terminally ill and dying people.”¹³⁵

The SALRC reported that while medical practitioners are permitted and required to provide adequate pain relief to their patients by prescribing a course and quantity of drugs that can do so, practitioners are acutely aware of the secondary effect that such drugs can have, i.e. the hastening of the patient’s death. As such, doctors are fearful of exposure to criminal prosecution and professional censure should the medication so prescribed or administered shorten the patient’s life even if done at the patient’s request and having been properly informed of the side effects.¹³⁶

The SALRC also reported that there were three possible options regarding VAE. The first was that the current legal position remains in place if it proved impossible to establish safeguards against abuse. The second and third options would legalise VAE, with both options providing safeguards.¹³⁷ The SALRC report included a proposed draft bill incorporating all options. However, given that the South African Law Reform Commission published its report¹³⁸ and made recommendations in this regard more than two decades ago, in 1998, it is clear that assisted dying is not on Parliament’s agenda.

1.3.4 The Health Professions Council of South Africa – medical ethics guidelines

The Health Professions Council of South Africa (HPCSA) is a regulatory body guided by the Health Professions Act 56 of 1974. Its mandate is to provide guidelines for ethical practice to doctors. It also serves to protect the public. It sets the ethical standards and requirements that dictate the role of doctors and the scope of medical practice. It also serves as a control mechanism in that it can take appropriate disciplinary action against members who do not

¹³⁵ SALRC op cit note 1 at para 1.9.

¹³⁶ SALRC op cit note 1 at para 1.10.

¹³⁷ SALRC op cit note 1 at pages (xi) and (xii)

“Option 2: Decision-making by the medical practitioner:

The practice of active euthanasia is regulated through legislation in terms of which a medical practitioner may give effect to the request of a terminally ill, but mentally competent patient to make an end to the patient’s unbearable suffering by administering or providing a lethal agent to the patient. The medical practitioner has to adhere to strict safeguards in order to prevent abuse.

Option 3: Decision-making by a panel or committee:

The practice of active euthanasia is regulated through legislation in terms of which a multi-disciplinary panel or committee is instituted to consider requests for euthanasia according to set criteria.”

¹³⁸ SALRC op cit note 1.

adhere to ethical practice guidelines. The core ethical values are centred on human rights,¹³⁹ patient autonomy,¹⁴⁰ beneficence¹⁴¹ and non-maleficence.¹⁴²

Medical professionals deal with cause, effect and intention on a daily basis in their interactions with patients. In acknowledgment of the uncertainties faced by physicians attendant to end-of-life care, in 2019, the HPCSA published ethical guidelines on palliative care.¹⁴³ However, it becomes evident that cause, effect and intention are interpreted and applied differently in the medical context than they are in the legal context.¹⁴⁴ The guidelines acknowledge that palliative care extends the constitutional rights to dignity and access to health care. Its goal is to achieve “the best possible quality of life for patients...even if life expectancy is short.”¹⁴⁵ The guidelines state in relation to patient autonomy that

“If a mentally and legally competent patient, who is fully informed of the benefits and risks of treatment, consents to or refuses a particular course of treatment, their decision must be respected, even if the health practitioner providing palliative care believes it will result in serious harm or even death.”¹⁴⁶

Thus, the ethical guidelines acknowledge that end-of life care practices¹⁴⁷ can cause deaths but that it is neither unlawful nor unethical provided the patient (or their proxy) has made an informed decision in the circumstances. However, the guidelines also categorically note that respect for patient autonomy “does not mean that patients are entitled to illegal, unethical or medically inappropriate treatment simply because they have requested it.”¹⁴⁸ As such, in the VAE context, the guidelines state that assisted suicide and euthanasia are not only unlawful in South Africa but are in stark contrast to the principle of non-maleficence¹⁴⁹ and the practitioner’s role as a healer.¹⁵⁰ As the guidelines refer to the conduct of medical professionals,

¹³⁹ HPCSA ‘*General Ethical Guidelines for Health Care Professions: Booklet 1*’ (2016) at para 2.3.4 “Health care practitioners should recognise the human rights of all individuals.”

¹⁴⁰ Booklet 1 op cit note 139 at para 2.3.5 “Health care practitioners should honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences.”

¹⁴¹ Booklet 1 op cit note 139 at para 2.3.3 “Health care practitioners should act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest.”

¹⁴² Booklet 1 op cit note 139 at para 2.3.2 “Health care practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest.”

¹⁴³ Booklet 17 op cit note 9.

¹⁴⁴ See chapters Two, Three and Four herein.

¹⁴⁵ Booklet 17 op cit note 9 at para 3.2.

¹⁴⁶ Booklet 17 op cit note 9 at para 7.2.5.

¹⁴⁷ For example the withdrawing and withholding of treatment or palliative care.

¹⁴⁸ Booklet 17 op cit note 9 at para 7.2.6.

¹⁴⁹ Booklet 17 op cit note 9 at para 9.2.

¹⁵⁰ Booklet 17 op cit note 9 at para 9.5.

under the current state of the law, they must also mean that PAS and PAE are unethical and unlawful.¹⁵¹

Seeking to justify PE, medical bodies rely on intention and causation,¹⁵² which approach is different from that in law. This also appears to set PE apart from VAE within the medical-ethical guidelines. In this thesis, I seek to consider why some deaths that result from medical care in relation to end-of-life care are considered to be permitted in law, while others are not.¹⁵³

1.4 PROBLEM STATEMENT, GOALS AND RESEARCH QUESTIONS

Even though the lawfulness and constitutionality of the restriction on patient autonomy to request a physician-assisted death was the issue in the *Stranham-Ford* matter, the SCA was unable to rule on constitutionality and thus lawfulness and permissibility. This has left unanswered the question which this thesis seeks to answer: *whether a terminally ill, competent adult patient has the right to request and consent to VAE, such that the physician who renders the required assistance is exempted from criminal liability for intentionally causing the death of the patient.*

The effect of the SCA decision in *Stranham-Ford* is that there is a lack of certainty about when or if a patient could ever seek VAE which would not result in criminal prosecution for the physician who concedes to such a request. All the court did was re-state the position in *Grotjohn* which leaves both patients and physicians exactly where they were in 1970. However, the court left the door open, inviting a challenge to the status quo. The court even noted what a sitting court would have to consider when it was faced with an appropriate case. Two routes were proposed: First, a sitting court would have to be convinced that the law should be developed to permit VAE. If so convinced, then it could determine how it should do so: could development occur through the elements of intention, causation or unlawfulness? The second route would be for the legislature to intervene and pass suitable legislation.¹⁵⁴

¹⁵¹ Booklet 17 op cit note 9 at para 9.5.

¹⁵² Booklet 7 at para 1.2: “the premise that any medical intervention where the health care professional’s PRIMARY intention is to end the patient’s life is both contrary to the ethics of health care and unlawful.” The guidelines make appear to make a distinction in the between a physician’s “primary” intention and other forms of intention. See also DJ McQuoid-Mason ‘Withholding or withdrawing treatment and palliative treatment hastening death: The real reason why doctors are not held liable for murder’ (2014) 104(2) *SAMJ* 102.

¹⁵³ Discussion of the fallacy between killing and letting die.

¹⁵⁴ *Stranham-Ford* (SCA) supra note 7 at para 56:

“Assuming that a matter reached the stage where the court thought that a development of the common law was required in relation to PAS, it would then have to decide whether that should take the form of a different view of causation, or of intention (*mens rea*), or of unlawfulness. The possibility of a special defence for medical practitioners or carers would arise and have to be explored.”

Litigation is not the only means of addressing the issue of permissibility. The other option is legislative intervention.¹⁵⁵ However, to date, there has been no forward movement from the legislature regarding the SALRC's recommendations made in 1998.¹⁵⁶ Thus, the first option that the commission proposed, that the status quo remain, has been *de facto* adopted.¹⁵⁷ So it would appear that the litigation route will have to be pursued.

¹⁵⁵ *Stransham-Ford* (SCA) supra note 7 at para 73:

"That would be an extremely important possibility bearing in mind that on issues of this nature, raising complex questions of the public interest, the nature of any regulations that should attach to permitted PAE or PAS and the supervisory regime that should accompany any relaxation of the law, the legislature is the proper engine for legal development."

¹⁵⁶ The report and the draft bill was handed over to Minister of Health at the time, Manto Tshabalala-Msimang. See K Magardie 'South Africa: Euthanasia not for us' *Mail & Guardian* 11 April 2001, available at <https://allafrica.com/stories/200104110364.html>, accessed on 8 January 2023. In *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (6) BCLR 737 (GP) the court notes at para 21 that the first respondent (the Minister of Correctional Services) recorded that the SALRC report

"was not attended to because other issues of national importance which required prioritization such as HIV and the Aids epidemic, he did not say why the Report was not given legislative attention since then."

In 2018, Ms D Carter, a member of parliament, posed the following questions to the Minister of Justice and Correctional Services:

"(1) With regard to the project undertaken by the SA Law Commission in 1998 at the behest of the former President, Mr Nelson R Mandela, into end-of-life-decision that, following extensive consultation, resulted in the compilation of a draft bill on end-of-life-decisions that was presented to the executive, but never acted upon, why was the specified draft Bill never processed any further; (2) whether he intends to revise and re-introduce the draft Bill; if not, why not?"

The Minister of Justice and Correctional Services responded as follows:

"1.. The South African Law Commission (as it then was) submitted its report on euthanasia and artificial preservation of life (which included the Bill on end of life decisions) to the former Minister of Justice, AM Omar, in terms of section 7(1) of the South African Law Commission Act, 1973. He, in turn, referred the report to the then Minister of Health, Dr NCD Zuma, for her attention on 15 June 1999.

Minister Omar's recommendation to the Minister of Health reads as follows:

"The sections of the Bill dealing with the cessation of treatment, palliative care and living wills are of vital importance to the medical profession and patients and I realise that their enactment should not be unnecessarily delayed. However, in order to ensure public participation on the question whether provision should be made for active euthanasia and if so, on what basis, I would like to recommend for your consideration that an appropriate ad-hoc select committee of Parliament be appointed to consider the issue of active euthanasia as set out in section 5 of the Bill."

2. No, this matter is within the competence of the Minister of Health."

See Parliamentary Monitoring Group 'Question NW1280 to the Minister of Justice and Correctional Services' *National Assembly* 11 May 2018 available at <https://pmg.org.za/committee-question/8799/>. Accessed on 9 January 2023.

From this exchange, it would appear that parliament is still waiting for an ad-hoc committee to be established. Further, according to the Minister of Justice and Correctional Services, the issue ought to be dealt with by the Minister of Health, not the Minister of Justice and Correctional Services.

¹⁵⁷ *Stransham-Ford* (SCA) supra note 7 at para 116:

"The Court went on to point out that there are a number of requirements that should be fulfilled to give effect to this decision and regulate it and that these could only be established by the legislature. It therefore exhorted the legislature to regulate the issue of death with dignity in the shortest possible period of time. However, nearly twenty years have passed and this exhortation has not been heeded."

1.4.1 Goals

The primary goal of this thesis is twofold:

- (i) to examine whether VAE currently prosecutable as the common law crime of murder, is an unjustifiable, unreasonable and unconstitutional limitation of the rights to dignity and the autonomy of patients who seek a medically assisted death, and
- (ii) to propose options for development which will enable law reform.

Legalising PAS and PAE is a matter of interest and debate, not only in South Africa but in many other jurisdictions. As has been the experience in Canada, the purpose of the prohibition ought to be considered to determine whether the broad prohibition is an unconstitutional violation of the rights of patients, even though it serves a legitimate State purpose. There, law reform was enabled through litigation¹⁵⁸ which was based on the breadth and scope of the criminal law prohibition on assisted suicide contrasted with a rights-based argument in that the criminal law sanction was a violation of the enshrined rights of certain patients. In that jurisdiction, the consideration of lawfulness and decriminalisation of PAS and PAE were based on the limitations analysis and whether the purpose, although reasonable, could be achieved through less restrictive means. Whether the same consideration in the rights analysis applies in terms of the South African Constitution and the constitutional imperative regarding the development of the law will be a focus I seek to answer through the research questions of this thesis.

1.4.2 Research questions

The research questions are gleaned from the questions posed in an obiter remark by Mahomed J in *Makwanyane*,¹⁵⁹ namely *whether the criminal law prohibition on VAE through the crime of murder unjustifiably limits a patient's rights to dignity and autonomy?* This thesis will seek to answer this overarching question by setting out and distinguishing the common law position governing PE and VAE through consideration of the definitional elements of the crime of murder. This then raises the following sub-questions, which this thesis seeks to answer:

- (a) What is the common law position on PE and VAE based on the definitional elements of the crime of murder?

¹⁵⁸ *Carter v Canada (Attorney General)* 2015 (SCC) 5; [2015] 1 SCR 331.

¹⁵⁹ *Makwanyane* supra note 109 at para 268: "Can such a practitioner go beyond the point of passive withdrawal into the area of active intervention? When? Under what circumstances?"

- (b) What is the reason for the lawfulness distinction between PE and VAE?
- (c) If the lawfulness distinction between PE and VAE is based on the interpretation of constitutionally guaranteed rights, can the interpretation of these rights also be extended to include VAE in the way they currently apply to PE?
- (d) If they can be extended to include VAE, do the common law principles defining VAE as murder justifiably limit the rights identified?
- (e) If the common law principles cannot be justified, should the law be reformed to legalise VAE? and
- (f) If so, what are the most appropriate remedies for law reform given competing interests and arguments for and against legalisation, so that a balance can be achieved?

1.5 RESEARCH METHODOLOGY

This thesis applies a doctrinal research methodology¹⁶⁰ combined with the comparative research methodology, and involves an analysis of existing legal principles, legislation, case law and debates surrounding the legalisation of VAE in South Africa through the Constitution and comparable foreign jurisprudence. This form of qualitative analysis of the source materials is used to support my hypothesis that through the Constitution, the law can reform to accommodate the legalisation of VAE in South Africa.

The rights-based analysis draws on the South African Constitution, and the Canadian Charter of Rights and Freedoms,¹⁶¹ considering whether the prohibition on PAS and PAE is an unjustifiable infringement and violation of a patient's rights as enshrined in our Constitution. The legal (basic principles and constitutionalism) and medical (medical ethics and professional guidelines) arguments for and against legalisation and regulation will be considered, not only from a South African perspective, but also from a comparative one, by drawing an analogy and distinction between foreign jurisdictions and their interpretation of equal rights and principles.

Focus will also be placed on the criminal law and the crime of murder. I will look at the definitional elements of the crime – causation, unlawfulness and intention – to determine whether there is room in the current common law discourse for the legalisation of PAS and PE through the re-interpretation of these elements. Drawing on the experiences in foreign

¹⁶⁰ Also known as a black-letter methodology.

¹⁶¹ The Republic of South Africa Constitution Act 110 of 1983, Part I.

jurisdictions and an examination of our own common law, I will seek to test whether legalisation is possible under a constitutional dispensation and in what form.

The approach begins by analysing the criminal law principles which categorise PAS and PAE as murder and then where necessary, draws on the jurisprudence in foreign jurisdictions which interpret and apply these principles in the same context.

1.5.1 Motivation for choice of comparative jurisdictions

In this thesis, reliance and reference will be made to constitutional texts, legislative texts and case law from jurisdictions which are identified as being appropriately comparative to our own based on our jurisprudential roots. In the context of assisted dying, a comparison will be made for the most part to the laws of England and Canada as they offer historical and current insights into the debate. Notably, the jurisdictions themselves have differing legal foundations, but all have had an influence on the development of law in South Africa since 1652¹⁶² to date. Developments, both successful and unsuccessful, that have emanated from these jurisdictions will be used to map the way forward for South Africa.

1.5.2 Legal developments in comparative jurisdictions

1.5.2.1 England¹⁶³

Assisted suicide in England is criminalised in the Suicide Act of 1961.¹⁶⁴ The Act decriminalised suicide, such that the act of suicide, or rather a failed attempt at such was no longer a criminal offence. However, section 2 of the Act provides that it is an offence to “aid, abet, counsel or procure the suicide of another” and further that a person acting in violation of section 2 would be liable to a term of imprisonment, not exceeding fourteen years. In England, the act of rendering such assistance is not prosecuted as murder, but rather the specific offence of aiding and abetting suicide and has a separate sentencing guideline structure. The specific offence also has definitional elements which are applied differently than they are to the crime

¹⁶² W George, F Du Bois, G Bradfield (ed) *Wille's Principles of South African Law* 9th ed (2007). See also A Barrat and P Snyman, *Researching South African Law* (2018) Globex, available at https://www.nyulawglobal.org/globalex/South_Africa1.html, accessed on 3 January 2023. South African law is a system which reflects the colonial governance and influence of the Dutch and the English, customary law as well as aspects of religious personal law. From the Dutch, the system inherited much of the uncoded law of the Netherlands as was brought to the Cape by the first Dutch settlers in 1652. The influence of the English can be seen in procedural law as well as many codified pieces of law which persist today.

¹⁶³ The basis for using England as a comparator is that South African law has been influenced by the law of England. The influence has seen our common-law as well as our statutory law being modelled, sometimes even directly imported from this jurisdiction, eg. Arson, housebreaking, etc.

¹⁶⁴ The discussion will be confined to the law of England.

of murder. In addition, there has been the implementation of a separate prosecutorial policy when there is an allegation of aiding and abetting suicide within a medically-assisted dying factual matrix.¹⁶⁵

For the larger part of this thesis, the way in which the elements of intention and causation are applied in English law causes us to look at the doctrine of double effect and the impact it has had on *mens rea* and liability. The extent to which the doctrine may apply in South African criminal law becomes the relevant focus.¹⁶⁶

1.5.2.2 Canada

PAS and PAE have been decriminalised and legalised in Canada. This was facilitated via the courts in a few landmark decisions, most notable that of *Carter v Canada*¹⁶⁷ which propelled legislative intervention and regulation. The decision has seen amendments to the Canadian Criminal Code, which still maintains that aiding and abetting suicide is a crime, but differentiates it from the act of medical assistance in dying. The relevant amendments also set out criteria for when and how PAS and PAE can be lawfully administered.

The rights-based arguments raised in *Carter v Canada*¹⁶⁸ will be considered and tested to see whether they have significance and applicability in South African jurisprudence and the development of law here.

1.6 LIMITATIONS OF THIS STUDY

This thesis focuses on only VAE as it relates to competent adults suffering from terminal and intractable diseases. The reason for this is linked to the requirements for assessing competency and capacity in the informed consent analysis. For the same reason, the rights of minors fall outside of the scope of this study as does illnesses that are of a psychological nature (like depression).¹⁶⁹ I will only be discussing the elements in relation to the crime of murder as the argument centred on the legalisation of PAS and PAE is that they are prosecutable as *inter alia*, the crime of murder. In this regard, the focus is on the *mens rea* element of intention and not

¹⁶⁵ *Policy for prosecutors in respect of cases of encouraging or assisting suicide* (February 2010, updated October 2014) Available at <https://www.cps.gov.uk/publication/assisted-suicide> accessed on 10 July 2022.

¹⁶⁶ *Stranham-Ford* (SCA) supra note 7 at para 34 – no court prior to this has made reference to the doctrine of double effect.

¹⁶⁷ *Carter v Canada* (Attorney General) 2015 (SCC) 5; [2015] 1 SCR 331.

¹⁶⁸ *Ibid.*

¹⁶⁹ Eg *Office of Public Prosecutions v Chabot* Sup Ct 21 June 1994 nr. 96.972 [*Nederlandse Jursiprudentie* 1994, nr 656] – assisted suicide where patient's suffering was non-somatic – patient was suffering from depression. *S v Nkwanyana* 2003 (1) SA 303 (W) – the deceased was suffering from anorexia nervosa accompanied by major depression – deceased repeatedly implored her friend (the accused) to kill her. The accused was not a medical doctor.

negligence, which forms the distinction between the criminal offences of murder and culpable homicide.¹⁷⁰ The submissions herein are correct as of date of submission (July 2023), and do not consider any legal advancements that may present after that date in this jurisdiction or others.

1.7 STRUCTURE OF THE THESIS

The first and current chapter titled *The Introduction* details the premise and purpose of this study. It maps out a brief history regarding the criminalisation of medically assisted dying thus far and exposes the complexities attendant to the issue in the context of VAE specifically. Further it provides insight into the approach to VAE in two other jurisdictions.

The next three chapters (Two to Four) focus on the elements of criminal liability: causation, unlawfulness and intention, and examine why VAE is the crime of murder under the current common law.

Chapter Two is titled *Causation and assisted dying*. In law, causation is assessed in two stages. First, it must be established whether the conduct of the accused person is a cause in fact. The second leg of the inquiry is whether the conduct is a cause in law, and has utility in more complicated cases which evidence more than one factual causal source.¹⁷¹ In this chapter, I consider the arguments regarding the causation of death as understood in law and medical practice, and whether passive euthanasia practices are permissible because they do cause death. If it is shown that PE causes death, then any argument founded on this as a reason why VAE should not be legalised will be insufficient for maintaining the prohibition.

Chapter Three is titled *Unlawfulness and assisted dying – consent as a defence*. Here the discussion turns to patient autonomy and consent in medical decision-making. Patients are recognised as autonomous agents, capable of making competent decisions regarding health care, including decisions which can adversely affect their longevity. Patients can choose to withdraw from medical treatment or choose a course of treatment with a risk of accelerated death. In this light, the recognition of consent and patient autonomy makes treatment options in the form of passive euthanasia lawful, even though they hasten death. It is also the case

¹⁷⁰ Culpable homicide is defined as “the unlawful, negligent causing of the death of another human being” – SV Hoorster *Snyman’s Criminal Law* 7 ed (2021) at 391.

¹⁷¹ A Politis *An Analysis of Causation in Medical Law* (unpublished PHD thesis, University of Pretoria, 2018) at 178, and at 360:

“It was established that a mathematical, purely scientific or philosophical approach to factual causation is eschewed by South African courts in favour of common sense, based on the practical way in which the minds of ordinary people work, against the backdrop of everyday-life experiences. Everyday life experiences are most certainly useful in establishing factual causation in cases where readily identifiable single agents are single actors or uncomplicated factual scenarios are involved.”

because PE is recognised as lawful and ethical medical treatment. However, for patient consent to be recognised as real and lawful, certain requirements must be met. If these are met, then the patient's consent is real, and any medical decision autonomously made must be respected. In appropriate circumstances, without patient consent, such treatment is the crime of assault and may also be murder. One of these requirements is that the act consented to must be one for which the law recognises consent; the other is that the consent must be real. The first requirement holds that the law can limit autonomy based on the type of conduct a person is consenting to. Thus, regardless of capacity or competency, if the law does not allow a person to consent to the proposed conduct, consent will never avail as a defence. The law is clear that one can never consent to be murdered, and because VAE is prosecutable as murder, the requirement regarding consent as a defence will be insurmountable. This chapter seeks to examine why consent is never a defence to murder and the reasons for this, and explores whether those reasons are appropriate in VAE cases.

Chapter Four is titled *Intention and assisted dying*. In South African law, intention has several forms, notably *dolus directus* (direct intention), *dolus indirectus* (indirect intention) and *dolus eventualis* (legal intention). Intention extends beyond the primary aim and, through *dolus indirectus* and *dolus eventualis*, casts the net of culpability for murder much wider than in other jurisdictions.¹⁷² Unlike in England and Canada, homicide offences in South Africa are not graded based on the type of intention harboured by an accused person. Even if an accused person is found only to have intention in the form of *dolus eventualis*, they will still be found guilty of murder, provided that all the other elements for liability have also been proved. The doctrine of double effect (which operates in the law of England) features prominently in medical practice in South Africa. Whether it applies in South African law is discussed in this chapter.¹⁷³ As far as medical practice is concerned, physicians rely on this doctrine as the reason for their exemption from criminal liability for deaths caused by passive euthanasia. This chapter considers whether the permissibility distinction between PE and VAE is based on the element of intention. If it is not, then any arguments on the permissibility of one and not the other based on the intention will fail.

¹⁷² In England and Canada, the homicide offences are graded, and for a conviction of murder the accused must (and only) have exhibited *dolus directus* for the mens rea requirement. All other forms of *mens rea* are stand-alone offences, for example, manslaughter.

¹⁷³ *Stransham-Ford* (SCA) supra note 7 at para 34.

Chapters Two, Three and Four intend to show that the real reason for the permissibility of PE is based on the assessment of lawfulness as gauged through the legal convictions of society.

In the fifth chapter, titled *Lawfulness, the legal convictions of society and the Constitution – Developing the South African common law*, I consider what the legal convictions of society are under a constitutional dispensation and whether and how these convictions can be used to legalise VAE and develop the common law. The constitutional rights to life and dignity as informed by autonomy are juxtaposed with the limitations analysis, based on the purpose served by criminalisation.¹⁷⁴ I consider s 36 of the Constitution and whether the purpose identified can be achieved through less restrictive means. If the purpose can be achieved through less restrictive means, then the obligation created in s 39 of the Constitution must be fulfilled and the common law must be developed to align with the constitutional imperative.

Chapter Six is the concluding chapter and is titled *Conclusion and recommendations*. This chapter seeks to consolidate the discussion on VAE in the context of the criminal law in South Africa and the Constitution by summarising the theories, legal principles, common law and legislation discussed. The chapter contains recommendations for the way forward drawn from the study and the jurisdictions that have legislated for lawful VAE.

¹⁷⁴ The reason for the focus on the right to dignity as the main right is because dignity is the core right and value which informs all other rights enshrined in the Constitution. See *S v Makwanyane and Another* 1995 (3) SA 391 (CC) para 329-330. Here, the Constitutional Court confirmed the centrality of dignity and its relatedness to all other rights enshrined in the Constitution. See also A C Steinmann 'The core meaning of Human Dignity' (2016) *PER/PELJ* 19; D Benatar 'A legal right to die: responding to slippery slope and abuse arguments' (2011) *Curr Oncol* 18(5) 206-207; A P Simester and A von Hirsch, *Crimes, Harms, and Wrongs: On the Principles of Criminalisation* (2011); V Jenness 'Explaining Criminalization: From Demography and status Politics to Globalization and Modernization' (2004) *Annu. Rev Sociol* 30:147-71; J Feinberg 'Harm to self: The moral limits of the Criminal Law, Vol 3' *Law and Philosophy* (1988) 7(1): 107-122; N Brown 'The "harm" in euthanasia' (1996) *The Australian Quarterly* 68(3) 26-35.

CHAPTER TWO

CAUSATION AND ASSISTED DYING

2.1 INTRODUCTION

VAE¹ is prosecutable as the materially² defined crime of murder which means that there must be a “causal link (or connection) between the initial act or omission of the accused and the ultimate unlawful consequence.”³ As death is inevitable, in law, causing death means to hasten death; to bring it about sooner than it would have naturally occurred.⁴ Under scrutiny is the conduct of the accused person (the physician) and its relevance to when, where and how the victim (the patient) died. Results matter but so does being able to attribute those results to a source,⁵ and in VAE scenarios, the causation question is *whether the state can prove that the conduct of the physician brought about the death of the patient sooner than would otherwise have been the case.*

¹ Includes both physician-assisted suicide and physician-administered euthanasia.

² SV Hoorntjens *Snyman's Criminal Law* 7 ed (2020) at 66:

“In formally defined crimes, a certain type of conduct is prohibited irrespective of the result of such conduct. Example of crimes falling in this category are the possession of drugs, driving a motor car negligently, and perjury. In materially defined crimes, on the other hand, it is not specific conduct which is prohibited, but any conduct which *causes* a specific condition. Examples of this type of crime are murder, culpable homicide and arson.”

³ EM Burchell, P M A Hunt & J M Burchell *South African Criminal Law and Procedure Vol 1 General Principles of Criminal law* 4 ed (1997) at 93.

⁴ *Snyman's Criminal Law* op cit note 2 at 66-67:

“In the determination of causation in cases of murder or culpable homicide it must be remembered that ‘to cause death’ actually means to cause the death at the time when, and the place where, Y died. All people die at some time; therefore to ask whether the act caused the death is in fact to ask whether the act precipitated the death. The fact that Y suffered from an incurable disease from which he would shortly have died in any event, or that Y would in any event have been executed a mere hour later, does not afford X a defence.”

⁵ Carl-Friedrich Stuckenberg ‘Causation’ in *The Oxford Handbook of Criminal Law* 2014 at 469-471 and at 470-471:

“People often succeed in doing what they intend. Whether the outcome was really the actor’s ‘doing’ and justly attributable to him or the work of uncontrollable factors, is the question that the doctrine on causation and imputation must answer in a principled manner.”

J M Burchell *Principles of Criminal Law* 5ed (2018) at 96 quoting with approval A Ashworth *Principles of Criminal Law* 6ed (2009) at 101 regarding autonomy and its relationship with causation:

“That principle respects individuals as capable of choosing their acts and omissions. It follows from this that they should be regarded as agents responsible, at the very least, for the normal consequences of their behaviour. Respect for individual autonomy and responsibility for conduct and consequences go hand in hand.”

As the *actus reus* considers the conduct of an accused person, causation focuses on that conduct and its relationship with the prohibited result. Causation is a necessary component of the *actus reus* in materially defined crimes.

Causation relates to conduct, which means that both acts⁶ and omissions⁷ can cause a result.⁸ The law assesses causation by attempting to draw a straight line between point A (the act or omission of the accused) and point B (the death of the victim) through a process of elimination of legally irrelevant causes,⁹ in a way that is reasonable, fair and logical, but also replicable for any future cases that may present.¹⁰ If that line is broken, then the perpetrator's conduct will not be the cause of the unlawful consequence, and no conviction can follow. For present purposes, a court will ask what has caused the patient's death? Was it the underlying illness, the increased amounts of palliative care medication, the withdrawing and withholding of medical treatment, or the administration of a final and lethal dose of medication (whether administered by the patient themselves or by the physician)?¹¹ There may be many lines

⁶ Understood as being positive conduct, for example, the physician injects the patient with a drug. *S v Hartmann* 1975 (3) SA 532 (C); *R v Cox* [1992] 12 BMLR 38. Fuller discussion of these cases as regards causation appears later in this chapter.

⁷ Understood as being negative conduct (or a failure to 'act'), for example where the doctor withdraws life supporting measures. Considered in *Clarke v Hurst NO* 1992 (4) SA 630 (D); *Airedale NHS Trust v Bland* [1993] 1 All ER 821. Fuller discussion of these cases as regards causation appear later in this chapter.

⁸ A McGee 'Ending the life of the act/omission dispute: causation in withholding and withdrawing life-sustaining measures' (2011) *Legal Studies* 31(3) 467-491; A McGee 'Does withdrawing life-sustaining treatment cause death or allow the patient to die?' (2014) *Medical L Rev* 26-47; F G Miller & R D Truog *Death, Dying and Organ Transplantation: Reconstructing Medical Ethics at the End of Life* (2012); R Huxtable (2020). 'On Killing and Letting Die, Acts and Omissions: For and Against the Distinctions'. In: Emmerich, N., Mallia, P., Gordijn, B., Pistoia, F. (eds) *Contemporary European Perspectives on the Ethics of End of Life Care*.

⁹ Carl-Friedrich Stuckenberg in 'Causation' in *The Oxford Handbook of Criminal Law* 2014 at 471:

"The use of the words 'causation' and 'cause' is ambivalent in many legal orders. Historically, in the common law traditions, the legal notion of 'cause' was used in a wider and somewhat circular sense which included normative consideration of answerability, so that 'legal causation' or 'cause-in-law' referred only to those events which triggered legal responsibility, hence the well-known terminology distinction between (legally relevant) 'causes' and (legally irrelevant) mere background 'conditions'."

¹⁰ I Freckelton & D Mendelson (eds) *Causation in Law and Medicine* (2002) at 21:

"Since judgements of appellate courts constitute binding or persuasive precedents for future courts they should enunciate clearly the principles and policies that have guided these guesses. This is why a judgement in favour of one side of a legal dispute cannot convincingly turn on mere assertions that it is a pragmatic matter of 'common sense'. This approach manages to be both patronizing and mystifying to ordinary people because it suggests that if the decision goes against what the particular observing citizen believes is fair this is because he or she is too obtuse to grasp what lawyers like the judge can see as pragmatic common sense."

¹¹ A Politis *An Analysis of Causation in Medical Law* (unpublished LLD thesis, University of Pretoria 2018) at 2:

"Causation presents unique difficulties which are compounded by a variety of complex factors. Those factors include, but are not limited to, the state of medical science pertaining to medical procedures; uncertainties in respect of the development, mechanisms and progression of disease; the existence of pre-existing medical conditions on the part of a particular plaintiff; or the uncertainties pertaining to drug interactions prior to, during and after medical treatment."

Carl-Friedrich Stuckenberg in 'Causation' in *The Oxford Handbook of Criminal Law* 2014 at 473-474:

"If each condition counts as a cause, the causal chains are endless, virtually leading back to Adam and Eve or the 'primeval slime.' Causal analysis, then, serves only as a first filter to exclude all those factors which are not causal and no basis for legal liability. In order to isolate legally significant causes, limitations have to be introduced under other rubrics."

JC Van der Walt (1979) *Delict: Principles and cases* at 955:

"The factual consequences of an act may theoretically stretch into infinity and the *causae* of a particular consequence go back to the beginning of time. A person can as a matter of practical politics not be held responsible for all the factual consequences of his conduct. Some limitation must be introduced and a

(‘causes’) leading toward the death of a patient, but the law is interested in determining which cause ought to result in liability.¹²

In South Africa, the SCA in *Mokgethi*¹³ confirmed that a two-stage inquiry into causation is necessary to achieve fair results based on whether the conduct of an accused person is linked¹⁴ to the unlawful consequence, and if an accused person is shown to satisfy both stages, then their conduct is the “legally relevant”¹⁵ cause of the unlawful consequence. The two-stage inquiry graduates relevant causes (events or conditions) to *legally relevant* causes. The first inquiry is into factual causation, and depending on the results yielded, a court then considers the legal causation question. Factual causation is the antecedent to legal causation – principally, an accused person’s conduct cannot be the legal cause if it was not found to first be a factual cause.¹⁶ The courts in Canada¹⁷ and England¹⁸ adopt a two-stage process as well.

In this chapter I consider the principles which underpin and inform how courts approach the inquiry into causation generally, how the principles are applied to passive euthanasia cases, and whether development of the law to legalise PAS and PAE can occur through causation. I consider causation in relation to PE and VAE with the purpose of showing that both cause death. For this reason, I intend to show that any arguments on the permissibility of PE and impermissibility of VAE based on causation alone are in law an artificial construct and indefensible in the light of legal principles and theories of causation. I intend to show that the reason for permissibility is not based on causation, but rather on a question of the circumstances

balance struck between the plaintiff’s claim for full reparation of the loss suffered and the defendant’s interest in not being overburdened by his legal liability.”

¹² *Snyman’s Criminal Law* op cit note 2 at 65:

“Many factors or events may qualify as factual causes of a prohibited condition. In order to eliminate factual causes which are irrelevant, the criterion of legal causation is applied.”

¹³ *S v Mokgethi* 1990 (1) SA 32 (A). See also *S v Daniels* 1983 3 SA 275 (A); *R v Makali* 1950 1 SA 340 (N); *S v Coetzee* 1974 3 SA 571 (T) 572; *S v Hartmann* 1975 3 SA 532 (C) 534; *Minister of Police v Skosana* 1977 1 SA 31 (A) 34.

¹⁴ *Skosana* supra note 13.

¹⁵ Supra note 11 - Carl-Friedrich Stuckenberg in ‘Causation’ in *The Oxford Handbook of Criminal Law* 2014.

¹⁶ Burchell *Principles of Criminal Law* op cit note 4 at 98: “The test for factual causation must be satisfied before legal policy is used to limit liability further.”

JC Van der Walt and JR Midgely *Principles of Delict* (2005) at 197 succinctly explain that:

“The complex problem of causation involves a consideration of two different questions: whether any factual relation exists between the defendant’s conduct and the harm sustained by the plaintiff; and whether, or to what extent, the defendant should be held legally responsible for the consequences factually induced by his or her conduct.”

¹⁷ *R v Maybin* 2012 SCC 24; *R v Smithers* [1978] 1 SCR 506; *R v Nette* 2001 SCC 78.

¹⁸ *R v Wallace* [2018] EWCA Crim 690; *R v Kennedy (No 2)* [2007] UKHL 38; *R v Pagett* [1983] 76 Cr App R 270; *R v Smith* [1959] 2 QB 35; *R v Malcherek and Steel* [1981] 2 All ER 422; *R v Jordan* (1956) 40 Cr App E 15; *R v Adams* (1957) Crim LR 773.

under which the law permits and sees as justifiable, the causing of death.¹⁹ The SCA in *Stransham-Ford* noted that a court faced with a similar case would first have to clarify whether the common law which prohibits assisted suicide also includes PAS. If it does not, then it would necessarily mean that PAS is (and perhaps always has been) lawful, and so no further development would be required. This would mean that either causation could not be established, or that causing death in PAS scenarios is justifiable. For present purposes the focus is on whether PAS causes death.²⁰

2.2 FACTUAL CAUSATION – *THE CONDITIO SINE QUA NON*

The unlawful consequence under judicial scrutiny may present due to a series of events or conditions, which in some measure appear to contribute to that result.²¹ The *conditio sine qua non* or “but for” test is used to determine whether an accused person’s conduct contributed²² to the prohibited result,²³ through hypothetical projection²⁴ of what would have transpired if the conduct did²⁵ or did not²⁶ occur. Where an accused has acted, we ask the question: *but for the act of the accused, would the consequence have occurred when it did?*²⁷ If the answer is *no*,

¹⁹ Justification is addressed in Chapter Five. This includes consideration of society’s legal convictions and how these resulted in the conclusion reached in *Clarke v Hurst NO 1992 (2) SA 630 (D)*. The relevant Chapter discusses *boni mores*, post *Clarke*, as interpretable through the Constitution.

²⁰ *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) at para 56.

²¹ John Stuart Mill *A system of Logic, Ratiocinative and Inductive* (1843), book III, ch V, S3, in John M. Robinson and R.F. McRae (eds), *Collected Works of John Stuart Mill*, Vol II (1974) at 434:

“it is not true that one effect must be connected with only one cause, or assemblage of conditions; that each phenomenon can be produced in only one way. There are often several independent modes in which the same phenomenon could have originated.”

Mokgethi supra note 13 where the court identified that both the bullet wound and the septicaemia were factual causes of the deceased’s death.

²² *Minister of Police v Skosana* 1977 (1) SA 31 (A) 34 at 34E-F where the court defined factual causation and noted that it exists if an act or omission “caused or materially contributed to...the harm in question.”

²³ Hart and Honore ‘Causation in law’ op cit note 13 at 60, 69, 74, 77; G Williams ‘Causation in law’ (1961) 19(1) *Cambridge L J* 62 at 63.

²⁴ CJ Visser and C Kennedy-Good ‘The emergence of a “flexible” *conditio sine qua non* test to factual causation? *Lee v Minister of Correctional Services* 2013 (2) SA 144 (CC)” 2015 *Obiter* 36(1) 150-163 at 151:

“What the *conditio sine qua non* test involves, according to the SCA in *International Shipping Co (Pty) Ltd v Bentley*(supra), is to employ a process of hypothetical deduction to establish whether the offending act is a necessary condition for the harm to occur (a *conditio sine qua non*) and not merely a pre-existing antecedent (700F–H).”

²⁵ Where the conduct under scrutiny is an omission (failure to act according to one’s legal duty), the factual causation question is: *Would the result have occurred if the accused did what they were supposed to do?*

²⁶ Where the conduct under scrutiny is an act (what the accused acted), the factual causation question is: *Would the result have occurred if the accused had not acted as they did?*

²⁷ *Snyman’s Criminal Law* op cit note 2 at 68:

“Conduct is therefore a *conditio sine qua non* for a situation if the conduct cannot be ‘thought away’ without the situation disappearing at the same time. A convenient English equivalent for this formula is but-for causation (or more precisely, but-for not causation). For conduct or an event to be a but-for cause, one must be able to say that but for the conduct or event, the prohibited situation would not have happened.”

the result would not have occurred when it did, then the prosecution has established causation in fact. For omissions where there is a duty to act, the factual causation question is: *would the result have occurred when it did if the accused had acted in accordance with his legal duty?*²⁸ If the answer is *no*, *it would not have occurred when it did*, then the accused person's omission is established as a factual cause. These hypothetical projections are aimed at assessing the effect on the prohibited result and whether it would have been different if the accused person had conducted themselves in a way other than they in fact did. The *conditio sine qua non* is thus used to determine whether a condition is an indispensable condition, without which the unlawful consequence could not have occurred.²⁹

In the case of *Minister of Police v Skosana*³⁰ the court had to decide whether the negligent omission of the police officers on duty was a factual cause of the deceased's death. The deceased suffered a ruptured bowel when he was involved in a motor vehicle accident, and had not received prompt medical attention. The first issue was whether this delay was a factual cause of his death.³¹ Corbett JA noted that factual causation assesses "whether the ...act or

²⁸ *S v Van As* 1967 (4) SA 594 (A); *Minister of Police v Skosana* 1977 (1) SA 31 (A); *R v Makili* 1950 (1) SA 340 (N); *S v Coetzee* 1947 (3) SA 571 (T); *S v Hartmann* 1975 (3) SA 532 (C).

²⁹ For example, assume you want to harvest your own apples (the result). To do this you need a seed, soil, water, and sunshine. We would call these necessary 'conditions' without which you would not be able to harvest apples. But which of these are *indispensable*? Which of these is the *conditio sine qua non*, or are all of them indispensable? See also CJ Visser and C Kennedy-Good 'The emergence of a "flexible" *conditio sine qua non* test to factual causation? *Lee v Minister of Correctional Services* 2013 (2) SA 144 (CC)" 2015 *Obiter* 36(1) 150-163 at 151:

"an act will be considered to be a necessary condition if the act cannot be removed hypothetically from the prevailing factual matrix without the harm also disappearing. Depending on whether the act is in the form of a commission or omission, the process will either involve hypothetical elimination of the offending act (for a commission) or hypothetical substitution of lawful conduct (for an omission) to determine whether the consequence of the act might also simultaneously disappear. Accordingly, if the hypothetical deduction or substitution exercise removes the harm in question, the act will be considered to be a necessary condition for the harm to occur."

³⁰ *Minister of Police v Skosana* 1977 (1) SA 31 (A). The facts of this case were briefly that the deceased, Timothy Skosana (TS), had been driving under the influence of alcohol. Subsequently he drove his vehicle into a ditch. The passengers were taken away in an ambulance, but TS was taken to the police station and placed in a holding cell. He was then examined by the district surgeon. At that point, he complained of minor chest pains. No internal injuries were detected. The next morning TS complained of severe abdominal pains. Some two hours later he was taken (across the road) to the office of the district surgeon, who wrote a letter to the hospital and instructed the police officers that TS was to be taken to hospital immediately. A further delay ensued, and only a further two hours later was he taken to hospital. On arrival his condition was dire, presenting with a ruptured bowel (which progressed into severe generalised peritonitis) and an emergency operation was performed. He did not survive the operation. The medical evidence noted that this was the immediate cause of death, but could have been prevented if he had had medical attention sooner. The bowel ruptured in the car accident. In a civil claim for damages, the wife of TS sued the Minister of Police in that the negligent omission on the part of the police officers caused her husband's death. To decide the causation question, the court first had to determine whether the omission was a factual cause: "The test is thus whether but for the negligent act or omission of the defendant the event giving rise to the harm in question would have occurred."

³¹ *Skosana* supra note 30 at 35:

"The test is thus whether but for the negligent act or omission of the defendant the event giving rise to the harm in question would have occurred. This test is otherwise known as the *casus (conditio) sine*

omission in question caused or materially contributed to...the harm giving rise to the claim.”³² Corbett JA further offered an understanding of what a material contribution is when he noted that the conduct of the defendants (in this case) “can only be regarded as having caused or materially contributed to his death if the deceased would have survived but for the delay.”³³ The court elaborated that factual causes were determined by scientific or objective factors.³⁴ In this respect, we understand that factual causes or a *conditio sine qua non* are identified through “facts”, that scientific notions include for example medical evidence,³⁵ and “objective” notions mean the natural order of things as they occur in regular human experience.³⁶

qua non and I agree with my Brother Viljoen that generally speaking... no act, condition or omission can be regarded as a cause in fact unless it passes this test.”

³² *Skosana* supra note 30 at 34.

³³ *Skosana* supra note 30 at 35:

“The ‘factual’ question whether the relation between the defendant’s breach of duty and the plaintiff’s injury is one of cause and effect in accordance with ‘scientific’ or ‘objective’ notions of physical sequence. If such a causal relation does not exist, that puts an end to the plaintiff’s case, because no policy can be strong enough to warrant the imposition of liability for loss to which the defendant’s conduct has not in fact contributed.”

³⁴ *Skosana* supra note 30 at 34.

³⁵ In the English case *R v White* [1910] 2 KB 124 which was taken on appeal, the accused poured a small amount of poison into his mother’s drink with the intention of incrementally poisoning her, eventually causing her death. She had a few sips of the drink, and later was found dead. Medical evidence produced showed that she died of a heart attack, and not as a result of the poison (a rather small quantity) she had ingested. The poison put into her drink was on its own too small an amount to have brought about death, and further she only ingested a small amount of what was already an insufficient amount of the poison. The appeal court ruled that the accused was not the factual cause of his mother’s death, and so justly, there could be no inquiry in to whether his conduct was the legal cause. He could not be found guilty of murder if, in the first instance, his conduct was not a factual cause of the prohibited end result. The court did however find that he was guilty of attempted murder.

³⁶ Carl-Friedrich Stuckenberg in *The Oxford Handbook of Criminal Law* at 473, refers to Hume’s observations and notes that

“He claimed that causal judgments are based on the belief that the temporal succession of certain events is necessary because we have observed the ‘constant conjunction’ of these events; put differently, it is the experience of regularity between prior cause and subsequent effect that creates in our minds the idea of necessary connection which constitutes the causal relation.”

Horder in *Ashworth’s Principles of Criminal Law* 9ed at 115-116:

“First, there are cases of direct causation, involving observed or scientifically proven facts. Suppose that you leave a dog locked in a car in extremely hot weather for the whole day, and fail to feed your baby for several days, and they both die. In such a case, in the absence of some exceptional explanation, proof of the causal influence of your conduct will come in the factual form of scientific evidence showing the effects on the victims, respectively, of dehydration or lack of nutrition.”

Snyman’s Criminal Law op cit note 2 makes the following observation:

“If X stabs Y with a knife and kills him, it is not only the stabbing which is a *conditio sine qua non* of the death, but also, for example, the manufacture and sale of the knife.”

DJ Baker in *Glanville Williams Textbook of Criminal Law* 3ed at 197 para 8-006 who notes the concern that the field of factual causes themselves may be too wide:

“Surely the notion of but-for causation is ridiculously wide, because it would take us back to Adam and Eve. The criminal’s mother is a but-for cause of his crimes, and so is his grandmother, and all his ancestors to infinity. That is perfectly true, but two factors limit judicial enquiry. First, one starts with the defendant who is charged; his mother does not come into it, much less Adam and Eve. Secondly, but-for causation is only half the story; the defendant who was a but-for cause of the harm is not responsible unless his conduct was also the imputable cause. We still have to deal with imputable causation.”

Snyman’s Criminal Law op cit note 2 at 67:

The *conditio sine qua non* assesses evidence and whether any exists to identify conduct on the part of the accused that could “factually” or “actually” have contributed to the materialisation of the prohibited consequence. This evidence is to be determined on the judicial standard, which considers probabilities and not certainties. Support for this submission is found in *Maqubela v S*³⁷ where the SCA ruled that in assessing evidence for the purposes of identifying factual causes, it is the judicial measure of proof (based on probabilities) and not the scientific one (certainty).³⁸

As in South Africa, English law also follows a two-stage process for determining causation,³⁹ with courts applying the *conditio sine qua non* test as the measure for determining factual causation.⁴⁰ Baker notes that “the but-for cause is sometimes referred to as the factual cause, the *de facto* case, or scientific cause.”⁴¹ This understanding of the *conditio sine qua non* has been adopted by the courts in South Africa.⁴²

“In order to determine whether an act is a factual cause of the prohibited situation all the relevant facts and circumstances must be investigated, and one has to decide with the aid of one’s knowledge and experience whether the prohibited situation flows from X’s conduct. Sometimes it may be necessary to rely on expert evidence.”

³⁷ *Maqubela v S* [2017] ZASCA 137. This was an appeal in respect of a conviction of murder emanating from the High Court. The SCA had to consider whether the cause of death established by medical evidence outweighed the allegation of death by unknown and medically undetectable means as the cause of the deceased’s death. The causal issue on appeal was whether the High Court was correct in concluding that the *actus reus* for murder had been proven where there was no medical evidence to that effect. The court had to determine whether there was conduct on the part of Mrs M that had causally contributed to her husband’s death to such an extent that it could be proven to be both a factual and the legal cause of death (as opposed to there being reasonable doubt as to causation due to death possibly being caused by natural causes). Her “guilty consciousness” is indicative of *mens rea*, which is distinct from and irrelevant to causation, which is what the SCA concluded.

³⁸ *Maqubela* supra note 37.

³⁹ DJ Baker *Glanville Williams Textbook of Criminal Law 3ed* at 199:

“When causation is in issue, the defendant’s act (or omission) must be shown to be not only a but-for cause but also an imputable or legal cause of the consequence. Imputable causes are some of the but-for causes. In other words, the defendant’s acts, but-for cause, must be sufficiently closely connected with the consequence to involve him in responsibility.”

⁴⁰ *R v White* [1910] 2 KB 124; *R v Broughton* [2020] EWCA Crim 1093; *R v McKechnie* [1992] 94 Cr App R 51 DJ Baker *Glanville Williams Textbook of Criminal Law 3ed* at 196-197:

“The question of causation, as it is generally used in law, involves both a problem of causation *sine qua non*, and a problem of imputability. A convenient English equivalent of the term causation *sine qua non* is but-for causation (properly speaking, but-for...not causation). For a factor to be a but-for cause, one must be able to say that but for the occurrence of the antecedent factor the event would not have happened.”

R v White [1910] 2 KB 124; *R v Broughton* [2020] EWCA Crim 1093; *R v McKechnie* [1992] 94 Cr App R 51.

⁴¹ DJ Baker *Glanville Williams Textbook of Criminal Law 3ed* at 196. See also G Williams ‘Causation in Law’ *The Cambridge Law Journal*, 1961 19(1) 62-65 at 62:

“Various expressions may be used: factual causation, causation in fact, actual causation, scientific causation, philosophic causation, the necessary of sufficient conditions of an effect, causation *sine qua non*.”

⁴² *Skosana* supra note 37. In fact, the court in *Skosana* quotes with approval English law sources for this understanding.

In the English case of *R v White*⁴³ the court had to determine whether the accused person's act of putting cyanide into the deceased's drink was a factual cause of her death. The medical evidence showed that she had in fact died of a heart attack and not cyanide poisoning. The factual causation question was *but for the accused putting cyanide into the deceased's drink would she have died when she did?* Another way of asking this question is *even if the accused had not poisoned the accused, would she have died of a heart attack?* The heart attack occurred before the cyanide could have any effect and was of so small an amount that it could not have caused the heart attack. For this reason, the accused's conduct was not a factual cause of her death, and so his conduct fell outside of the scope of a conviction of murder for having failed to pass the first threshold of the causation inquiry.⁴⁴

As in England and South Africa, Canadian courts also ascribe to the two-stage assessment of causation,⁴⁵ noting that

“factual causation, as the term implies, is concerned with an inquiry about how the victim came to his or her death, in a medical, mechanical, or physical sense, and with the contribution of the accused to that result.”⁴⁶

As with the law in England and South Africa, the “cause in fact is a necessary precondition that ties the accused's conduct to the consequence.”⁴⁷ The Supreme Court in *Smithers v R*⁴⁸ had to consider whether the kick administered by the accused was the imputable cause of death, summing up the causation issue as being whether the prosecution had “proven beyond a reasonable doubt that the accused died as a result of the kick.”⁴⁹ To answer this question, it first

⁴³ *R v White* [1910] 2 KB 124. The accused was the son of the deceased. He put some cyanide into her evening drink, intending to poison her. She took a few sips of her drink, and later died. However, the medical evidence showed that she had died of a heart attack and not as a result of the poison she had ingested.

⁴⁴ The accused was however found guilty of attempted murder.

⁴⁵ *R v Nette* 2001 SCC 78 at para 44

⁴⁶ *R v Nette* 2001 SCC 78 at para 44

⁴⁷ T Skolnik ‘Causation, Fault, and Fairness in the Criminal Law’ (2019) *McGill Law Journal* 65(1) at 5.

⁴⁸ *Smithers v R* [1978] 1 SCR 506. The accused (Smithers) had kicked the deceased (Cobby) in the stomach and Cobby died. This happened after both had been playing in opposing teams at a hockey match which was quite heated. Smithers uttered threats and said to Cobby that he would ‘get him’ after the match. After the match Smithers pursued Cobby, who was fleeing to a nearby car. Cobby was caught, punched, and subsequently kicked in the abdominal region by Smithers. Some moments later, Cobby died. The trial (via jury) found that Smithers was guilty of second degree murder. This decision was taken on appeal regarding the burden of proof for causation in toto. Medical evidence indicated that Cobby died as result of aspiration (the kick induced vomiting which then caused the deceased to asphyxiate) which could have been caused by the kick. The jury had to be satisfied that but for the kick the deceased would not have died of aspiration (at 514-515):

“The assault by the appellant upon the deceased boy was undoubtedly an unlawful act. The principal issue was whether the appellant had committed homicide by directly or indirectly, by any means, causing the death of Cobby and whether such homicide was culpable for the reason that it was caused by an unlawful act. The Crown quite properly chose to establish causation principally through medical evidence and the doctors, men of high professional standing, understandably were disinclined to speak in absolute terms.”

⁴⁹ *Smithers* supra note 48 at 514:

had to be established that the kick administered by the accused was a factual cause of death, without which the deceased would not have died when he did. The medical evidence noted that “death was due to the aspiration of foreign materials present from vomiting.”⁵⁰ The medical experts testified that it would be unusual for a person as young as the deceased to have spontaneously or without some precipitating cause, vomit. The only evident act of precipitation was the kick administered by Smithers. In other words, the kick was a necessary antecedent without which the death of the victim would not have occurred.⁵¹ But so was the aspiration, which occurred because of the victim’s underlying medical condition.⁵² In short, both the kick and the underlying medical condition were factual causes.⁵³ This meant that the court could consider these factual causes under the legal causation lens.

The court in *Skosana*,⁵⁴ referring with approval to Fleming,⁵⁵ stressed that without conduct being established as a factual cause, it would be unjust to find an accused person’s conduct is the legal cause. Just because conduct is established as being a *conditio sine qua non* does not without more mean that an accused person is responsible for the prohibited consequence. More than one condition can contribute to a result, but for the purposes of the fuller causation inquiry, a court would be concerned with whether a factual cause is linked sufficiently closely to the prohibited result. For this a second stage of the causation inquiry becomes indispensable – legal causation.

2.3. LEGAL CAUSATION

Whether a court is faced with a single factual cause or several, a court must be able to link it to the prohibited result in order to conclude that the conduct of the accused is the reason in law

“If you find the Crown has satisfied you beyond a reasonable doubt that the kick was unlawful and that it was the cause of death, satisfied on both those both those matters, then it is your duty to convict.”

⁵⁰ *Smithers* supra note 48 at 509. One of the medical experts testified that spontaneous vomiting could occur without any precipitating cause, but the general consensus was that this was rare and unexpected particularly as the victim was young and healthy. So the factual question was whether the kick precipitated (caused) the vomiting. As regards vomiting and aspiration, the medical evidence recorded that “Normally, when a person vomits the epiglottis folds over to prevent the regurgitated stomach contents from entering the air passage. In the instant case this protective mechanism failed.” Cobby had a latent medical condition which prevented his epiglottis from functioning as it ought to. Had he not had this condition, it would have ‘folded over’ to prevent aspiration. As regards the legal causation question (discussed later), the court had to consider the thin skull rule, and whether this latent condition broke the causal chain.

⁵¹ The *Smithers*’s formulation for assessing factual causation has been followed in subsequent criminal cases in Canada, including in *R v Nette* 2001 SCC 78 at para 44.

⁵² Invoking the thin skull rule.

⁵³ The thin skull rule re the underlying medical condition came under closer scrutiny in the legal causation analysis. However, for present purposes the discussion is restricted to the first leg of the causation inquiry.

⁵⁴ Supra note 37 at 34.

⁵⁵ F Harper & J Fleming, *The Law of Torts*, 4th ed at page 169.

why the victim died. From the factual causes, the court asks “which earlier conditions best account for”⁵⁶ the prohibited result. In other words, the purpose of the legal causation analysis is to assess remoteness⁵⁷ between a factual cause and the prohibited result.⁵⁸

To determine whether a connection between a factual cause and consequence is sufficiently close, the courts have relied on various tests or theories, which according to Milton culminate in the *novus actus interveniens* theory,⁵⁹ which “is strongly influenced by considerations of whether an intervening act or event is unusual or abnormal or foreseeable in the light of common experience.”⁶⁰ In this vein, while authors⁶¹ have tended to identify the individualisation theories, the adequate causation theory, the reasonable foreseeability theory and the *novus actus interveniens* theory as separate theories, it is submitted that the latter is applied in a way that is inclusive of these other named theories.⁶² However, it settled in South African law that no single theory takes preference and that the theory which yields the fairest result is the one that ought to be applied.⁶³

⁵⁶ M Moore ‘Causation in the law’ in Edward N Zalta (ed) *Stanford Encyclopedia of Philosophy* (2018) (Winter edition 2019), available at <https://plato.stanford.edu/entries/causation-law/> accessed on 15 May 2019.

⁵⁷ DJ Baker *Glanville Williams Textbook of Criminal Law 3ed* at 199:

“Several attempts have been made to find a suitable name for this second notion of cause. To call it the ‘direct’ or ‘proximate’ cause (as is often done) is misleading, because several stages may intervene between the so-called direct cause and the effect...To say that a particular cause is ‘too remote’ is only another way of saying that the defendant’s act (or omission) is not an imputable cause.”

⁵⁸ CJ Visser and C Kennedy-Good ‘The emergence of a “flexible” *conditio sine qua non* test to factual causation? *Lee v Minister of Correctional Services* 2013 (2) SA 144 (CC)” 2015 *Obiter* 36(1) 150-163 at 151: “a determination of factual causation establishes only prima facie liability on the part of the defendant, as legal causation is required to impute the plaintiff’s harm to the defendant’s conduct.”

DJ Baker *Glanville Williams Textbook of Criminal Law 3ed* at 199:

“when causation is in issue, the defendant’s act (or omission) must be shown to be not only a but-for cause but also an imputable or legal cause of the consequence. Imputable causes are some of the but-for causes. In other words, the defendant’s acts, being a but-for cause, must be sufficiently closely connected with the consequence to involve him in responsibility.”

⁵⁹ JRL Milton *South African Criminal Law and Procedure: Common-Law Crimes Vol II* (1996) at 327:

“At the same time it is usual to treat causation as at least in part a factual question, adopting as the test the *sine qua non*: the necessary condition. The shortcomings of this test, which, standing alone, would spread the net of liability too wide, are corrected, for policy reasons, by a further test of legal causation which may require X’s conduct to be not only a *sine qua non* but a ‘decisive’ or ‘substantial’ or ‘proximate’ or ‘direct’ or ‘adequate’ cause of Y’s death; or, otherwise put it may require that no ‘*novus actus interveniens*’ interrupt the chain of effects which can be traced back to X’s act.”

⁶⁰ JRL Milton *South African Criminal Law and Procedure Volume II common -Law Crimes* at 327.

⁶¹ Snyman op cit note 2, Burchell op cit note 5.

⁶² See also JRL Milton *South African Criminal Law and Procedure: Common-Law Crimes Vol II* (1996) at 331: “Sometimes the test is expressed *positively*; for example, it is said that Y’s death must flow *directly* from X’s conduct; or that X’s conduct must be a *substantial factor* in causing Y’s death; or that X’s act must be the *causa causans* or the *proximate cause* or an *adequate cause* of Y’s death. Sometimes the same idea is expressed *negatively* by saying that there must be no *novus actus* (or *nova causa*) *interveniens* which intervenes between X’s conduct and Y’s death.”

For completeness these tests will be discussed individually and then it will be shown how they have been incorporated into the *novus actus interveniens*.

⁶³ *R v Loubser* 1953 (2) PH H190 (W); *R v Motomane* 1961 (4) SA 569 (W); *S v Daniëls* 1980 (3) SA 275 (A); *S v Mokgethi* 1990 (1) SA 32 (A); *De Klerk v Minister of Police* 2020 (SACR) 1 (CC).

For immediate purposes the established theories that feature most prominently in South African case law and textbooks will briefly be discussed.

2.3.1 *The Foreseeability Theory*

This theory assesses the link between the accused person's conduct and the prohibited result, focusing on whether the accused person foresaw the course of events leading to the prohibited consequence. According to Snyman, "an act is a legal cause of a situation if the situation is reasonably foreseeable for a person with normal intelligence."⁶⁴ It is unclear whether "situation" refers to the prohibited consequence or the events leading to it. If it is the former, then a criticism to be levelled against this theory is that it can usurp the role of foreseeability in the *mens rea* analysis, which is a separate enquiry. However, if it refers to the series of events leading to the prohibited consequence, then the theory finds parity with both the theories of adequate causation and *novus actus interveniens*.

Snyman⁶⁵ and Hoorntje⁶⁶ caution against the use of foreseeability as a theory of legal causation, but do acknowledge that it has some role to play. On analysis, it is submitted that foreseeability is a central feature in assessing legal causation,⁶⁷ but that it is a criterion to be applied not a stand-alone theory.

2.3.2 *The Individualisation Theories*

An umbrellaesque term used to group a number of theories which seek to single out a factual cause as *the* cause, the individualisation theories aim to identify from the factual causes that

⁶⁴ Snyman's *Criminal Law* op cit note 2 at 73.

⁶⁵ Snyman's *Criminal Law* op cit note 2 at 73

⁶⁶ Snyman's *Criminal Law* op cit note 2 at 73; Burchell *Principles of Criminal Law* op cit note 4 at 113.

⁶⁷ SV Hoorntje *LAWSA 'Criminal Law volume 11'* 3ed, Causation at para 31:

"Again causation has often been determined by the application of the criterion of foreseeability. The accused's act is regarded as legally causative of a given harmful event if a person of ordinary intelligence and experience in his or her position could have anticipated the event. In terms of this criterion the driver of a lorry will be guilty of culpable homicide, if through negligent driving, he or she knocks down a cyclist with the result that the cyclist, still alive, lands on the road, where the cyclist is struck by a second motor vehicle and killed. In this case the driver is criminally liable because the course of events is reasonably foreseeable. In effect, however, this enquiry into foreseeability cuts across the two separate questions of causation and *mens rea*; in practice the question of foreseeability usually arises in the context of *mens rea*."

Ex parte die Minister van Justisie: In re S v Grotjohn 1970 2 SA 355 (A) where it was held that a deceased's last independent and voluntary act does not so qualify as a *novus actus interveniens* when that independent act was foreseeable and normal in the circumstances.

single cause which is the “proximate”, “substantial”, “operative”, “direct”, “efficient” or most decisive (“*causa causans*”).⁶⁸ Hoctor notes that

“These (and similar) expressions (such as ‘immediate’ or ‘effective cause’) amount to substantially the same thing, namely that one must search for *only one* individual condition as the legal cause of the prohibited condition.”⁶⁹

In *S v Daniëls*⁷⁰ the Appellate Division criticised the proximate cause theory and its appropriateness for determining legal causation in cases where more than one accused person acts towards causing the prohibited consequence. In the instance, the court noted that reliance on the proximate cause theory would not always be appropriate when viewed in terms of the overarching causal consideration of “policy”. Referring with approval to the case of *S v Masilela*,⁷¹ Jansen JA noted that the proximate cause theory was not inflexible and ought to give way to policy considerations of fairness and reasonableness.⁷² While the individualisation theories have been criticised, the semantics thereof inadvertently feature in the language of the courts when discussing both the theory of adequate causation and the theory of *novus actus interveniens*, and causation more generally.

2.3.3 The Theory of Adequate Causation

Snyman advocates the theory of adequate causation as the preferred theory for determining legal causation, noting that

“an act is a legal cause of a situation if, according to human experience, in the normal course of events, the act has the tendency to bring about that type of situation.”⁷³

⁶⁸ Snyman’s *Criminal Law* op cit note 2 at 70.

⁶⁹ Snyman’s *Criminal Law* op cit note 2 at 70.

⁷⁰ *S v Daniëls* 1983 (3) SA 275 (A).

⁷¹ *S v Masilela and Another* 1968 (2) SA 558 (A).

⁷² *Daniëls* supra note 7 at 331:

“It is interesting that *Hunt* says that the additional test ‘may require...’ From his discussion in general it is clear that he does not envisage any hard and fast rule – that everything depends on circumstances and policy consideration and that in a given situation this requirement may be dispensed with. Even the existence of a *novus actus interveniens* is not linked to principle so much as it is linked to policy considerations.”

And at 333:

“Admittedly, *Hunt* (op cit at 337-8) would not have regarded the first accused liable for the death of the deceased. However, in his discussion of this type of case he in fact applies the proximate cause without giving consideration to the fact that, according to his own view, it does not entail inflexible limitation of liability and without reference to policy considerations.”

⁷³ Snyman’s *Criminal Law* op cit note 2 at 70.

This theory assesses whether there is an “adequate relationship” between the accused’s conduct and the prohibited result, based on normality, abnormality and reasonable predictability of the “situation”, with a focus on the series of events.⁷⁴ Although Snyman prefers the theory of adequate causation, he notes that it is markedly similar to the *novus actus interveniens* theory.⁷⁵ He notes that although the court in *Grotjohn* relied on the *novus actus interveniens* theory, it would have reached the same conclusion if it had used the theory of adequate causation.⁷⁶

2.3.4 The Novus Actus Interveniens Theory

Akin to the theory of adequate causation, the *novus actus interveniens* theory considers whether an abnormal or intervening act interrupted or severed the causal nexus between a particular factual cause and the unlawful consequence.⁷⁷ Examination of the case law indicates criteria

⁷⁴ Snyman’s *Criminal Law* op cit note 2 at 70-71:

“If the turn of events is atypical in the sense that the act has brought about an unlikely, unpredictable or uncontrollable result, the is ‘no adequate relationship’ between the act and the result and the act cannot be said to have caused the result.”

See also *S v Counter* 2003 (1) SACR 143 (SCA) where it was held that the accused should be held responsible for the consequences of his actions (the death of the victim) as what flowed from his initial conduct was entirely predictable in the light of human experience.

⁷⁵ Snyman’s *Criminal Law* op cit note 2 at 72:

“In *Grotjohn* Steyn CJ said that a later event can be deemed to have broken the causal link only if it is a completely independent act, having nothing to do with and bearing no relationship to X’s act. A reasonable inference to be drawn from the examples in our case law is that an event can be a *novus actus interveniens* only if it is an *unsuspected, abnormal or unusual event*, in other words, one which, according to general human experience, deviates from the ordinary course of events and cannot be regarded as a probable result of X’s act. Viewed this, there is practically no difference between the test to determine a *novus actus interveniens* and the test of adequate causation.”

See also at footnote 34 on page 71 of Snyman’s *Criminal Law* op cit note 2 regarding the case of *Daniels*:

“It is evident that both the adequate causation and *novus actus* approaches are in any event subservient to the application of ‘beliedsoorwegings’ (policy consideration) in the reasoning of Jansen JA (see 331D-333A).”

Burchell *Principles of Criminal Law* op cit note 5 at 110:

“It is immediately apparent that the criterion for judging whether an act is an adequate cause of a consequence, is what is ‘normal in the light of human experience’ and the test for determining whether a *novus actus* (or *nova causa*) is present is the converse – what is ‘abnormal in the light of human experience’.”

⁷⁶ Snyman’s *Criminal Law* op cit note 2 at 74 refers to *Ex parte die Minister van Justisie: in re S v Grotjohn* 1970 (2) SA 355 (A). It is also compatible with the *novus actus interveniens* theory:

“If X encourages Y to commit suicide, or provides him with the means of doing so, and Y indeed commits suicide, the fact that the last act which led to Y’s death was his (Y’s) own conscious and voluntary act does not mean that the causal chain which X has set in motion has been broken; Y’s voluntary act therefore does not constitute a *novus actus*. This conclusion is perfectly compatible with the theory of adequate causation: as was pointed out above, the particular circumstances of which X was aware must, according to this theory, also be considered when determining whether the act had the tendency to bring about that kind of result.”

⁷⁷ Burchell *Principles of Criminal Law* op cit note 5 at 100:

“The *novus actus* (or *nova causa*) *interveniens* test is expressed in terms of an ‘abnormal’, intervening act or event which serves to break the chain of causation. The normality or abnormality of an act or event is judged according to the standards of general human experience.”

for when an intervening event is sufficient to break the causal nexus, rendering the conduct of the accused person nugatory:

- *The intervening act must not be one that is usually or normally expected to follow as a result of the conduct of the accused.*⁷⁸
- *The intervening act was a voluntary and independent form of conduct carried out by the deceased.*⁷⁹
- *The intervening act must not have been foreseen, planned or anticipated by the accused.*⁸⁰

Consideration of the *novus actus interveniens* does not typically present itself in relation to PAE as in such cases there is no intervening event between the conduct of the physician and the death of the patient. This is because in PAE the physician personally administers the final

⁷⁸ This appears to accommodate the theory of adequate causation, and foreseeability as a criterion thereof. See *Snyman's Criminal Law* op cit note 2 at 72:

“A reasonable inference to be drawn from the examples in our case law is that an event can be a *novus actus interveniens* only if it is an *unsuspected, abnormal or unusual event*, in other words one which, according to general human experience, deviates from the ordinary course of events and cannot be regarded as a probably result of X's act. Viewed thus, there is practically no difference between the test to determine a *novus actus* and the test of adequate causation.”

See also at 74 where Hoctor in *Snyman's Criminal Law* discusses *Grotjohn* as regards both the *novus actus interveniens* theory and the theory of adequate cause.

⁷⁹ See discussion below regarding *Ex Parte Die Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A). An accused person cannot rely on the independent voluntary conduct of the deceased where the conduct was foreseen by the accused. Compared with the English case of *R v Kennedy (No. 2)*. Here too, foreseeability was applied as a criterion within the *novus actus interveniens*.

⁸⁰ This identifies that foreseeability is a criterion and not a standalone test of causation. E M Burchell, P M A Hunt & J M Burchell *South African Criminal Law and Procedure Vol 1 General Principles of Criminal law* op cit note 3 at 64-65. See also discussion below regarding *Ex Parte Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A). *Grotjohn* was applied in *S v Hibbert* 1979 (4) SA 7171(D) at 328 where, regarding foreseeability and causation the court held that where the accused persons conduct set the chain of events in motion (so as to be a factual cause), the seemingly independent act of the victim (pulling the trigger) would not serve as a *novus actus interveniens*, if such conduct was foreseeable as in being expected to follow from the accused person's conduct:

“Now in the present case the accused set in motion a chain of events which ended in the deceased pressing the trigger of a fire-arm which she had been given by the accused and thus causing her death. The successive words and actions of the accused were designed to place her in possession of that fire-arm and were accompanied by the obvious hazard that the deceased might be persuaded to inflict upon herself an injury which could result in her death. The accused's conduct fell short only of the final act of pulling the trigger. It seems to me that the act of pulling the trigger to which all the other conduct conduced, cannot in any sense be described as independent of the course of conduct. That being so, we conclude that there was in the proper sense of that expression, no *actus novus interveniens* which broke the chain of causation set in motion and continued by the series of acts of the accused which I have mentioned. The accused must, as we have found, have appreciated that injury and possibly death could result from his actions.”

See also JH Hugo ‘To Kill a Mocking Bird – Murder or Suicide’ (1969) *SALJ* 86(2) 148-151 where Hugo critiques the correctness of the decisions of the courts a quo in *Gordon* and *Grotjohn* at 150:

“Even if one should term the pulling of the trigger a *actus novus interveniens*, it would not affect the liability of the accused. In *S v Stavast*, 1964 (3) S.A. 617 (T), the Court held that if an *actus novus* is foreseeable it does not affect liability. In *Grotjohn's* case the Court made the following interesting finding: ‘die beskuldigde ten minste behoort te voorsien het dat die oorledende haarself met die gelaaide geweer wat hy aan haar orrhandig het sou doodskiet.’

lethal dose, and as such there is no break in the causal chain between his conduct and the death of the patient. For present purposes, this chapter focuses on voluntary, independent conduct on the part of the “victim”; under what conditions such autonomy is sufficient to sever the causal nexus, and what foresight of conduct means for the causal connection between a physician’s conduct and the death of a patient.

2.3.5 Policy Considerations

Unlike factual causation, the inquiry into legal causation involves more than a formulaic application of tests or theories to identify an imputable cause in that “the essence of legal causation lies in policy limits on the extent of liability.”⁸¹ Just what these policy considerations are and how they are determined is a focus in this chapter, further interrogating the value or utility of identifying tests/theories at all if the over-arching test is, in fact, a policy consideration. Over the years, academics and the courts have acknowledged that the inquiry into legal causation is more of a moral reaction and the theories are used to guide and support that moral reaction, so even if a sufficiently close connection is, through reliance on the various theories, established, *policy considerations*, may still be invoked to support a conclusion that in the circumstances the accused person’s conduct is not the legal or imputable cause of the prohibited consequence or vice versa.⁸²

It was settled in *Mokgethi*⁸³ that a flexible approach to the various theories ought to be resorted to if a fair, policy-based outcome is to be achieved. If the courts have accepted that the legal causation question is a *boni mores* or policy issue, it may be asked why consider tests or theories at all. In response, Hoctor states that

⁸¹ Burchell *Principles of Criminal Law* (2016) op cit note 29 at 99. Burchell notes further that there “appear(s) to be a similarity between the test of adequate cause and the test of the absence of a *novus actus* (or *nova causa*) *interveniens*.”

⁸² DJ Baker *Glanville Williams Textbook of Criminal Law 3ed* at 199:

“Going back to the formulation in the Model Penal Code, the use of the word ‘just’ indicates the true nature of the problem. When one has settled the question of but-for causation, the further test to be applied to the but-for cause in order to qualify it for legal recognition is not a test of causation but a *moral reaction*. The question is whether the result can fairly be imputable to the defendant. Sometimes the question of fairness is settled by rules of law, sometimes it is left for impressionistic decision in the individual case. If the term ‘cause’ must be used, it can be distinguished in this meaning as ‘imputable’ or ‘responsible’ or ‘blameable’ cause, to indicate the value-judgement involved...Whereas the but-for cause can generally be demonstrated scientifically, no experiment can be devised to show that one of a number of concurring but-for outcomes is more substantial or important than (sic) another, or that one person who is involved in the causal chain is more blameworthy than another.”

⁸³ *S v Mokgethi* 1990 (1) SA 32 (A).

"The traditional tests for legal causation remain relevant, but specifically as subsidiary determinants, to considerations of public policy, reasonableness, fairness and justice, which in turn are rooted in the Constitution and its values."⁸⁴

As stated, the tests cannot be discounted entirely, but they are in fact subordinate to the values which underpin the Constitution.⁸⁵ Theories do exist, but which theory and how to apply it is essentially determined by the court, driven by the purpose of ascribing causal responsibility in cases where policy considerations would approve of such subscription (and vice versa).⁸⁶ Thus, even if, through the application of any theory, it is established that a factual cause is sufficiently closely linked to the end result, a finding that the accused is also the legal cause will actually be determined by normative, constitutional values, so that the result reflects those values.⁸⁷ So the next question is, do courts pre-determine the issue of imputability based on common sense, morality, *boni mores* or public policy and *then* apply whichever of the tests support that pre-determination? And if this is true, what does it mean for precedent and legal certainty?

"The courts' flexible, open approach to legal causation, with its references to 'what is fair and just', may, on a purely theoretical level, appear to be very equitable, but the question does arise whether this open approach is not – precisely because of its flexible nature – too vague. The price a legal system pays for criteria which are too vague is lack of legal certainty. The danger of adopting such a wide criterion is that when a court is confronted with a concrete set of facts in respect of which there has not yet been an earlier precedent, it would simply rely on its intuition in deciding whether a particular act or event is legally a cause of a situation."⁸⁸

⁸⁴ *Snyman's Criminal Law* op cit note 2 at 73.

⁸⁵ *Mashongwa v Passenger Rail Agency of South Africa* 2016 (2) BCLR 204 (CC) at para 68:

"When proximity has been established, *then* liability ought to be imputed to the wrongdoer *provided* policy considerations based on the norms and values of our Constitution and justice *also* point to the reasonableness of imputing liability to the defendant."

⁸⁶ *Snyman's Criminal Law* op cit note 2 at 73:

"The traditional tests for legal causation remain relevant, but specifically as subsidiary determinants, to considers of public policy, reasonableness, fairness and justice, which in turn are rooted in the Constitution and its values."

⁸⁷ *Mahleza v Minister of Police* 2020 (1) SA SACR 392 (ECG) at para 69:

"PRASA's failure to keep the doors closed while the train was in motion is the kind of conduct that *ought* to attract liability. This is so not only *because* of the constitutional rights at stake but *also because* PRASA has imposed the duty to secure commuters on itself through its operating procedures... This dereliction of duty certainly arouses the moral indignation of society. And this negligent conduct is closely connected to the farms suffered by Mr Mashongwa. It is thus reasonable, fair and justifiable that liability be imputed to PRASA."

See also *Nohour v Minister of Justice and Constitutional Development* 2020 (2) SACR 229 (SCA).

⁸⁸ *Snyman's Criminal Law* op cit note 2 at 73.

Firkins⁸⁹ is similarly cautious of the English courts' reliance on a normative test for legal causation in that it blurs the line between moral responsibility and causal responsibility. He Firkins opines that:

“...the additional criteria, known as legal (or ‘proximate’) causation, have rendered the law of causation ‘unstable and irrational’. However, there is a further, neglected problem with these standard tests in the context of criminal-responsibility ascription...those tests represent a normative exercise in finding D responsible for a prohibited outcome, often grounded only in D’s moral responsibility for that outcome. Such an approach is problematic because moral responsibility is irrelevant to causal responsibility; and a failure to distinguish causal responsibility from moral responsibility results in inappropriate criminal-responsibility ascription for result crimes.”⁹⁰

Endorsing this formulation as per *R v Cribbin*,⁹¹ the Canadian Supreme Court noted in *Maybin*⁹² that

“Any assessment of legal causation should maintain focus on whether the accused should be held legally responsible for the consequences of his actions, or whether holding the accused responsible for the death would amount to punishing the morally innocent.”⁹³

This has received academic criticism with Skolnik noting that

“The argument that legal causation is necessarily justified by the need to prevent the conviction of morally innocent persons, however, is problematic...”⁹⁴

In this vein, would this normative analysis mean that a physician who assists a patient to end their lives should not be seen as the legal cause of the patient’s death but that any other person who conducted themselves in the same way should be? To answer this question, we must look at *Grotjohn* and other cases more closely.

⁸⁹ G Firkins ‘Rethinking causation in English criminal law’ (2023) *The Journal of Criminal Law*

⁹⁰ G Firkins ‘Rethinking causation in English criminal law’ (2023) *The Journal of Criminal Law* at 2. See also D J Baker *Glanville William’s Textbook of Criminal Law* 3ed at 199.

⁹¹ *R v Cribbin* 1994 (CanLII) 391 (ONCA) at para 87.

⁹² *R v Maybin* 2012 SCC 24.

⁹³ *R v Maybin* 2012 SCC 24 at para 29. See also *R v Nette* 2001 SCC 78 at para 45.

“Legal causation, which is also referred to as imputable causation is concerned with the question of whether the accused person should be held responsible in law for the death that occurred. It is informed by legal considerations such as the wording of the section creating the offence and principles of interpretation. These legal considerations, in turn, reflect fundamental principles of criminal justice such as the principle that the morally innocent should not be punished...In determining whether legal causation is established, the inquiry is directed at the question of whether the accused person should be held criminally responsible for the consequences that occurred.”

See also D Stuart *Charter Justice in Canadian Criminal Law* 7ed: Carswell (2018) at 157.

⁹⁴T Skolnik ‘Causation, Fault, and Fairness in the Criminal Law’ (2019) *McGill Law Journal* 65(1) at 24.

2.4 THE CAUSAL NEXUS THROUGH SELECTED HOMICIDE CASES

The leading case in South Africa regarding the permissibility of assisting another in an act of suicide is that of *Ex Parte Die Minister van Justisie: In Re Grotjohn*.⁹⁵ Although that case did not deal with a factual matrix where a physician was the one who renders the assistance, the case has long been regarded as applying to those situations as well. The Minister of Justice raised the following questions necessitated by the decision in the trial courts of *Gordon*⁹⁶ and *Grotjohn*:⁹⁷

- “1. Does a person who instigates, assists or puts another person in a position to commit suicide, commit a crime?
2. If so, what crime?”⁹⁸

Briefly, the facts in *Grotjohn* were that the accused and his wife were in an unhappy marriage. On the day in question, they were engaged in a heated argument. The deceased (Mrs Grotjohn) became increasingly angry and told her husband to give her his shotgun so that she could kill herself. This he did, and Mrs Grotjohn shot herself and she died. Mr Grotjohn was charged with murder, but was acquitted by the court a quo. That court held that the independent act of the deceased served as a *novus actus interveniens*. The court a quo⁹⁹ in this case followed and applied the decision of *S v Gordon*.¹⁰⁰ *Gordon* was a case of a suicide pact between the deceased and the accused. They were involved in an extra-marital affair. Having been exposed, the deceased expressed that she would commit suicide. The accused said that he would join her, and they would commit suicide together. The accused procured a quantity of sleeping pills which they both ingested in equal quantities. However, the accused survived. He was subsequently charged with murder. The court a quo in this case also acquitted the accused on the basis that the independent act of the deceased was an act of suicide, which, despite the fact that the accused had provided the means by which suicide would be committed, the chain of causation was broken when the deceased voluntarily, willingly and independently consumed the drugs.

⁹⁵ *Ex Parte Die Minister van Justisie: In Re Grotjohn* 1970 (2) SA 355 (A). An article by JH Hugo ‘To Kill a Mocking Bird – Murder or Suicide’ (1969) SALJ 86(2) 148-151, appears to have prompted the Minister to refer particular questions of law emanating from *Gordon* and *Grotjohn* to the Appellate Division, see at 151.

⁹⁶ *S v Gordon* 1962 (4) All SA 473 (N).

⁹⁷ *S v Grotjohn* WLD (13th February 1969) (unreported).

⁹⁸ *Ex Parte Die Minister van Justisie: In Re Grotjohn* 1970 (2) SA 355 (A) at 359.

⁹⁹ Witwatersrand Local Division, 13th February, 1969 unreported.

¹⁰⁰ *S v Gordon* 1962 (4) All SA 473 (N).

The trial courts in both *Gordon*¹⁰¹ and *Grotjohn*¹⁰² were able to come to their conclusions by relying on the decision of the court in *R v Nbakwa*.¹⁰³ Related to causation, both trial courts concluded that the independent acts of the ‘victim’ served to break the causal nexus between the initial conduct of the accused and the unlawful consequence.¹⁰⁴

In the ex parte application of *Grotjohn* Steyn CJ proceeded to answer the questions raised by the Minister of Justice¹⁰⁵ by embarking on a historical discussion of whether suicide was a crime in South Africa. He began by considering Stoic philosophy and the Digests under Roman law, and confirmed that neither suicide nor attempted suicide was criminally or civilly punished, if committed with just cause.¹⁰⁶ Just cause was determined by the motive for suicide or attempted suicide. Having considered the old authorities and their influence on South African law, Steyn CJ confirmed that neither suicide nor attempted suicide was a crime due to the impossibility of punishing the deceased in suicide cases. Attempted suicide was last prosecuted in 1781 and was held to be abrogated by disuse.¹⁰⁷

However, contrary to the decision of the courts a quo in *Grotjohn* and *Gordon* this did not mean that inciting or assisting another person to commit suicide was not a crime, even though suicide itself was not a crime.¹⁰⁸ The SCA explained that in *Grotjohn* the independent

¹⁰¹ Supra note 96.

¹⁰² Supra note 95.

¹⁰³ *R v Nbakwa* 1956 (2) SA 557 (SR) where the accused prepared a noose and instructed his mother (the deceased) to hang herself.

¹⁰⁴ *Grotjohn* supra note 95 at 363:

“In the *Gordon* case and in the present case the accused were acquitted on the ground that the different acts which caused death were the voluntary and ‘independent’ acts of the deceased. In each of these cases the acts of the accused – in the once case the concluding of a suicide pact and the acquisition and handing over of tablet, and in the other case the loading of the rifle and the handing over thereof with the accompanying remark – had a place in the series of acts which culminated in the death of the deceased. Apparently the Court proceeded from the premise that the last act of the deceased was voluntary and ‘independent’ act which as *novus actus interveniens* interrupted the causality of the preceding events effectively in so far as the accused’s acts were concerned. I need not consider the correctness of the findings in the particular circumstances of these cases.”

¹⁰⁵ *Grotjohn* supra note 95 at 359: “1. Whether encouraging, providing the means for or helping a man or woman to commit suicide is a crime? and 2. If so, what crime?”

¹⁰⁶ *Grotjohn* supra note 95 at 359.

¹⁰⁷ *Grotjohn* supra note 95 at 363:

“it is sufficiently clear that our common law gradually adopted a more indulgent attitude towards suicide. Although suicide was initially regarded as a crime and all the way through was a wrongful act, the obvious impossibility of punishing the perpetrator must have had, with the passing of time, the unavoidable effect...except for the isolated case in 1781 mentioned in *R v Peverett*, 1940 AD. 213 at p 214 *i.f.*, as far as is known, never [been] a prosecution for attempted suicide. If attempt in certain circumstances was still a crime in the later Roman-Dutch law, it became totally abrogated by disuse here.”

¹⁰⁸ *Grotjohn* supra note 95 at 365:

“From the fact that neither suicide nor attempted suicide is a crime it does not follow that the first question must be answered in the negative ...it is clear in the case of suicide that the deceased’s last act, although it may be a personal, independent act and the immediate cause of the death need not necessarily be a completely independent act in the aforesaid sense and the fact that it is not criminal is hardly relevant in

conduct on the part of victim would not serve to break the causal nexus if the independent act of the victim was not ‘truly independent’. In this regard, the court noted that:

“To have that effect the intervening cause must be a completely independent action (‘n volkome onafhanklike handeling) in the sense of being separate from and unconnected to the earlier conduct.”¹⁰⁹

The court explained that:

“Where the act of the other person...is a calculated part of the chain of causation which the perpetrator started, an eventuality which the perpetrator foresees as a possibility and which he desires to employ to attain his object, or as something on which he may depend to bring about the desired result, the intention will also not be absent, *and* it would be contrary to accepted principles of law and to all sense of justice to allow him to take shelter behind the act as a *novus actus interveniens*.”¹¹⁰

Thus, although the court confirmed that suicide itself was not a crime, assisting another to commit suicide would be murder because in the circumstances, the independent conduct on the part of the victim was not sufficient to render it a *novus actus interveniens*. Given that the victims conduct was anticipated or expected to flow ‘normally’ from the conduct of the accused, it was not be truly independent for purposes of breaking the causal chain.¹¹¹ If we were to enlist the theory of adequate causation, one would similarly conclude that in the light of general human experience, the conduct of the victim (ingesting the pills provided by the accused, or shooting themselves with the firearm provided by the accused) would be expected as normal or anticipated, and the same outcome would result if we relied on the reasonable foreseeability theory. The dictum in *Grotjohn* was followed in *Hibbert*¹¹² and these two judgments collectively confirmed that for a *novus actus interveniens* to qualify as such, the conduct of the victim must be independent and voluntary and only qualifies as such if it was not precipitated by conduct on the part of the accused, and the victims’ conduct would not normally flow therefrom.¹¹³

connection with the question of causality in regard to the actions and behaviour of the person who instigates, assists or puts another in a position to commit suicide.”

¹⁰⁹ *Grotjohn* supra note 95 at 365.

¹¹⁰ *Grotjohn* supra note 95 at 363-364.

¹¹¹ J R L Milton *South African Criminal Law and Procedure: Common -Law Crimes* Vol II (1996) at 331:

“An event (including a natural event and voluntary human conduct on the part of Y himself or a third person) is likely to be regarded as a *novus actus* if it is *abnormal*; unlikely, in the light of human experience, to follow an act such as that committed by X.”

¹¹² *S v Hibbert* 1979 (4) SA 717 (D).

¹¹³ *S v Hibbert* 1979 (4) SA 717 (D) at 720-721:

“we find it inconceivable that a person with the knowledge and background of the accused could not have appreciated that putting a person in possession of an obviously lethal and clearly loaded weapon was attended by a substantial measure of risk that the deceased would pull the trigger and cause injury and possibly death to herself.”

As far as whether the decision in *Grotjohn* brings within its ambit conduct of a physician, the submission is that it does. Returning to the questions raised by the Minister which focussed on the criminal liability of a *person* who assists another to commit suicide, use of this word means all persons regardless of their qualifications and in this sense certainly includes medical doctors. The court did not draw any liability distinction in this regard, and focused its decision on an analysis of causation. The applicability of *Grotjohn* specific to a PAS scenario was considered by the Supreme Court of Appeal in *Stransham-Ford*, where the court stated that “[a] court confronted with a case of PAS would have to consider how the principles articulated in *Grotjohn* should be applied and adapted to the present day,”¹¹⁴ noting that this would require more than merely looking at causation.¹¹⁵

In the light of the discussion regarding conduct of a victim that is independent enough to sever the causal nexus, a court so confronted would thus have to determine whether the independent conduct of a patient who requests assistance in dying through the provision of lethal drugs for self-administration, would be sufficient to render remote the conduct of an assisting physician. On this point, the court indicated that South African courts may be assisted in the causal analysis by the facts and reasoning in the English case of *R v Kennedy (No. 2)*.¹¹⁶ The Appellate Committee of the House of Lords in *Kennedy (No. 2)* had to consider the following question:

“When is it appropriate to find someone guilty of manslaughter where that person has been involved in the supply of a class A controlled drug, which is then freely and voluntarily self-administered by the person to whom it was supplied, and the administration of the drug then causes his death?”¹¹⁷

In this case, a drug dealer prepared and supplied a syringe with a quantity of heroine to the deceased. The deceased stated that he wanted “a bit to make him sleep”¹¹⁸ to which the accused told the deceased to “take care that he did not go to sleep permanently.”¹¹⁹ The deceased

¹¹⁴ *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) at para 55.

¹¹⁵ *Stransham-Ford* (SCA) supra note 114 at para 54 where the SCA considers whether Fabricus J was correct in stating that *Grotjohn* criminalised assisted suicide where assistance is rendered by a physician:

“The first question posed to the court was not answered with a simple yes or no. That demonstrates that the court did not decide that a criminal offence is committed whenever a person encourages, helps or enables someone to commit suicide or to attempt to do so. Whether they will depend on the facts of the case and issues of intention (*mens rea*), unlawfulness and causation. It follows that it cannot be said that in the current state of our law PAS is in all circumstances unlawful. The judge’s statement to that effect went too far.”

¹¹⁶ *R v Kennedy (No.2)* [2007] UKHL 38.

¹¹⁷ *Kennedy (No.2)* supra note 116 at para 2.

¹¹⁸ *Kennedy (No.2)* supra note 116 at para 3.

¹¹⁹ *Kennedy (No.2)* supra note 116 at para 3.

injected himself with the contents of the syringe and handed the empty vessel back to the accused. The accused then left the room. Subsequently the deceased died due to “inhalation of gastric contents while acutely intoxicated by opiates and alcohol.”¹²⁰ The legal causation question was whether the deceased’s conduct of self-administration served as a *novus actus interveniens* sufficient to break the causal nexus between the conduct of the accused and the death of the deceased, through the voluntary, informed, consensual, and independent conduct of an adult person themselves. Regarding manslaughter, the court noted that

“the act of supplying, without more, could not harm the deceased in any physical way, let alone cause his death. As the Court of Appeal observed in *R v Dalby* [1982] 1 WLR 425, 429, ‘the supply of drugs would itself have caused no harm unless the deceased had subsequently used the drugs in a form and quantity which was dangerous’. So, as the parties agree, the charge of unlawful act manslaughter cannot be founded on the act of supplying the heroin alone.”¹²¹

Referring to *R v Cato*¹²² the court noted that the Crown would have to prove that the accused person’s unlawful conduct “was a significant cause of the death of the deceased.”¹²³ There was no dispute that the act of supplying the heroine was unlawful under s 4(1) of the Misuse of Drugs Act 1971,¹²⁴ but as for the charge of manslaughter under s 23 of the Offences Against the Person Act 1861,¹²⁵ it would have to be proved that the accused had administered the drug, or had caused the administration of the drug against the wishes of the victim.¹²⁶ In this regard the court in *Kennedy (No. 2)* noted that the situation was markedly different from what transpired in *Cato*.¹²⁷ In the present case, the court noted that administration of the drug for the purpose of s 23 would occur:

¹²⁰ *Kennedy (No.2)* supra note 116 at para 3.

¹²¹ *Kennedy (No.2)* supra note 116 at para 7.

¹²² *R v Cato* [1976] 1 WLR 110, 116-117.

¹²³ *R v Cato* supra note 122 at para 7.

¹²⁴ Misuse of Drugs Act 1971:

“4 Restriction of production and supply of controlled drugs.

(1) Subject to any regulations under section 7 of this Act, or any provision made in a temporary class drug order by virtue of section 7A, for the time being in force, it shall not be lawful for a person—

(a) to produce a controlled drug; or

(b) to supply or offer to supply a controlled drug to another.”

¹²⁵ Offences Against the Person Act 1861:

“23 Whosoever shall unlawfully and maliciously administer to or cause to be administered to or taken by any other person any poison or other destructive or noxious thing, so as thereby to endanger the life of such person, or so as thereby to inflict upon such person any grievous bodily harm, shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for any term not exceeding ten years.”

¹²⁶ *Kennedy (No.2)* supra note 116 at paras 10-12.

¹²⁷ *R v Cato* [1976] 62 Cr App R 41. Cato was charged with manslaughter under s 23 of the Offences Against the Person Act and was convicted. The matter was taken on appeal. The deceased (Farmer) presented Cato and two others with a bag of heroin and some syringes and invited them to have a ‘fix’ with him. Each participant

“where the noxious thing is not administered to V but taken by him, provided D causes the noxious thing to be taken by V and V does not make a voluntary and informed decision to take it.”¹²⁸

While the charge under s 4(1) of the Misuse of Drugs Act (re the supply of an illegal drug) was not in dispute, the only matter for consideration was causation through interpretation of the word ‘administer’ as used in s 23 of the Offences Against the Person Act and the effect of voluntary independent conduct of an adult. The court noted that s 23 drew a clear distinction between “a noxious thing administered to another person and a noxious thing taken by another person.”¹²⁹ A further aspect of relevance was the weight of the evidence that the heroin had been “freely and voluntarily self-administered.”¹³⁰ This the court noted was distinguishable from the facts in *Cato*, where the accused had personally injected the deceased with heroin:¹³¹

“There is, clearly, a difficult borderline between contributory acts which may properly be regarded as administering a noxious thing and acts which may not. But the crucial question is not whether the defendants *facilitated* or *contributed* to administration of the noxious thing but whether he went further and administered it. What matters, in a case such as *R v Rogers* and the present, is whether the injection itself was the result of a voluntary and informed decision by the person injecting himself.”¹³²

It would appear then that since *Kennedy* (No. 2), on a charge of manslaughter as relates to the administration of a noxious thing, voluntariness as well as self-administration is sufficient to sever the causal nexus, because of the value placed on individual autonomy.

The *Kennedy* (No. 2) formulation has been rejected in Canada in the *Haas*¹³³ case. The accused (Haas) was found guilty of manslaughter and had taken the matter on appeal. Haas admitted that he provided the deceased with morphine pills, but argued that the chain of

prepared their own syringe but did not self-administer the drug. Cato and Farmer paired-off, with Cato injecting Farmer with the syringe prepared by Farmer (and vice versa). Each person prepared the syringe to their own ‘tastes and desired level of potency. This continued throughout the night. The next morning, around 11am, Farmer was found dead. The appeal was dismissed in that causation had been established through the direct administration of the drug by the accused, uninterrupted by the victim:

“It is also to be noticed that the actual act of injection was done by the other half of the patient, which of course has a very important influence on this case on the issue of causation.”

¹²⁸ *Kennedy* (No. 2) supra note 116 at para 12. This begins to bring *Kennedy* (No. 2) within the contemplation of *Grotjohn*, but voluntariness will have to be scrutinised to determine its possible applicability.

¹²⁹ *Kennedy* (No. 2) supra note 116 at para 19.

¹³⁰ *Kennedy* (No. 2) supra note 116 at para 19.

¹³¹ *Kennedy* (No. 2) supra note 116 at para 21.

¹³² *Kennedy* (No. 2) supra note 116 at para 20. Related to unlawfulness (discussed in a subsequent chapter) the court noted that the act of injecting oneself with a drug (illicit or otherwise) was not unlawful, and so it would not be legitimate to hold the accused liable as either an accomplice, an instigator or a principle offender where the conduct under scrutiny was not in fact unlawful – see paras 21 and 22 of *Kennedy* (No. 2).

¹³³ *R v Haas* (CJ) 2016 MBCA 42.

causation had been broken when the deceased freely and voluntarily took the pills herself.¹³⁴ *Kennedy (No. 2)* was rejected in *Haas* for disregarding the overarching purpose of legal causation¹³⁵ and for ignoring the reasonable foreseeability approach and its effect on a *novus actus interveniens*, making it inconsistent with Canadian jurisprudence.¹³⁶

With this in mind, and the direction presented by the SCA in *Stransham-Ford*, we must more closely scrutinise foreseeability, autonomy and voluntariness of the victim's own conduct and its effect on remoteness in relation to the *novus actus interveniens* in South African law. A further question would be, whether considerations of policy will allow South African courts to adopt the *Kennedy (No. 2)* formulation, or whether they will reinforce *Grotjohn* through *Haas*.¹³⁷ At its core, *Kennedy (No. 2)* and *Haas* differed on the application of the criterion which informs the *novus actus interveniens*.

2.5 CAUSATION AND DEATH IN MEDICAL PRACTICE CASES

2.5.1 Death caused through withdrawing of life-sustaining treatment

Clarke v Hurst NO was an application made by the wife of a patient for permission to withdraw the artificial feeding regime which was keeping her husband alive, so that she would not be criminally prosecuted for causing his death.¹³⁸ The patient was in a persistent vegetative state,

¹³⁴ *Haas* supra note 133 at para 2.

¹³⁵ *Haas* supra note 133 at para 48:

“Legal causation ‘is directed at the question of whether the accused person should be held criminally liable for the consequences that occurred’ (*Nette* at para 45) It is based on “concepts of moral responsibility and is not a mechanical or mathematical exercise” (at para 83).”

Here the court referred with approval to *Nette* at paras 45 and 83, further referring to *Maybin* at para 29:

“Any assessment of legal causation should maintain focus on whether the accused should be held legally responsible for the consequences of his actions, or whether holding the accused responsible for the death would amount to punishing a moral innocent.”

¹³⁶ *Haas* supra note 133 at para 61:

“To conclude, *Kennedy* is not consistent with the development of Canadian jurisprudence. The key issue in determining whether the unlawful act in question is objectively dangerous is the risk of harm, and not, as concluded in *Kennedy*, whether the actual harm flowed immediately from the unlawful act. The Supreme Court of Canada has directed that the determination of causation is to focus on the accused person's moral responsibility, as opposed to the autonomy of the victim and the victim's choices, as in *Kennedy*. Furthermore, the House of Lord's rejection of the reasonable foreseeability approach is contrary to *Maybin*, which accepted the use of such an approach as an analytical aid when determining whether or not an intervening act has severed the chain of causation.”

¹³⁷ *AK v Minister of Police (Centre for Applied Legal Studies and Another as amicus curiae 2022 (11) BLCR 1037 (CC)* at 1310:

“As to legal causation, no legal system permitted liability without bounds. It is universally accepted that a way has to be found to impose limitations on the wrongdoer's liability. The imputation of liability to the wrongdoer depends on whether the harmful conduct is too remotely connected to the harm caused or closely connected to it. When proximity has been established, then liability ought to be imputed to the wrongdoer provided policy considerations based on the norms and values of the Constitution and justice also point to the reasonableness of imputing liability to the wrongdoer.”

¹³⁸ *Clarke v Hurst NO* 1992 (4) SA (4) 630 (D) at 634:

and had been in this condition for a number of years. Essentially, the application was concerned with sanctioning a form of euthanasia which would cause him to die.¹³⁹ The court based its decision on whether the conduct intended to be undertaken would be lawful, not whether it would be the legal cause of death. It is submitted that had the court been able to conclude that the applicant's intended conduct would not in law be the cause of the patient's death, then the court would not have had to venture into the realm of unlawfulness, as where an element of liability has not been proved, then that is the end of the matter, no liability can follow.¹⁴⁰ Thirion J's obiter remarks that the proposed acts of the applicant "would not in law be the cause of the patient's death"¹⁴¹ but was not the ratio for granting the application. It was premised on a consideration of lawfulness and the defences available. Lawfulness (or unlawfulness) is adjudged by the legal standards of the community.

The court drew a distinction, not based on causation, but rather on the status of the person who would in law be permitted to cause death. Here the court noted that

"The person who pre-empt[s] the function of the executioner and kills the condemned man while he is taking the last few steps to the gallows, acts wrongfully irrespective of his motive for

"Counsel who appeared on behalf of the Attorney-General submitted that despite the form which the applicant's order prayed for takes, she is in effect asking for an order declaring that she would not be acting unlawfully if, in her capacity as curatrix, she were to withhold her agreement to the giving of medical and surgical treatment to the patient or if she were to authorise the discontinuance of artificial life-sustaining measures such as naso-gastric feeding, even though the discontinuance of such measures or the withholding of such treatment would result in the termination of the patient's life. I agree with this submission. Admittedly the order which is sought is not couched in the form of a declaratory order but takes the form of an order conferring on the applicant, as curatrix to the person of the patient, certain powers (which have been set out at the beginning of this judgment). However, despite the form of the order, it is implicit in it that the applicant is asking the Court to declare that she would not be acting unlawfully if she were to exercise those powers. I say that because if, in exercising the powers which she is asking for she would be acting unlawfully, the Court would be exceeding its competence if it were to grant to her those powers. No Court would be competent to sanction the commission of a crime or a wrongful act. In essence, therefore, what the applicant is asking for is an order declaring that if she were to take the steps envisaged by her and if as a result of the taking of those steps the life of the patient were to terminate, she would nonetheless not be acting unlawfully."

¹³⁹ J L Taitz, 'Euthanasia and the Legal Convictions of Society in a South African Context,' (1993) *SALJ* 110(3) 440-445; N Boister 'Causation at the death? *Clarke v Hurst* 1992 2 SA 676 (D)' (1993) *THRHR* (56) 516-522; M L Lupton 'Clarke v Hurst NO, Brain NO & Attorney-General, Natal (unreported 1992 (N)) A living will, brain death and the best interests of a patient' (1992) *SACJ* (3) 342-348. See also Burchell *Principles of Criminal* op cit note 4 at 211 where the author discusses *Clarke v Hurst NO* under the heading of 'Death with dignity and voluntary euthanasia':

"But, societal attitudes to death and voluntary euthanasia are not static and it is certainly arguable that a person who is in a persistent vegetative state could be permitted to agree to die with dignity in special circumstances. In fact, in *Clarke v Hurst NO*, the court based its decision on the legal convictions of the community, and held that a wife who was the curatrix of her husband, a patient in a persistent vegetative state and being treated in hospital, would not be acting unlawfully in authorising the withholding of his life-support system."

¹⁴⁰ *S v Mokgethi* 1990 (1) SA 32 (A) at 39 D-G where the court quotes with approval from *Skosana*.

¹⁴¹ *Clarke v Hurst NO* supra note 138 at 660.

killing the condemned man. He acts wrongfully because he has no right to meddle in the matter.”¹⁴²

Even though the conduct of the interloper and the executioner are the same and the end results are the same, it is only the executioner who acts lawfully, albeit causally. In *Clarke* the applicant was not a physician, but the court sanctioned her conduct. It is submitted that had her application not been granted by the court she would be acting criminally in bringing about the patient’s death. Although scientifically and clinically the course of treatment would be the cause of the patient’s death (regardless of who administered it), as PE¹⁴³ is a form of medical treatment which the medical fraternity and the law both accept as reasonable, and the person administering the treatment is licensed (or permitted by an order of court) to do so, it is only in the narrow confines of medical practice (or a court order) that no criminal liability will follow for the death that has been scientifically, clinically, factually and legally caused.¹⁴⁴ McGee agrees that the determining who is legally responsible for the death of a patient is important.¹⁴⁵ Permissibility is not founded on causation, but rather on lawfulness and who is permitted to hasten death and under what conditions.¹⁴⁶ What these conditions are will be the focus of the next chapter.

2.5.2 Death caused through palliative care

¹⁴² *Clarke v Hurst NO* supra note 138 at 657.

¹⁴³ W Landman includes within his definition of passive euthanasia the practice of withholding and withdrawing of life-sustaining treatments, at 29: “Withholding and withdrawal of potentially life-sustaining treatment (sometimes referred to as “passive euthanasia”) – the right to a natural death.”

See also MN Slabbert “South Africa” in *International encyclopaedia of laws: Medical law* Nys H and Aan den Rijn A (eds) (Wolters Kluwer Netherland 2014), p144 referring to *Clarke v Hurst NO* supra note 138:

“the result of the judgment in this case is generally regarded by jurists in South Africa as recognition, within the narrow factual parameters of the case of (lawful) passive euthanasia [withholding and withdrawal of potentially life-sustaining treatment.”

¹⁴⁴ Provided of course that the patient has consented to the form of treatment having been informed of the consequences.

¹⁴⁵ McGee op cit note 8 ‘Ending the life of the act/omission dispute’ at 471:

“Consider the following examples. A layperson writes a prescription for a friend so that the friend can obtain a sufficiently strong dose of pain-relieving drugs. A doctor writes a prescription for a patient so that the patient can obtain a sufficiently strong dose of pain-relieving drugs. In these cases, from the point of view of ‘what they are doing’, it seems as though the doctor and the layperson ‘do exactly the same thing’. But this is not so. Only the doctor actually writes a prescription. Even though the layperson’s ‘prescription’ is effective and fools the chemist, it does not follow that it is a prescription. It is a forgery. A forged prescription is not a prescription, any more than a fake van Gogh is a van Gogh. Similarly, a layperson who mistakenly thinks they can witness a signature on a legal document when the witness should be a Justice of the Peace or a lawyer, ‘performs the same physical actions’ as a Justice of the Peace or lawyer does when witnessing the document. It is simply that it does not count as a legally recognised event of witnessing.”

¹⁴⁶ McGee op cit note 8 ‘Ending the life of the act/omission dispute’ at 471.

The English case of *R v Adams*¹⁴⁷ considered whether a medical practitioner was guilty of murder where pain-alleviating medication was administered and caused the patient's death in what is understood to have been a palliative care scenario¹⁴⁸ related to end-of-life care. Dr Adams was charged with the murder of Edith Morrell, an elderly woman who was his patient. The cause of her death was alleged to have been the administration of a series of doses of morphine which Dr Adams had instructed nurses to administer.¹⁴⁹ Devlin J's instructions to the jury related to causation, intention as well as grounds for justification:

"It does not matter whether her death was inevitable and her days were numbered. If her life was cut short by weeks or by months it was just as much murder if it was cut short by years. There has been much discussion as to when doctors might be justified in administering drugs which would shorten life. Cases of severe pain were suggested and also cases of helpless misery, the law knows no special defence in this category."¹⁵⁰

Later, referring to this earlier direction, Devlin J added further:

"...but that does not mean that a doctor who was aiding the sick and dying had to calculate in months, or even hours, perhaps not in days or weeks, the effect of a patient's life of the medicines which he would administer. If the first purpose of medicine – the restoration of health – could no longer be achieved there was still much for the doctor to do and he was entitled to do all that was proper and necessary to relieve pain and suffering even if the measures he took might incidentally shorten life by hours or perhaps longer."¹⁵¹

¹⁴⁷ *R v Adams* (1957) Crim LR 365.

¹⁴⁸ C M Barlow 'Law and the quality of life: A right to die?' (1992) *Nottingham Law Journal* (1) 36-60 at 37: "The case of *R v Bodkin Adams* is instructing as to the approach adopted so far by English judges. The defendant was charged with murdering some of his patients by prescribing for them palliative drugs which while reducing the pain suffered by his patients also hastened their deaths."

A Samuels 'The doctor, the patient, and easing the passing: The law' (2000) *Medico-Legal Journal* 68(2) 39-42 at 39 regarding causation:

"For murder the defendant (D) must cause the death of the victim (V), or at least play a contributory or participating role in the cause of death. It has been argued that where the doctor gave diamorphine and accelerated the death of a terminally ill patient the cause of death was the illness of the patient, not the diamorphine. This argument is generally thought to be unsound, sophistry. You can kill a dying person. If, but for what you did, he would not have died when he did, then you have caused his death. The jury must take a common sense approach to causation. The doctor will be unlikely and ill advised to rely on lack of causation as his defence, or even part of his defence (*Bodkin Adams*)."

¹⁴⁹ *R v Adams* supra note 147 at 367:

"On November 12, 1956, at ten p.m., Mrs Morrell was lying in a coma, when Dr. Adams came and prepared an injection in a five cubic-centimetre syringe. The syringe was three-quarters full and he instructed Sister Randall to inject it into the unconscious woman, which she did. Dr. Adams then prepared a second similar injection and gave instructions that it should be given later if the patient had not become quieter. At this time Mrs. Morrell was having jerky spasms, and after that first injection she quietened down for a time. Later, when the patient had further spasms, Sister Randall gave the second injection, and at two a.m. the following morning, Mrs. Morrell died."

¹⁵⁰ *R v Adams* supra note 147 at 375.

¹⁵¹ *R v Adams* supra note 147 at 375.

This latter direction, it is submitted, refers to the possibility of a defence, which would only have been scrutinised if causation had been established. It is further submitted that this case is not authoritative regarding causation (i.e. that doctors acting in palliative care scenarios do not in law cause their patient's deaths), but rather for the question of lawfulness (when is causing death justified).¹⁵²

In *Clarke v Hurst NO*,¹⁵³ the court made obiter remarks regarding death caused by palliative medication, and made reference to *R v Adams*¹⁵⁴ noting that

“it has come to be accepted that the doctor may give a terminally ill patient drugs with the object of relieving his pain, even if, to the doctor's knowledge, the drugs will certainly shorten the patient's life... On the principles of our law the doctor would in each of the above examples be exempt from liability if, judged by the legal convictions of society, his conduct was reasonable.”¹⁵⁵

Here Thirion J brings into play the possibility of a defense against unlawfulness which may be available to medical practitioners, but draws a distinction between passive euthanasia (palliative care deaths) and active euthanasia performed by a doctor:

“consequently, society adjudges the former's conduct justified in accordance with its criterion of reasonableness and therefore not wrongful, while it condemns the conduct of the latter as wrongful.”¹⁵⁶

Thus, a physician who prescribes or even administers pain-alleviating medication, knowing that it could shorten the patient's life, acts lawfully provided they have followed “the precepts and ethics of his profession.”¹⁵⁷ The conclusion found in law is that palliative care of the type described does cause death, and unless it is justifiable, an accused person can be prosecuted for murder, even in those circumstances. In contrast, the health profession offers a simple denial of the causal role that palliative care treatment plays: “1.2 Palliative care:...1.2.1 intends neither to hasten or postpone death.”¹⁵⁸

¹⁵² C M Barlow ‘Law and the quality of life: A right to die?’ (1992) *Nottingham Law Journal* (1) 36-60 at 37
“Brazier appears to take this analysis one step further and argues that the direction introduces into the law a 'double effect' principle whereby an act causing a bad consequence e.g. death might be justifiable if it also created a comparatively good one e.g. the relief of severe pain.”

¹⁵³ Supra note 138.

¹⁵⁴ Supra note 147.

¹⁵⁵ *Clarke v Hurst NO* supra note 138 at 656H-657A.

¹⁵⁶ *Clarke v Hurst NO* supra note 138 at 657E.

¹⁵⁷ *Clarke v Hurst NO* supra note 138 at 657D.

¹⁵⁸ HPCSA Booklet 17 *Ethical Guidelines on Palliative Care* (2019). Further at para 9.2 the guidelines note that euthanasia and physician-assisted suicide are contrary to the ethical principle of non-maleficence and at 9.5
“euthanasia and doctor-assisted suicide are fundamentally incompatible with a practitioner's roles as a healer, and a practitioner guilty of either is regarded as having acted unethically and unlawfully.”

2.5.3 Death caused through physician-administered euthanasia

Recently, in South Africa, the case of Professor Sean Davison brought assisted-suicide and euthanasia back into the courtroom. In 2019 Professor Davison's case (unreported) attracted prominent media coverage.¹⁵⁹ Davison entered into a plea and sentence agreement with the State. He pleaded guilty to three counts of premeditated murder for the deaths of Anrich Burger, Justin Varian and Richard Holland.¹⁶⁰ The court accepted the plea, and sentenced him as per the plea and sentencing agreement. There was no argument made regarding the merits, as the accused had admitted guilt to all of the definitional elements of murder. Causation would typically not have presented any difficulties for the prosecution, as in all three incidents, Davison admitted to having admitted, in relation to Burger and Varian, for providing assistance, and direct administration of a lethal quantity of drugs in the case of Holland. It is reported that he did not want a protracted criminal trial that would cause strain to himself and his family, and as such did not plead not guilty.

In England, *R v Wallace (Berlinah)*¹⁶¹ brought causation and physician-administered euthanasia within the lens of the court of appeal. Van Dongen (the deceased) and Wallace had been in a relationship, when after five years, Van Dongen left Wallace for another woman. In 2015 Wallace purchased sulphuric acid, and threw it on the deceased. She is reported as having laughed saying "if I can't have you, no-one else will."¹⁶² Van Dongen's injuries were extensive and debilitating,¹⁶³ which caused him in 2016 to travel to Belgium to seek euthanasia. On 2 January 2017, doctors ended van Dongen's life "by inserting drugs via a catheter into his heart."¹⁶⁴ Once this happened, Wallace was charged with murder. The trial court found that the causal link between the deceased's death and the accused's conduct had been severed through the conduct of the medical team in Belgium (where euthanasia is lawful) which was independently and voluntarily sought out by the deceased. The appeal centred on a victim's

¹⁵⁹ P Nombembe 'Right-to-die activist Sean Davison gets three years' house arrest for murders' *Times Live*, 19 June 2019, available at <https://www.timeslive.co.za/news/south-africa/2019-06-19-right-to-die-activist-sean-davison-gets-three-years-house-arrest-for-murders/> accessed on 2/01/2021. In 2020, the New Zealand Medical Board struck Prof Davison off their register.

¹⁶⁰ Ibid:

"Davison was arrested in April 2018 in connection with the death in 2013 of Anrich Burger, a quadriplegic. A second charge of murder was later added in connection with the death of Justin Varian, who had motor-neuron disease. When Davison appeared in Cape Town magistrate's court on April 29 he was charged with a third murder, for allegedly "administering a lethal amount of drugs" to Richard Holland in 2015..

¹⁶¹ [2018] 2 Cr. App. R. 22.

¹⁶² *Wallace* supra note 161 at para 10.

¹⁶³ *Wallace* supra note 161 at paras 12-14.

¹⁶⁴ *Wallace* supra note 161 at para 19.

conduct subsequent to an attack, and whether this severed the causal nexus.¹⁶⁵ The unanimous view of the appeal court was that factual causation had been established¹⁶⁶ which meant that it would be open to consider the legal causation question. In the circumstances, it would focus on the *novus actus interveniens* – was the act of euthanasia sufficiently independent for these purposes to sever the nexus? It would only be so if this type of conduct could be identified as being an abnormal or unusual turn of events and not a foreseeable event.¹⁶⁷ On appeal a new trial was ordered, noting that as regards causation and whether “in the light of the decision in *Dear*¹⁶⁸ the seeking of death (suicide in that case) as a response to horrific injuries does not preclude the jury finding that the defendant’s conduct made a significant contribution to Mr Van Dongen’s death.”¹⁶⁹

2.6 CONCLUSION

The dictum in *Grotjohn* has not been overturned by any court, nor has it been applied to the particular circumstances of physician-assisted deaths.¹⁷⁰ Therefore, the position in South Africa as regards a physician who assists a patient to die is that the physician would be criminally liable for the death of the patient if a causal nexus is established. The causal nexus is only broken by remoteness for example, the presence of a *novus actus interveniens*. An independent act by the victim can establish remoteness, but only if the conduct of the victim was not abnormal or unusual in the circumstances. In a case where a patient requests assistance to end their life, it would be difficult to conclude that the physician who provides assistance would not have anticipated or expected that the patient would ingest the pills provided or prescribed to end their life. Relying on both the adequate causation test and the *novus actus interveniens*, the conduct of the patient would not be ‘abnormal’ and thus would not sever the nexus.

¹⁶⁵ T Storey ‘Court of Appeal: Voluntary Acts and the Chain of Causation in Homicide Cases: The Need for ‘Free and Unfettered Volition’ *R v Wallace* [2018] EWCA Crim 690’ 2018 *The Journal of Criminal Law*, 82(4), 292–295.

¹⁶⁶ *Wallace* supra note 160 at para 58.

¹⁶⁷ *Wallace* supra note 160 at para 76 “the jury may conclude on the very special facts of this case, that there was nothing that could decently be described as voluntary either in the suffering or in the decision by Mr van Dongen to end his life, given the truly terrible situation he was in.” See also *Roberts* [1971] 56 Cr. App R 95.

¹⁶⁸ *R v Dear* [1996] Crim LR 595. In this case the accused had stabbed the victim, and after treatment, the victim re-opened the wounds in an effort to commit suicide. The victim died. The court held that the victim’s conduct was not a *novus actus interveniens* as the wounds inflicted by the accused were on their own sufficient to have killed the victim.

¹⁶⁹ *Wallace* supra note 160 at para 86.

¹⁷⁰ Milton *South African Criminal Law and Procedure Vol. II* op cit note 154 at 356.

If development of the law in relation to PAS were to happen in relation to causation, it would necessitate re-consideration of the rule relating to foresight of independent conduct and the chain of events in respect of materially defined crimes. In terms of the current, established and trite principles of causation in South African law, it would be impossible to conclude that a physician acted without there being a sufficient causal link between his conduct and the death when the charge is murder, particularly when the patient's own (independent) conduct was foreseen.¹⁷¹

The SCA in *Stransham-Ford* did not answer definitively regarding PAS; however, from the discussion above it is clear that the physician who renders assistance will always be causally responsible for the death of the patient who seeks assistance in ending his life. The SCA in *Stransham-Ford* suggests that a different view of causation could lead to PAS cases being rendered lawful.¹⁷² However, taking a different view of causation, particularly the *novus actus interveniens* or the theory of adequate causation, would in South African law require that the 'independence' of the victim's conduct where such is within the contemplation of the accused, as expounded in *Grotjohn* and *Goosen*, be excluded from the causal analysis for materially defined crimes like PAS.

The dicta in *Grotjohn* and *Goosen*¹⁷³ exclude the independent act of the victim as a *novus actus interveniens* when the causal sequence is expected to normally flow from the assistance rendered by the accused. It is clear that in all cases of assisted dying, including PAS, and for all perpetrators, the element of causation will always be proven. No distinction is drawn

¹⁷¹ The Constitutional Court in *De Klerk v Minister of Police* 2020 (1) SACR 1 (CC) at paras 80-81 refers to Snyman with approval:

"All the . . . rules relating to a *novus actus* are subject to the qualification that if X planned the unusual turn of events or foresaw it, it cannot amount to a *novus actus*. This accords with the rule of the adequate causation test . . . that, in determining whether an act tends to lead to a certain result, one should take into account not only the circumstances ascertainable by the sensible person, but also the additional circumstances known to X" and thus "subjective foresight of harm cannot itself necessarily imply that harm is not too remote from conduct. It is, however, a weighty consideration. In the present matter, Constable Ndala subjectively foresaw the precise consequence of her unlawful arrest of the applicant. She knew that the applicant's further detention after his court appearance would ensue. She reconciled herself to that consequence. What happened in the reception court was not, to Constable Ndala's knowledge, an unexpected, unconnected and extraneous causative factor – it was the consequence foreseen by her, and one which she reconciled herself to. In determining causation, we are entitled to take into account the circumstances known to Constable Ndala. These circumstances imply that it would be reasonable, fair, and just to hold the respondent liable for the harm suffered by the applicant that was factually caused by his wrongful arrest. For these reasons, and in the circumstances of this matter, the court appearance and the remand order issued by the Magistrate do not amount to a fresh causative event breaking the causal chain".

¹⁷² *Stransham-Ford* (SCA) supra note 114 at para 56.

¹⁷³ *Ex Parte Die Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A); *S v Goosen* 1989 (4) SA 1013 (A).

between medical contexts and other contexts and no distinction is drawn between physicians and non-physicians.

The question *why are physicians not criminally liable for deaths caused through passive euthanasia* is different from *do physicians cause death through passive euthanasia*? This chapter sought to answer the latter question. The SCA in *Stransham-Ford* referred to *Clarke v Hurst NO*, at footnote 28 that

“The distinction is possibly a fine one, but it is hard to see why the refusal of continued treatment is distinguishable from the refusal of treatment in the first place. It is a different matter whether the disconnection of the ventilator is a cause of death. From the perspective of the criminal law it will be so, but the question then will be whether it was unlawful.”¹⁷⁴

In so stating, the SCA confirms my submissions above regarding the causal nexus and lawfulness. This raises two questions that need to be answered: Who is permitted to cause death, and under what conditions? These answers will not be found in causation. So causing death and being allowed (in law) to cause death are distinct issues. This latter issue will be discussed in the next chapter.

Referring to the dictum in *Clarke v Hurst NO*, the SCA in *Stransham-Ford* confirmed that “a medical practitioner commits no offence by prescribing drugs by way of palliative treatment for pain that the doctor knows will have the effect of hastening the patient’s death.”¹⁷⁵ Physicians are not criminally responsible for the deaths of patients resulting from PE because in the light of the legal convictions of society PE is justifiable, even though it causes death.¹⁷⁶ Equally, VAE also causes death, but is not justifiable because in the light of decided cases, notably *Grotjohn* and *Hartmann*, the legal convictions of society do not recognise any grounds for justification for such conduct. This is an important distinction for the VAE paradigm, particularly as medical ethics claim that VAE is unethical because it causes death, and is contrary to the ethical principles of beneficence and non-maleficence.¹⁷⁷ McQuoid-Mason

¹⁷⁴ *Stransham-Ford* (SCA) supra note 114 at para 32.

¹⁷⁵ *Stransham-Ford* (SCA) supra note 114 at para 34.

¹⁷⁶ *Clarke v Hurst NO* supra note 138.

¹⁷⁷ HPCSA Booklet 17 op cit note 158 at para 9:

“9.1 Non-maleficence requires health practitioners providing palliative care not to harm their patients and complements beneficence and the balancing of risks and benefits.

9.2 Euthanasia and doctor-assisted suicide are often perceived as inconsistent with the principle of non-maleficence.

9.3 Euthanasia and doctor-assisted suicide are presently prohibited under South African law, and the courts frequently do not distinguish between the two when it comes to culpability.

9.4 Euthanasia is the employment of any medical intervention primarily aimed at ending a patient’s life (e.g. giving a patient lethal drug or injection).

9.5 Doctor-assisted suicide occurs when the health practitioner provides the means necessary to enable the patient to end their own life (e.g. handing a patient a lethal drug or prescribing a lethal drug for a patient).

explains that both passive euthanasia¹⁷⁸ and active euthanasia¹⁷⁹ intend to and do cause death, but the real reason why physicians are not criminally liable for the deaths of their patients in PE matters is that their conduct is deemed to be justifiable, “not because they did not intend their patients to die or did not cause their patients’ death.”¹⁸⁰ Legally, both these elements are present, but unlawfulness is not.”¹⁸¹

The SCA in *Stransham-Ford* noted that both PE and VAE cause death, but the former is justifiable.¹⁸² The court referred to Burchell who notes that “It is still open for a court in South Africa to hold that, in certain limited circumstances, the legal convictions of society do

9.5 (sic) At present, South African courts have acknowledged that both euthanasia and doctor-assisted suicide are fundamentally incompatible with a practitioner’s role as a healer, and a practitioner guilty of either is regarded as having acted unethically and unlawfully.”

See also N Ebrahimi ‘The ethics of euthanasia’ (2012) 3(1) *Australian Med Student J* 73-75:

“Opponents of euthanasia argue that there is a clear moral distinction between actively terminating a patient’s life and withdrawing or withholding treatment which ends a patient’s life. Letting a patient die from an incurable disease may be seen as allowing the disease to be the natural cause of death without moral culpability. Life-support treatment merely postpones death and when interventions are withdrawn, the patient’s death is caused by the underlying disease. Indeed, it is this view that is strongly endorsed by the Australian Medical Association, who are opposed to voluntary active euthanasia and physician-assisted suicide, but does not consider the withdrawal or withholding of treatment that result in a patient’s death as euthanasia or physician-assisted suicide.”

See also B Spina ‘Ethical justifications for voluntary euthanasia’ (1998) 3(1) *Richmond J Law & Pub Interest* 71-81. J Rachels ‘Active and passive euthanasia’ in J M Humber & R F Almeder (eds) *Biomedical Ethics and the Law* (1979) 511-516 at 515 notes that the causal distinction is a fallacy:

“Fixing the cause of death may be very important from a legal point of view, for it may determine whether criminal charges are brought against the doctor. But I do not think that this notion can be used to show a moral difference between active and passive euthanasia. The reason why it is considered bad to be the cause of someone’s death is that death is regarded as a great evil and so it is. However, if it has been decided that euthanasia even passive euthanasia is desirable in a given case, it has also been decided that in this instance death is no greater an evil than the patient’s continued existence. And if this is true, the usual reason for not wanting to be the cause of someone’s death simply does not apply.”

¹⁷⁸ 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’ at 102:

“The usual view is that doctors are not liable because they do not intend to kill the patients in such circumstances, and the underlying illness, injury or condition causes the death.] Such acts and omissions are said to constitute passive euthanasia, which is not regarded as murder, rather than active euthanasia. However, the distinction is artificial because what is sometimes called ‘passive’ euthanasia involves a positive act, e.g. switching off a ventilator or turning down a pacemaker.”

¹⁷⁹ Ibid.

¹⁸⁰ RK Jacobs and M Hendricks ‘Medical students’ perspectives on euthanasia and physician-assisted suicide and their views on legalising these practices in South Africa’ (2018) *SAMJ* 108(6) 484-489 at 484:

“SA law regards both euthanasia and PAS as forms of active euthanasia [The South African Law Commission holds that ‘such an act [euthanasia and/or PAS] would undoubtedly be unlawful and the person giving the assistance could be convicted of murder’, as both euthanasia and PAS contain the definitional elements of murder.”

¹⁸¹ 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’ op cit note 188 at 103.

¹⁸² *Stransham-Ford* (SCA) supra note 114 at para 2, where the court noted that PAS and PAE were to be distinguished from passive euthanasia practices:

“They are to be distinguished from the refusal or withdrawal of treatment or life support or other conduct that is lawful in South Africa, but which in certain jurisdictions is regarded as passive euthanasia and may be illegal. In doing so I am aware that there are those who regard these distinctions as sophistry and treat virtually any action, ranging from refusal of treatment by the patient to the administration of lethal drugs by a physician, as different manifestations of euthanasia.”

not require that the conduct of the person facilitating another's suicide be labelled 'unlawful'.”¹⁸³ The next chapter considers unlawfulness.

¹⁸³ Burchell *Principles of Criminal Law* (2016) op cit note 29 p 213; and at para 57 of *Stranham-Ford* (SCA) supra note 114 at footnote 56.

CHAPTER THREE

UNLAWFULNESS AND ASSISTED DYING – CONSENT AS A DEFENCE

3.1. INTRODUCTION

It has been shown in the previous chapter that both passive euthanasia (PE) and voluntary active euthanasia (VAE) are forms of conduct which cause death, meaning that as a starting point, both practices are *prima facie* unlawful.¹ However, this alone does not mean that a perpetrator must be found guilty of the crime they are accused of having committed. A further requirement is that of unlawfulness, and if an accused person successfully raises a defence to justify their conduct, they will not be found guilty. Conduct is justified if there is no “social need to punish the accused for the performance in question.”²

Consent is one ground of justification. We see that consent operates in medical contexts and for present purposes, to death caused in a PE scenario. McQuoid-Mason notes that when physicians cause their patient’s deaths by for example withholding or withdrawing treatment, or when they provide palliative care medication which can hasten death, their conduct falls within the ambit of the criminal law because it satisfies “the elements of intention and causation of a charge of murder”,³ however, liability does not follow if, for example, the patient has consented.

¹ P Carstens & D Pearmain *Foundational Principles of South African Medical Law* (2007) at 499:

“It is submitted that the difficulties in the Canadian experience in even attempting (under one interpretation) to exclude medical interventions from the definition of assault and render them *prima facie* lawful demonstrate the value of the current approach of South African law that they are *prima facie* unlawful violations of well established and long recognised rights. If one starts from the premise that they are lawful it starts to become extremely difficult to define just what it is that is lawful and where lawfulness begins and ends. In South African law this problem does not arise because the intervention is *prima facie* unlawful. The maxim *volenti no fit injuria* provides a key element of this system of legal principle in that it both recognises and supports the fundamental importance of ‘absolute’ human rights as the rights to life, to human dignity, to freedom and security of the person and to bodily and psychological integrity. It also places squarely in the hands of the individual the right to self-determination.”

² J M Burchell *South African Criminal Law and Procedure, Volume I General Principles of Criminal Law* 4 ed (1997) at 114.

³ 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) *SAMJ* 104(2) 102-103 at 102:

“Doctors who hasten the termination of the lives of their patients by withholding or withdrawing treatment or prescribing a potentially fatal palliative dose of medication satisfy the elements of intention and causation of a charge of murder against them. However, the courts have held that, for policy reasons based on ‘society’s legal convictions’, such conduct is not unlawful if the patient

In the law of delict, the maxim *volenti non fit injuria* (no harm is done to he who consents) applies and holds that no injury is done to the person who consents to such injury.⁴ The maxim absolves from liability any person who has impaired the interests of another provided that the person consented to such impairment.⁵ For the conduct in question the law permits consent as a defence in that it acknowledges a person's right to autonomy to make choices including those which carry risks (voluntary assumption of risk).⁶ However, in criminal law, consent as a ground for justification has a narrow and limited scope, and we find that the criminal law places limits on what forms of harm can be consented to and then under certain conditions.⁷

consented to it or medical treatment would be futile or palliative treatment may hasten death. Doctors are not held liable for murder because society regards their omissions or acts as lawful - not because they did not have the intention in law to kill or did not cause the death of their patients."

⁴ Consent would have to be established as having been 'real'. Real consent can be explicit or implicit. See P Labuschagne, "Violence" in sport and the *volenti non fit iniuria* defence: A perspective on the death of the cricket player Phil Hughes' (2018) 21 *PER/PELJ* at 7, available at <http://dx.doi.org/10.17159/1727-3781/2018/v21i0a2409>, accessed on 11 February 2021.

⁵ J Kleinig 'Consent as a defence' (1977) 65(3) *Archives for Philos of Law and Social Philos* 1. See also NS Kim *Consentability: Consent and its limits* (2019) Cambridge University Press at 3: "In some cases, the public interest in prohibiting the act is deemed to be so strong that the act itself is criminalized. But why are some acts considered inconsistent?"

⁶ *Stoffberg v Elliott* 1923 CPD 148 at 149-150:

"In the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statue or contract, but they are rights to be respected, and one of the rights is absolute security to the person...Any bodily interference or restraint of a man's person which is not justified in law, or excused in law or consented to is a wrong, and for that wrong the person whose body has been interfered with has a right to complain such damages as he can prove he has suffered owing to that interference...he still has the right to say what operation he will submit to, and, unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control over his own body, and is a wrong entitling him to damages in he suffers any."

Castell v De Greef 1994 (4) SA 408 (C). This case recognised that even if a patient is not terminal or close to death, patient autonomy allows a patient to make any decision about medical treatment, including the right to refuse treatment, where the risk of such refusal could result in death. This case effectively rejected medical paternalism in favour of patient autonomy. SV Hoorntje *Snyman's Criminal Law* 7 ed (2020) at 102: "Consent by the person who would otherwise be regarded as the victim of X's conduct may, in certain cases render X's otherwise unlawful conduct lawful."

⁷ The report of the South African Law Reform Commission (Project 86) *Euthanasia and the Artificial Preservation of Life* (1998) draws a point of caution related to the gravity of harm as a definer of what types of harm are *contra bonos mores* based only on the gravity of the harm at para 4.7:

"A further requirement is that the consent to injury is considered valid only if it is not *contra bonos mores*. In our law it is for instance accepted that a person cannot consent to serious bodily mutilation. This requirement should however be approached with caution as consent to serious bodily mutilation is not in all cases considered *contra bonos mores*. Say, for instance, that in light of medical considerations it is found that the amputation of a leg is inevitable. The patient's consent to the amputation, that is to say the serious bodily mutilation, would certainly not be seen as invalid."

This argument is discussed later herein. See also SA Strauss 'Bodily injury and the defence of consent' (1964) 81 *SALJ* 179 at 332.

3.2 CONSENT IN LAW

In relation to consent's applicability, albeit limited, the criminal law has a set of factors that must be present for consent to be valid. Burchell lists the requirements as follows

“(a) the complainant's consent in the circumstances must be recognised by law as a possible defence; (b) it must be real consent; and (c) it must be given by a person capable in law of consenting.”⁸

In addressing these requirements I will focus on consent to medical treatment because the arguments made in this thesis are centred on the legalisation of *medically* assisted dying where such a request is made by a competent, adult patient.

3.2.1 *Consent must be recognised by the law as a possible defence*

The criminal law distinguishes between crimes that target a specific individual, and those that target the state. In the case of the latter, consent is never a defence. As regards the former, the criminal law endeavours to acknowledge individual autonomy, but in the main does so, selectively; the law will only respect an individual's right to make autonomous choices if a socially acceptable choice is made.⁹ Devlin notes that

“If the law existed for the protection of the individual, there should be no reason why he should avail himself of it if he did not want it. The reason why a man may not consent to the commission of an offence against himself beforehand or forgive it afterwards is because it is an offence against society...A murderer who acts only upon the consent, and maybe the request, of his victim is no menace to others, but he does threaten one of the great moral principles upon which society is based, that is, the sanctity of human life. There is only one explanation of what has hitherto been accepted as the basis of the criminal law and that is that there are certain standards of behaviour or moral principles which society requires to be observed; and the breach of them is an offence not merely against the person who is injured but against society as a whole.”¹⁰

Because a crime is not just a harm against the individual victim, but a harm against society as a whole, the individual purporting to consent is divested of autonomy when the harm consented

⁸ J M Burchell *Principles of Criminal Law* 5 ed (2016) at 209.

⁹ J Omar ‘Clarity, consistency, and community convictions: Understanding the defence of consent in South African criminal law.’ (2022) *SACJ* 35 131 at 135:

“We may think of the defence of consent as a legal recognition of the right to individual choice. However, such legal recognition will only apply in situations where society's *bono mores* are aligned with those personal choices. In situations where consent by the direct victim removes an act's social disruption, then there is no need to criminalise. In other words, the defence of consent will justify unlawful conduct if we decide that such conduct can be lawful with consent.”

¹⁰ P Devlin *The Enforcement of Morals* (1965) at 6-7.

to harms society's interests. In criminal law, this limited applicability of consent is the middle ground between liberalism and paternalism as "the criminal law reserves the right to determine which choices will be respected, and on what grounds."¹¹ Hart argues that in some cases legal paternalism is necessary and so justifies limits on autonomy.¹² Justifiable limits on autonomy depend on the nature of the offence, the gravity of the harm, and society's sense of fairness with respect to tolerance for the circumstances under which the harm was caused.¹³ Burchell notes that the grounds on which the law is prepared to accept consent as a defence to, is based on reasons of public policy which

¹¹ Burchell *South African Criminal Law and Procedure Vol 1* op cit note 2 at 217-218.

¹² HLA Hart *Liberty, Law & Morality*, London (1963) at 31: "the rule excluding the victim's consent as a defence to charges of murder and assault may perfectly well be explained as a piece of paternalism designed to protect individuals against themselves."

¹³ *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) at para 31:

"A person may refuse treatment that would otherwise prolong life. This is an aspect of personal autonomy that is constitutionally protected and would not ordinarily be regarded as suicide. Medical treatment without the patient's consent is regarded as an assault so that the patient is always entitled to refuse medical treatment."

Consent on the part of the victim may also have implications for the severity of the sentence that the accused will be given if found guilty. Hoctor *Snyman's Criminal Law* (2020) op cit note 7 at 102:

"To generalise about consent as a ground for justification in criminal law is possible only to a limited degree since consent can operate as a ground for justification in respect of certain crimes only, and then only under certain circumstances."

S A Strauss *Doctor Patient and the Law: A Selection of Practical Issues* 3 ed (1991) at 268:

"Where there has been no consent to a medical procedure – or what is legally the same, where the consent in fact given was so 'uninformed' as to the nature of the procedure or consequences thereof that may well manifest themselves, that it cannot be said that there was a 'real' consent – the patient will have an action based upon assault."

And at 31:

"It follows that to perform a medical operation upon or to administer treatment to a person against his will, or even without his consent, amounts to an assault, for which the doctor may be held liable in a civil action for damages and be criminally prosecuted."

See also *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T). See also K D Bolton 'Informed consent' (2012) 11 *SA Orthopaedic J* at 108

"In South African law any and all investigation and treatment of patients constitutes assault but this assault is condoned by proper informed consent."

See also *Stransham-Ford* (SCA) where the court discusses situations where patients are unable to consent at para 32:

"The only qualification to what appears in the preceding paragraph is that the patient must have the mental and legal capacity to make that decision. This gives rise to problems where a person suffers a catastrophic injury without any prior expression of their views, or is afflicted with a mental handicap that limits their legal capacity or where, as with a child, they lack legal capacity. It is in circumstances such as these that courts may be called upon, usually by family members or the medical authorities, to make decisions as to the legitimacy of the withdrawal of medical treatment or artificial nutrition and hydration. That is what occurred in South Africa in *Clarke v Hurst NO*, in the United Kingdom in *Bland*, and in the United States in *Cruzan* and *Quinlan*. In each of these cases the patient was in a persistent vegetative state and the court authorised the cessation of artificial means of keeping them alive, including the removal of artificial nutrition and hydration."

“depend[s] upon identifying the societal objective of the crime in question. In the end, the determining issue is whether, in all the circumstances, public policy warrants juristic recognition of the consent.”¹⁴

In this context the benchmark is whether public policy would accept as reasonable the inviting of harm in particular contexts. For harms occasioned against an individual, the criminal law draws consentability¹⁵ distinctions between crimes in which consent never operates as a defence (for example murder) and those for which it might sometimes do so (for example assault).

Consent is never a defence to murder because it is conduct which is morally reprehensible and contrary to public policy - it offends against what is understood as being “one of the great moral principles upon which society is based, that is, the sanctity of human life.”¹⁶ Kleinig notes that

“Proof of consent to murder, euthanasia, castrations, sado-mastic practices, mayhem, duelling and street-fighting is frequently unacceptable as a defence, the more so as the bodily intrusion increases in gravity. But proof of consent to therapeutic surgical operations...is generally an acceptable defence to charges of assault.”¹⁷

Because VAE is categorised as murder (a grave harm) and is prosecutable as such, the result is that consent will not avail as a defence in these cases.¹⁸ So a question worth answering is

¹⁴ Burchell *South African Criminal Law and Procedure Vol 1* op cit note 2 at 333:

“Thus the recognition of consent as a defence depends upon identifying the societal objective of the crime in question. In the end, the determining issue is whether, in all the circumstances, public policy warrants juristic recognition of the consent.”

¹⁵ *Consentability: Consent and its limits* op cit note 5 at 3:

“Consent is distinct from consentability. This book gives the term “consentability” two different meanings. The first involves possibility. An act which is consentable means that it is possible for there to be consent given the nature of the proposed activity. The second meaning of consentability involves legality. An act which is consentable is (or under the right circumstances, can be) legal. The possibility of valid consent is essential to consentability but it is not sufficient. Consentability is thus determined by assessing the effect of an activity upon both the individual and society.”

¹⁶ Devlin *The Enforcement of Morals* op cit note 10 at 6-7.

¹⁷ Kleinig ‘Consent as a defence in Criminal Law’ op cit note 5 at 2.

¹⁸ *S v Hartmann* 1975 (3) SA 532 (C); *S v De Bellocq* 1975 (3) SA 538 (T); *S v Nkwanyana* 2003 (1) SACR 67 (W); *S v Robinson* 1968 (1) SA 666 (A); *S v Hibbert* 1979 (4) SA 717 (D); *S v Agliotti* 2011 (2) SACR 437 (GSJ). A Rall ‘The doctor’s dilemma: Relieving suffering or prolong life’ (1977) 94 SALJ 40 at 44:

“Euthanasia, according to the court in the *Hartman* (sic) case, is murder. The court applied the principles of criminal law to a typical euthanasia situation and did not consider that the unique features of euthanasia differed sufficiently from any other form of killing to justify it. The fact that death was brought about in order to end intense pain was considered to be only an extenuating factor and not a ground for justification. It cannot be denied that as a rule neither the consent of the victim, nor the fact that the killing was only a ‘hastening of death’, is sufficient to justify the killing of the person.”

whether society's legal convictions have ever permitted a person to consent to grave harm, and if they have, why?¹⁹

Assault²⁰ is the type of offence where consent has limited or selective applicability. In this respect, injuries occasioned during sporting activities (for example rugby or boxing) and medical treatment (for example operations) will be understood as being lawfully caused or justified where persons have consented to the harm, and where the harm is of the type that is normally to be expected from that activity. These activities can be consented to because they are deemed to be acceptable to the interests of society.²¹ These activities carry with them the risk of death, but this does not appear to be reason enough to tarnish their consentability. Social utility and approval of the activities bring them within the scope of types of conduct that can be consented to.²² But whether consent will avail in a particular context will require closer inspection of the quality of the consent, and in some cases the state of mind of the aggressor.²³

Consent to medical treatment is required for the treatment to be lawful, without which a physician can be criminally charged.²⁴ Adjoined to this is consent to the side effects or risks which may result from the treatment. Where a risk or side effect results, the physician who

¹⁹ *Clarke v Hurst NO 1992 (4) SA 630 (D)* at 656 where the court referred with approval to the English case of *R v Adams* 1957 Crim LR 365:

"The hastening of a person's death is ordinarily not justified and is therefore wrongful even when the person is terminally ill and suffering unbearable pain. *S v Hartmann (supra)*. This is however not an absolute rule. It has come to be accepted that the doctor may give a terminally ill patient drugs with the object of relieving his pain, even if, to the doctor's knowledge, the drugs will certainly shorten the patient's life...On the principles of our law the doctor would in each of the above examples be exempt from liability, if judged by the legal convictions of society, his conduct was reasonable."

See also SV Hoorster *Snyman's Criminal Law* 7 ed (2020) at 103.

²⁰ Burchell *Principles of Criminal Law* 5ed at 591: "Assault consist in unlawfully and intentionally (1) applying force to the person of another, or (2) inspiring a belief in that other person that force is immediately to be applied to him or her."

See also Hoorster *Snyman's Criminal Law* 7ed supra note 18 at 395:

"Assault consists in any unlawful and intentional act or omission (a) which results in another person's bodily integrity being impaired, or (b) which inspires a belief in another person that such impairment of her bodily integrity is immediately to take place."

²¹ J Omar 'Clarity, consistency, and community convictions: Understanding the defence of consent in South African criminal law.' (2022) *SACJ* 35 131 at 134.

²² *Ibid.*

²³ *Roux v Hatting* 2012 (6) SA 428 (SCA).

²⁴ *Stransham-Ford* (SCA) supra note 13 at para 31:

"A person may refuse treatment that would otherwise prolong life. This is an aspect of personal autonomy that is constitutionally protected and would not ordinarily be regarded as suicide. Medical treatment without the patient's consent is regarded as an assault so that the patient is always entitled to refuse medical treatment."

Consent on the part of the victim may also have implications for the severity of the sentence that the accused will be given if found guilty. Hoorster *Snyman's Criminal Law* 7ed op cit note 18 at 102:

"To generalise about consent as a ground for justification in criminal law is possible only to a limited degree since consent can operate as a ground for justification in respect of certain crimes only, and then only under certain circumstances."

caused the injury can raise the patient's consent as a defence²⁵ to exclude unlawfulness, even if the risk consented to is death, provided that the law recognises the conduct as being socially acceptable and not *contra bonos mores*.²⁶ Burchell notes that in South Africa "the general ground for the justification of medical operations on and treatment of a patient is the voluntary, informed consent of that patient."²⁷ But this does not mean that consent always operates as a defence in medical treatment cases, and arguments surrounding whether the type of conduct can be consented to, even in these contexts, have centred on the inviolability and sanctity of life and the gravity of the harm caused.²⁸ These factors influence whether the conduct is consentable.

In the case of *S v Hartmann*²⁹ the court noted by way of an obiter remark that even if the patient had consented, the consent would not avail as a defence to the crime of murder.³⁰ Devlin³¹ posits that while one is empowered to waive one's own interests, in relation to murder (which VAE is categorised as), what an individual purports to waive is, in fact, the interests of society and the State. For that reason, the law will never accept as a defence that the victim consented to be murdered. Thus, for as long as VAE is categorised and prosecutable as the crime of murder, a physician will not be able to rely on the consent of the patient as a defence. This requirement relates directly to the gravity of the harm (death), as public policy does not permit consent where the harm is grave *and* the conduct serves no social or public interest, would a closer look at evolving *mores* mean that patients can consent to VAE?³²

Baker observes that a call to society's sense of fairness appears to be the strongest motivator for determining when consent can avail as a defence and is actually a moral limit

²⁵ Provided of course that in addition the other requirements for valid consent are met.

²⁶ *Stoffberg v Elliot* 1923 CPD 148; Burchell *Principles of Criminal Law* 5ed op cit note 8 at 211:

"Consent to run the risk of serious bodily harm, or even death, will excuse physical injury inflicted in the course of normal therapeutic medical operations or treatment."

²⁷ Burchell *Principles of Criminal Law* 5ed op cit note 8 at 222.

²⁸ P Devlin *The enforcement of Morals* (1965), pages 6-7.

²⁹ *S v Hartmann* 1975 (3) SA 532 (C).

³⁰ *Hartmann* supra note 29 at 534-535:

"There is some suggestion in the accused's statement to the police that he asked his father whether he wanted to sleep and that his father vaguely nodded his head in approval. I do not know whether this portion of the statement is intended to indicate that the deceased desired to have administered to him some drug permanently to end his suffering. It seems highly doubtful that the deceased was at that stage able to appreciate what he was being asked, or that he was sufficiently rational to signify his assent to the administration of such a drug, or even whether he in fact did so when he nodded his head. Be that as it may, it would not constitute a defence to the charge that the deceased had consented to the administration of pentothal. It has more than once been held in the Appellate Division that the fact that the deceased wished to be killed does not exclude the criminal responsibility of him who gratifies the deceased's wish. See, for instance, *S v Peverett*, 1940 AD 213, and *S v Robinson and Others*, 1968 (1) SA 666 (AD)."

³¹ Devlin *The Enforcement of Morals* op cit note 28.

³² Kim *Consentability: Consent and its limits* op cit note 5 at 49.

placed on consent's applicability.³³ Accepting that conventional morality evolves over time, there certainly is room for the law to reconsider the types of conduct that are morally permissible and thus can be consented to.³⁴ Omar similarly observes that the types of conduct or harms which can be consented to are rationalised by calls to the legal convictions of community, but

“What is in the interests of the collective or the community is not an unchanging thing. These malleable interests, referred to as the ‘legal convictions of the community’ inform public policy, which becomes the underlying rationale for why certain types of conduct are criminalised or punished more severely than others. But the changing nature of collective interests affects the static nature of public policy. Law thus evolves over time and space.”³⁵

We see from McQuoid-Mason's position that a patient's consent to death caused through conduct categorised as passive euthanasia³⁶ absolves physicians from criminal liability, and from the preceding discussion it would appear that policy considerations are the first hurdle which will have to be surmounted to bring VAE within the realm of conduct which can be consented to.³⁷ For the immediate purpose, the point is that the gravity of the harm consented to is not a bar to accepting consent to death. Patients are allowed to consent to medical treatment and even the undesired side effects thereof, meaning that if an injury or death is caused as a result of such treatment, a physician can raise consent as a defence. However, a further proviso is that the consent must be real and the patient must have the capacity to consent.³⁸

3.2.2 *Consent must be real*

Where conduct can be consented to, that consent must be given freely, voluntarily and without coercion.³⁹ Voluntariness can be affected where one person exerts their influence over the other or where the person purporting to consent has done so due to intimidation or threats, or where

³³ D J Baker ‘The moral limits of consent as a defence in the criminal law’ (2009) *New Criminal Law Review* 12(1) 93-121.

³⁴ D J Baker ‘The moral limits of consent as a defence in the criminal law’ op cit note 33 at 118.

³⁵ J Omar ‘Clarity, consistency, and community convictions: Understanding the defence of consent in South African criminal law.’ (2022) *SACJ* 35 131 at 134.

³⁶ 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) *SAMJ* 104(2) 102-103 at 102.

³⁷ *S v Hartmann* 1975 (3) SA 532 (C); *S v De Bellocq* 1975 (3) SA 538 (T); *S v Nkwanyana* 2003 (1) SACR 67 (W).

³⁸ Burchell *Principles of Criminal Law* 5ed op cit note 8 at 222.

³⁹ *S v C* 1952 (4) SA 117 (O); *S v M* 1953 (4) SA 393 (A).

the material facts related to the consent have not been provided. This relates to the quality of the information provided:

“The consenting person must be aware of the true and material facts regarding the act to which she consents. What the material facts are depends on the definitional elements of the particular crime.”⁴⁰

Facts are material if information which, if made known, could have caused the decision-maker to make a different decision.⁴¹ Carstens and Pearmain observe that consent is only lawful or ‘real’ if “the consenting party knows and appreciates what it is that he or she is consenting to”⁴² and so “in the absence of information, *real* consent will be lacking.”⁴³ As stated, for consent to be real requires the giving of the right kind of information.⁴⁴ A patient with capacity⁴⁵ is able to make a competent decision if they have the requisite information about the procedure and the risks, which in turn allows them to make an informed decision. An informed decision is a ‘real’ decision.

This understanding of real consent is founded on the provision of information as well as patient autonomy, and is known as the doctrine of informed consent. It is “the paradigm shift

⁴⁰ Hoctor *Snyman’s Criminal Law* 7ed op cit note 18 at 105.

⁴¹ *Castell v De Greef* [1994] 4 All SA 63 (C) at 81:

“I therefore conclude that, in our law, for a patient’s consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn the patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of a particular case:

- (a) a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it; or
- (b) The medical practitioner should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.”

See also Burchell *Principles of Criminal Law* 5ed op cit note 8 at 229: “It is surely arguable that the complainant who is *misled* or *ignorant* of the risks involved, does not consent to sexual intercourse carrying with it the risk of contracting a serious disease.”

⁴² Carstens & Pearmain op cit note 1 at 878. This aspect relates to whether the person has decision-making capacity.

⁴³ Carstens & Pearmain op cit note 1 at 879. This aspect relates to whether the consent is real.

⁴⁴ Hoctor *Snyman’s Criminal Law* 7ed op cit note 18 at 105. See also Carstens and Pearmain op cit note 1 at 879:

“Since the patient is usually a law person in medical matters, knowledge and appreciation on his or her part can only be effected by appropriate information. In this way, adequate information becomes a requisite of knowledge, appreciation and acquiescence and, therefore, also of lawful consent.”

⁴⁵ See below at para 3.2.3.

from medical paternalism to patient autonomy.”⁴⁶ In *Stoffberg v Elliot*⁴⁷ the plaintiff was admitted to hospital for treatment related to cancer of the penis. The plaintiff submitted to an operation. During the course of the operation, the surgeon proceeded to amputate the plaintiff’s penis. In a claim for damages, the plaintiff argued that he did not consent to his penis being amputated, nor had been informed that such amputation was a possibility. Although the jury ruled in favour of the surgeon, the court did make the following clear regarding consent:

“In the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or upon contract, but they are rights to be respected, and one of the rights is absolute security to the person...Any bodily interference with or restraint of a man’s person which is not justified, or excused or consented to is wrong...A man by entering a hospital does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary...He remains a human being, and he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to, and...any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body and is a wrong entitling him to damages if he suffers any.”⁴⁸

Thus, where consent has not been given, any treatment is an offence against the patient, unless there is some other reason to justify why treatment was pursued without consent. In directing the jury, Watermeyer J stated that they should consider whether, despite a lack of consent to the amputation, the surgeon acted reasonably in assessing why it was immediately necessary to perform the amputation. The plaintiff’s medical expert testified that the nature of the cancer

⁴⁶ Carstens & Pearmain op cit note 1 at 877.

See also A le Roux-Kemp *A legal perspective on the power imbalances in the doctor-patient relationship* (unpublished PHD thesis, University of Stellenbosch, 2010) at 123:

“The paternalistic approach in medical decision-making has been accurately described as a sad tale of high hopes, good intentions, dashed expectations, much anguish and ensuing recriminations. Clearly, there is no place for medical paternalism in either the medical profession and doctor-patient relationship or medical- and health law, not even if it is thought to be in the name of the patient’s best interests...Patient autonomy and self-determination are values fundamental to the Constitution and the general rights-based approach in South Africa. The medical paternalistic practices and justifications for the limitation of this basic human right are therefore intolerable.”

And at 60:

“Medical paternalism refers to the traditional beneficence-based mode of health service delivery which has dominated orthodox medical practice for the past 2500 years. In spite of far-reaching social and cultural changes as well as great advances and developments in medical science, paternalism has remained the preferred and dominant ethos in medical practice. Paternalism requires that a person’s liberty be restricted for his/her own good in circumstances that would normally be perceived as violating that person’s autonomy. Motivated and justified by an allegedly beneficent concern for the welfare of patients, paternalism expects them to act in a certain way, employing mechanisms and means other than reasoned persuasion to reach its objectives and assuming that medical practitioners internalise the interests of patients. The patient is not considered as an active participant in decision-making.”

⁴⁷ *Stoffberg v Elliot* 1923 CPD 148.

⁴⁸ *Stoffberg v Elliot* supra note 47 at 149-150.

was such that in his expert opinion he would be surprised if the plaintiff would have lived beyond two years if the procedure had not been performed.⁴⁹ This fact is what appears to have swayed the jury to rule in favour of the surgeon. It is only in situations of emergency and where a patient's consent cannot be obtained, or where a delay in performing the procedure in waiting for the patient to regain consciousness would endanger the life of the patient, that a physician would be permitted to pursue treatment that had not been consented to by the patient.⁵⁰ Strauss notes that a consequence of the principle established in *Stoffberg* is that

“to perform a medical operation upon or to administer treatment to a person against his will, or even without his consent, amounts to an assault, for which the doctor may be held liable in a civil action for damages and be criminally prosecuted.”⁵¹

This has a direct impact on whether a patient can lawfully refuse treatment, even if it will serve effectively to alleviate or even cure them of their illness. *Stoffberg* established the grounds for applying the legal requirement of consent to medical practice. Strauss notes that where a patient has both capacity and competency to make a decision in appreciation of the consequences and risks attendant thereto, then that decision is real and must be respected.⁵² What this means is that any medical procedure, regardless of how therapeutic or efficacious, is only lawful if a patient consents in this ‘real’ or informed sense. This calls into play the requirement of voluntariness and the principle that voluntariness (and thereby consent) is vitiated if the material facts have not been provided.⁵³ In so doing, the person must consent not only to the act in question, but also any risks, side effects and consequences that may flow therefrom. But just because information has been provided does not without more mean that a person has ‘consented.’ Consent will only avail if in addition, the person has capacity to consent.

3.2.3 *The person consenting must have capacity to consent*

⁴⁹ *Stoffberg v Elliot* supra note 47 at 153.

⁵⁰ Burchell *Principles of Criminal Law* 5ed op cit note 8 at 223:

“Where the patient's consent cannot be obtained because he or she is unconscious, or for some other reason, the operation may still be justified on the ground of necessity; but where it is performed against his or her will it is unlawful.”

⁵¹ Strauss op cit note 13 at 31:

“there is no principle in our law whereby a court can overrule a patient's will in these circumstances. I have never understood the Roman-Dutch standpoint that a person is not *dominus membrorum suorum* – master of his own bodily members – to mean that the doctor has a professional right to treat a patient against his will.”

See also *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T).

⁵² Strauss op cit note 13 at 31.

⁵³ Burchell *Principles of Criminal Law* 5ed op cit note 8 at 229:

“A prerequisite for the defence of consent is that the complainant's consent covered the harm that is the subject matter of the charge. A person cannot consent to run a risk of which he or she is unaware.”

In law, a person has capacity to consent if they “understand the nature of the act to which he or she is alleged to have consented.”⁵⁴ This is an assessment of a person’s cognitive ability, which can be impaired by youth, mental defect, intoxication or unconsciousness,⁵⁵ if the condition means that the person is unable to rationalise and make competent decisions. In this respect, Faden and Beauchamp argue that determining competence first requires assessors to identify “persons from whom it is appropriate to obtain informed consent”.⁵⁶

Hocrot notes that “cognitive function is related to a person’s reason or intellect, in other words his ability to perceive, to reason and to remember. Here the emphasis is on a person’s insight and understanding.”⁵⁷ Carstens and Pearmain note that capacity includes competence noting that it “refers to the functional ability to meet the demands of specific decision-making situations, weighed in light of its potential consequences.”⁵⁸ This leg of the inquiry assesses whether the patient is able to receive material information in a meaningful manner *and* whether they can rationalise the information and make a choice. The terms capacity and competency have come to be used interchangeably and in the context of medical-decision making are understood as referring to a patient’s capacity to make competent decisions (decision-making capacity).⁵⁹

Where a person lacks decision-making capacity for any of the above stated reasons, the law accepts proxy-consent by a third party who is in law authorised to make decisions on the person’s behalf. In the case of minors, this would usually be a parent or guardian, and in the case of adults, their next of kin. This also necessarily means that the proxy-decision maker must have been given the relevant information to empower them to make a ‘real’ decision. In this sense, the decision-making capacity of the decision maker speaks to the quality of consent they are able to give, which is also dependent on the information provided.⁶⁰ In this way,

⁵⁴ Burchell *Principles of Criminal Law* 5ed op cit note 8 at 223.

⁵⁵ Carstens & Pearmain op cit note 1 at 898-899:

“Provided they are sane and sober, adults have the capacity validly to consent to medical interventions...Generally incapacitated patients, such as patients in the state of unconsciousness, intoxication, delirium, trance, shock or coma, may be incapable of consenting in law.”

See Section 8 of the National Health Act 61 of 2003 - where patients lack decision-making capacity, fictional/substituted consent is applied, including cases of medical emergency where failing to treat would result in harm to the patient or the public.

⁵⁶ RR Faden and L Beauchamp *A History and theory of informed consent* at 274:

“Judgements of competence, we argue, primarily serve a gatekeeper function by identifying persons from whom it is appropriate to obtain informed consents.”

⁵⁷ Hocrot *Snyman’s Criminal Law* 7ed op cit note 18 at 138.

⁵⁸ Carstens & Pearmain op cit note 1 at 879.

⁵⁹ J Hawkins and L C Charland ‘Decision-Making Capacity’ (2020) *Stanford Encyclopedia of Philosophy*.

⁶⁰ *Esterhuizen v Administrator, Transvaal* at 719:

“Generally speaking...to establish the defence of *volenti non fit injuria* the plaintiff must be shown not only to have perceived the danger, for this alone would not be sufficient, but also that he fully appreciated it and consented to incur it...Indeed if it is to be said that a person consented to bodily

determining whether a capacitated person has made a competent decision relies on whether they are able to process the information provided specific to the situation at hand - whether the person demonstrates understanding and appreciation of the information provided.⁶¹

Where an adult has decision-making capacity, the law accepts the decision made, even (objectively) bad ones.⁶² This allows decision-making capacity to serve as the threshold of autonomy. Strauss notes that

“The mentally competent individual’s right to control his own destiny in accordance with his own value system, his *selfbeskikkingsreg*, must be rated even higher than his health and life. To put it in slightly different terms: if there is a conflict between the desire of a person to go his own way, to forego medical treatment and to expire in his own manner, on the one hand, and the desire of the doctor to cure him of his disease or to secure his health, on the other, the former should be accorded preference. There is neither a general right not a general duty on the part of a person to protect another against himself.”⁶³

3.3 CONSENT THROUGH THE MEDICAL PRACTICE GUIDELINES

In South Africa, the National Health Act⁶⁴ (NHA) holds patient consent and autonomy as a central feature and goal in its designated purpose of meeting constitutional obligations in offering health care services which respect a patient’s rights to dignity, autonomy and bodily integrity.⁶⁵ This includes the right not to be subjected to medical treatment without a patient’s consent.⁶⁶ This is further endorsed and elaborated upon in the Health Professions Council of South Africa’s (HPCSA) various ethical guidelines.⁶⁷ Before the advent of the Constitution and

harm or to run the risk of such harm, then it presupposes, so it seems to me, knowledge of that harm or risk; accordingly mere consent to undergo X-ray treatment, in the belief that it is harmless or being unaware of the risks it carries, cannot in my view amount to effective consent to undergo the risk or the consequent harm.”

⁶¹ J Karlawish ‘Assessment of decision-making capacity in adults’ *UpToDate* (2023) available at [Assessment of decision-making capacity in adults - UpToDate](#) accessed on 24 April 2023:

“The law and ethics have settled on four decision-making abilities that constitute capacity: understanding, expressing a choice, appreciation, and reasoning. A formal assessment of an individual’s decision-making abilities in the context of a specific medical decision constitutes an assessment of capacity; the capacity assessment focusses on a person’s ability to transact a decision about a particular set of options.”

⁶² Subject of course to the proviso described in 3.2.1 above.

⁶³ Strauss *Doctor, Patient and the Law* op cit note 13 at 31.

⁶⁴ Act 61 of 2003, section 8.

⁶⁵ Section 12(2) of the Constitution provides that

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

⁶⁶ The National Health Act 61 of 2003, section 7.

⁶⁷ These guidelines can be accessed via https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf.

the enactment of the NHA, the principle of patient autonomy and informed consent was confirmed in the case of *Stoffberg v Elliott*⁶⁸ and endorsed in subsequent cases,⁶⁹ as being a right protected by law, based on the maxim *volenti non fit injuria* as well as a patient's right to bodily integrity.⁷⁰ Through these cases the courts explicitly rejected medical paternalism⁷¹ and endorsed patient autonomy as a fundamental right, confirming that the requirements for informed consent apply to the medical profession as well; even before those rights were enshrined in the Constitution and codified in the NHA.⁷² Burchell notes that

“In South African law, the general ground for the justification of medical operations on and treatment of a patient is the voluntary, informed consent of that patient. Civil cases indicate that a medical practitioner in South Africa has the duty to inform a patient of the ‘material’ risks of harm attendant upon medical procedures. The word ‘material’ is conveniently supplied to be able to qualify the chance of the risk materializing and the gravity of the harm if it does materialize.”⁷³

In the medical context, the body of law and medical ethics guidelines cater for individual autonomy in that it requires patient consent to any form of treatment, without which the

⁶⁸ *Stoffberg v Elliot* supra note 47.

⁶⁹ *Castell v De Greef* 1993 (4) SA 408 (C); *Richter v Estate Hammann* 1976 (3) SA 226 (C).

⁷⁰ *Stoffberg* supra note 47 at 148-150:

“In the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or upon contract, but they are rights to be respected, and one of those rights is absolute security of the person...Any bodily interference with or restraint of a man's person which is not justified, or excused or consented to is a wrong...[A] man by entering a hospital does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary...He remains a human being, and he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to, and...any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body and is a wrong entitling him to damages if he suffers any.”

⁷¹ K D Bolton ‘Informed consent’ (2012) 11 *SA Orthopaedic J* at 108:

“The American Courts began to set precedents in this area in the early 20th century. In a landmark case in 1914, (*Schloendorf v. Society of New York Hospital*) Justice Cardozo stated, ‘Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an insult for which he is liable in damages...’ He noted that exceptions may be made in true emergencies and in the unconscious patient. Prior to this time, and since the days of Hippocrates, doctors practiced their art under a cloak of benign paternalism. Paternalism (or as the more gender-sensitive community would have it: parentalism) implies acting for the good of another person without that person's consent, ‘as parents do for children’. In Kantian terminology the end is benevolent while the means are coercive. Paternalism, by its very nature, interferes with individual autonomy. In the medical research arena, the recognition of the rights of subjects to autonomy and informed consent was enshrined in the judgement against Nazi doctors at Nuremburg and has been refined in the Helsinki protocols and other more recent ethical doctrines and policies.”

⁷² FFW Van Oosten ‘*Castell v De Greef* and the doctrine of informed consent: medical paternalism ousted in favour of patient autonomy’ (1995) 28 *De Jure* 164; K Stern ‘Competence to refuse life-sustaining medical treatment’ (1994) 110 *L Q Rev* 541.

⁷³ Burchell *Principles of Criminal Law* 5ed op cit note 8 at 333.

treatment is unlawful.⁷⁴ The law and the medical profession respect the right to make choices as well as the choices made. Both schools of thought are on common ground when it comes to the requirements for consent to render medical treatment (including harms suffered as a result of such treatment) lawful. As a ground of justification, consent places obligations on the person who intends to rely on consent as a defence. The general principles established in law regarding the applicability of consent as a defence apply to medical treatment and have been endorsed through various ethics policy documents which refer holistically to the requirements under the broad heading of ‘informed consent.’

3.3.1 *The treatment must be ethically and legally permissible*

This requirement coincides with the first legal requirement for consent to qualify as a defence. Booklet 7, *Guidelines for the Withholding and Withdrawing of Treatment*⁷⁵ and Booklet 17, *Guidelines on Palliative Care*⁷⁶ deal with VAE and conduct which falls within the PE spectrum. Regarding VAE, the guidelines state that euthanasia and physician-assisted suicide are prohibited in law⁷⁷ (even where a request has been made by a patient)⁷⁸ and is also prohibited in medical practice as it is “contrary to the ethics of health care and [is] unlawful.”⁷⁹ As such, a physician cannot rely on patient consent where a patient has voluntarily requested PAE or PAS. The HPCSA maintains that VAE is unethical because “it is inconsistent with the

⁷⁴ The Constitution of the Republic of South Africa, 1996, Section 12(2)(b); The National Health Act 61 of 2003, sections 6 and 7; *Castell v De Greef* 1994 (4) SA 408 (C). Exceptions to the rigours of obtaining informed consent do exist, but where other grounds for justification, for example necessity or emergency do not present, failing to obtain a patient’s informed consent would in the main be a violation of their right to dignity as well as the right to bodily and psychological integrity; it could also amount to a criminal offence.

⁷⁵ HSPCA (2016), available at https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf accessed on 20 October 2021.

⁷⁶ HSPCA (2019), available at https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf accessed on 20 October 2021.

⁷⁷ Booklet 17 *Ethical Guidelines on Palliative Care* (2019) at paras 9.2 and 9.3:

“9.2 Euthanasia and doctor-assisted suicide are often perceived as inconsistent with the principle of non-maleficence. 9.3 Euthanasia and doctor-assisted suicide are presently prohibited under South African law, and the courts frequently do not distinguish between the two when it comes to culpability.”

⁷⁸ This brings VAE within the ambit of ‘euthanasia’ as discussed in the guidelines. See Booklet 17 *Ethical Guidelines on Palliative Care* (2019) at paras 7.2.6, 7.2.8 and 9.6.

⁷⁹ Booklet 7 *Guidelines for the Withholding and Withdrawing of Treatment* op cit note 57 at para 1.2:

“The guidance which follows is intended to provide an ethical framework of good practice for health care practitioners in circumstances where they are faced with making a decision on whether to withhold or withdraw life-prolonging treatment. It is based on those areas of broad consensus so far established and recognises the need to ensure that patients can die with dignity and that their families and others close to them are appropriately involved in their care. It takes account of existing law in this area, that allowing for withholding and withdrawing of life sustaining treatments and that which prohibits killing, active euthanasia, and assisted suicide. It is, therefore, based on the premise that any medical intervention where the health care professional’s primary intention is to end the patient’s life is both contrary to the ethics of health care and unlawful.”

principle of non-maleficence,”⁸⁰ particularly in that VAE causes a grave harm (death). This ethical principle requires physicians not to harm their patients, and is colloquially understood as the ‘first do no harm’ principle. “This principle, however, offers little useful guidance to physicians since many beneficial therapies also have serious risks. The pertinent ethical issue is whether the benefits outweigh the burdens.”⁸¹ It involves an assessment of the purpose that the treatment is meant to achieve when harm is inadvertently caused, and if the purpose is beneficial or therapeutic, then the harm caused has been caused ethically.⁸²

In contrast to VAE, Booklet 17, *Ethical Guidelines on Palliative Care*⁸³ states palliative care and the withholding or withdrawing of treatment are forms of conduct that can be consented to,⁸⁴ which means that patients with decision-making capacity can consent to a hastened death.⁸⁵ In context then causing death in the circumstances described is conduct that is not *contra bonos mores* and for this reason, can be consented to.⁸⁶ Because VAE is, in terms of medical practice guidelines and the law *contra bonos mores*, patients and physicians cannot rely on consent to justify this type of death-causing conduct.

3.3.2 Consent must be real and informed

Where conduct is the type that can be consented to, for the consent to be operable, it must have been obtained appropriately. So although the law through the NHA recognises a patient’s right to autonomously decide on a course of treatment, regardless of the risk, the proviso is that the

⁸⁰ Booklet 7 *Guidelines for the Withholding and Withdrawing of Treatment* (2016) op cit note 79.

⁸¹ ‘Nonmaleficence’ *Pallipedia* [5 July 2016], available at <https://pallipedia.org/nonmaleficence/>, accessed on 21 October 2021.

⁸² P D Motloba ‘Non-maleficence – a disremembered moral obligation’ (2019) 74(1) *SA Dental J* 40-42 at 40: “Simply put, a clinician’s harmful actions may not be deemed morally or legally wrong provided they are aligned with specific rules of non-maleficence or are not superseded by other moral principles. Causing some harm in order to benefit the patient may be desirable, necessary and justifiable. Clinicians often face serious moral and ethical dilemmas in which they have to determine whether the harm they may cause is justified in terms of any associated possible benefits to the patient. According to the Catholic doctrine of the rule of ‘double effects’, clinicians are obligated to consider jointly the principles of beneficence and non-maleficence when making clinical decisions. It is therefore incumbent on clinicians to assess the risks or the occurrence of inadvertent and yet predictable untoward effects of a prescribed intervention. Additionally, the clinician must assess the benefits of the intervention primarily to the patient, before considering other parties such as family and society. Armed with these facts, it is obligatory for clinicians to balance anticipated benefits against risks and harm as evaluated by patients, society and normatively by clinicians. Without this information the patients may be placed in harm’s way.”

⁸³ Op cit note 77.

⁸⁴ Booklet 17 *Ethical Guidelines on Palliative Care* op cit note 76 at para 1.2.3.

⁸⁵ Booklet 17 *Ethical Guidelines on Palliative Care* op cit note 76 at para 8.2.3:

“Treatment can legally and ethically be withheld or withdrawn if the patient refuses further treatment, further treatment is futile, or if it is no longer in the patient’s best interests (e.g. when treatment merely prolongs the dying process).” See discussion below for instances where despite the fact that a patient may not be able to personally consent, treatment is rendered lawful by proxy-consent.”

⁸⁶ *R v Adams* 1957 Crim LR 365; *Clarke v Hurst* NO 1992 (2) SA 630 (D).

physicians must provide patients with sufficient information to empower them to make a decision.⁸⁷ In this sense, consent provides a justification for harms caused when what is given is informed consent and not mere agreement or submission. This places a duty on the physician to ensure that patients are adequately informed. Bolton notes that

“Except in the case of an emergency, a doctor/healthcare worker must obtain a patient’s agreement (informed consent) to any course of investigation, treatment or research. Doctors are required to tell the patient anything that would substantially affect the patient’s decision. Such information typically includes the nature and purpose of the treatment, its risks and consequences and alternative courses of treatment. In South African law any and all investigation and treatment of patients constitutes assault but this assault is condoned by proper informed consent.”⁸⁸

Booklet 1 of the HPCSA ethical guidelines, *General Guidelines for Health Care Professions*⁸⁹ holds that a patient’s consent is real and informed when physicians

“give information to their patients in the way they can understand it. The information given must be in a language that the patient understands and in a manner that takes into account the patient’s level of literacy, understanding, values and belief systems.”⁹⁰

Even if the treatment is needed and can be remedial and therapeutic, if it is refused or another option is elected, the patient’s choice must be respected and adhered to by the physician,⁹¹ unless there is some other reason that would suggest that the patient lacks decision-making capacity.⁹²

⁸⁷ HPCSA Ethics Booklet at https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf, accessed on 20 October 2021.

⁸⁸ KD Bolton ‘Informed consent’ (2012) *SA Orthop. J.* 11(3) 108-110 at 108.

⁸⁹ HPCSA *Ethical Guidelines for Good Practice in the Health Care Professions: Booklet 1: General Ethical Guidelines for Health Care Professions* (2016) https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf, accessed on 20 October 2021.

⁹⁰ HPCSA Booklet 1 op cit note 89 at para 5.3.2.

⁹¹ Carstens & Pearmain *Foundational Principles of South African Medical Law* op cit note 1 at 882:

“Patient autonomy as a fundamental right has been endorsed and medical paternalism rejected. The ultimate decision to undergo (informed consent) or refuse (informed refusal) a medical intervention lies with the patient and not with the physician. This applies even if, from the point of view of the medical profession, a refusal by the patient to undergo the proposed intervention would be grossly unreasonable and might result in his or her death.”

HPCSA *Ethical Guidelines for Good Practice in the Health Care Professions: Booklet 4: Seeking Patients’ Informed Consent: The Ethical Consideration* (2016), available at https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf accessed on 20 October 2021 at para 8.1.2

“If a patient’s choice appears irrational, or does not accord with the health care practitioner’s view of what is in the patient’s best interests, this is not evidence in itself that the patient lacks competence.”

⁹² JV Welie and SP Welie ‘Patient decision-making competence: outlines of a conceptual analysis’ (2001) 4 *Med Health Care Philos* 127 at 129:

“it is generally believed that patients...carry final responsibility for their own health care (or at least the acceptance or refusal thereof). If a patient refuses much needed medical care, no one but the patient is responsible for that decision. Patients have a right to be left alone. We can only hold persons

3.3.3 The patient must have capacity

The HPCSA guidelines on informed consent⁹³ endorse the legal standard and specifically state that

“8.1.1 Health care practitioners must work on the presumption that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand information presented in a clear way.”⁹⁴

So in this respect, the assessment of capacity is actually an assessment of individual competency, determined by whether a patient understands the information provided⁹⁵ and thus assesses a patient’s decision-making capacity. It focuses on factors which could be impeding a patient’s ability to make a decision. Once information has been given, a physician must be satisfied that the information has been understood and to gauge competency⁹⁶ doctors ask

responsible (for their choices) if they could have made a different decision and if they were free and able to reach a different decision. Competence is the patient’s ability to make a choice about the various medical interventions offered to him by the caregiver, and to bear accountability for that choice.”

⁹³ HPCSA *Ethical Guidelines for Good Practice in the Health Care Professions: Booklet 4: Seeking Patients’ Informed Consent: The Ethical Consideration* (2016), available at https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf accessed on 20 October 2021.

⁹⁴ Booklet 4 op cit note 93 at para 8.1.1.

⁹⁵ BL Mishara and DN Weisstub ‘The legal status of suicide: a global review’ (2015) 44 *International Journal of Law and Psychiatry* 54 at 58 note that:

“In embracing, in very limited and restricted conditions, the right of a person to have “another”, namely medical practitioners, to assist in ending one’s life, the Supreme Court has underlined certain essential social values that it claims are a part of, as we have already observed, both constitutional and common law decisions. That is to say, they do not conclude that they have made a new law but rather, consolidated prevailing trends. In Canadian law as elsewhere there is no governmental interference with persons who refuse medical lifesaving treatment, as it is considered a first principle that one has bodily integrity and the right to decide about one’s future, even over and against sound medical advice. The decision does not go so far as to indulge the possibility that ordinary citizens could take on the interventionist responsibility once called upon by a person suffering from irremediable and unbearable illness and whose competency is beyond reproach. Where there is a compromise of intelligence or judgement, i.e. incapacity, there are means and measures already existing in law that are meant to protect vulnerable populations. In deferring to the responsibility of the federal Parliament and the Provincial Legislatures to frame and develop legislative provisions following *Carter v. Canada*, the Supreme Court has made it clear that it is in the hands of the public conscience through their representatives to fix the contours that are a part of a civilised society that has at its centre a commitment to the respect for personhood.”

⁹⁶ Bolton ‘Informed Consent’ op cit note 88 at 109:

“A number of criteria should be considered in the evaluation of the decision-making capacity of the patient. These include:

- The recognition of choices and selection of one option. Frequent vacillation may indicate lack of capacity.
- The understanding of relevant information. The patient should be able to paraphrase the benefits and risks of the options.
- The appreciation of the medical situation and the consequences of actions or inactions. Denial is a common cause for impairment.
- The rational manipulation of information regarding options. This looks at the process by which a choice is made. Remember, the competent patient still has the right to make an ‘unreasonable choice’.”

patients to explain in their own words what they understand the information provided to mean. The patient must be able to show recall of the information, that they have made a choice, why they made a particular choice, and that they understand what the effect is of their choice.⁹⁷ In the light of these principles a physician would have to be satisfied that the patient's decision was truly voluntary because the patient was, first able to understand; second, did understand and appreciate the information provided; and third, was able to rationalise and make a choice.

Sometimes patients may choose a course of action which objectively does not seem reasonable. However, just because a patient has decided contrary to what the physician believes would be in the patient's best interest, or if another option would prove medically to be more efficacious, does not necessarily mean that the patient lacks competency.⁹⁸ In such a case, physicians are required to consult further with the patient to ensure that all their information needs have been met. This essentially requires physicians to go back to the informed consent stage. If after such consultation there is still doubt about a patient's capacity, then psychologists can be consulted to assess competency.⁹⁹ After such consultations, where a patient is proved to be competent, then the treatment option made by the patient must be followed.

Sometimes a patient's ability to make decisions is impeded but this does not automatically mean that the patient is not able to meaningfully participate in decision-making.¹⁰⁰ Key to this is whether the impediment is temporary, permanent or fluctuating, and nuanced ways of obtaining consent for treatment may have to be devolved to proxy-decision

⁹⁷ Doctors must frame their questions such that they invite a fuller response rather than a simple "yes/no". "Tell me what you understand by..." Words like "What", "How", "Why", and "Tell me" are good for framing open-ended questions." See 'Consent to medical treatment in South Africa: an MPS guide' (2010) 7 op cit note 90. See also Carstens & Pearmain *Foundational Principles of South African Medical Law* op cit note 1 at 883:

"Pivotal to the application of the doctrine of informed consent in South African medical law, is an understanding of the broader purpose and function of the doctrine. According to Van Oosten these are twofold:

- To ensure the patient's right to self-determination and freedom of choice; and
- To encourage rational decision-making by enabling the patient to weigh and balance the benefits and disadvantages of the proposed intervention in order to come to an enlightened choice to undergo or refuse it."

⁹⁸ Booklet 4 op cit note 93 at para 8.1.2

"If a patient's choice appears irrational, or does not accord with the health care practitioner's view of what is in the patient's best interests, this is not evidence in itself that the patient lacks competence."

Bolton 'Informed Consent' op cit note 88 at 109:

"Remember, the competent patient still has the right to make an 'unreasonable choice'."

⁹⁹ Booklet 4 op cit note 93 at para 8.1.3.

¹⁰⁰ Booklet 4 op cit note 93 at para 8.2.1:

"Where patients have difficulty retaining information, or are only intermittently competent to make a decision health care practitioners should provide any assistance they might need to reach an informed decision."

makers.¹⁰¹ The NHA¹⁰² allows for decision-making to be mandated to a person authorised by a patient in writing to do so on his or her behalf, or by anyone who has by legislation or a court order been given such capacity.¹⁰³ In such a case, reference is had to the presumption of what is in the patient's best interests based on what a reasonable person would consent to.¹⁰⁴ It is submitted that regardless of what a reasonable person would choose, it would still be necessary that the option elected by proxy is the one that least intruded into or affected the patient's future choices, and necessarily implies its effect on a patient's *ability* to make *future* choices once they regain capacity.¹⁰⁵ It is only in cases of clear futility, and where a patient would never be able to regain capacity, for example cases of a persistent vegetative state as in *Clarke v Hurst NO*,¹⁰⁶ where a proxy decision could be made that would hasten a patient's death provided that it is in the patient's best interests. This then raises a further question, when would it be in a patient's best interest to cause their death?

The HPCSA *Guidelines for Withholding and Withdrawing of Treatment*¹⁰⁷ focus on the ethical nature of withdrawing and withholding treatment¹⁰⁸ of patients who lack decision-making capacity at the relevant time.¹⁰⁹ Where the patient has previously expressed their

¹⁰¹ A le Roux-Kemp 'Deferred consent in emergency care research: A comparative perspective of South African Regulations' (2014) *The Journal of Philosophy, Science & Law: RCR Special Issue* 14 47-62 make observations regarding challenges in obtaining voluntary consent in emergency care related to research participants, observing at 47-48 that:

"While some researchers suggest that an independent physician should provide consent on behalf of the patient, others submit that the subject's deferred consent should be obtained at a time when the subject is able to provide it. Or, that the subject's legal representative should give his/her deferred proxy consent as soon as the representative had been located and been informed of the material benefits and risks of the study. Yet, many researchers submit that these approaches are opportunistic at best and that consent should rather be waived completely for the purposes of ECR."

¹⁰² National Health Act 61 of 2003, section 7.

¹⁰³ This opens up the possible acceptability of advanced directives, powers of attorney, and legally recognised next of kin, as proxy decision makers in limited circumstances.

¹⁰⁴ S Anthony 'Consent to Medical Treatment in South Africa – An MPS Guide' (2012) available at <https://www.medicalprotection.org/southafrica/advice-booklets/consent-to-medical-treatment-in-south-africa-an-mps-guide> note 44:

"If the patient has never been mentally competent, or if his or her beliefs, values and preferences are unknown, the best interests principle should be applied by choosing the option a reasonable person would be most likely to prefer".

¹⁰⁵ HPCSA Booklet 17 op cit note 76 at para 7.3.11.5:

"Where more than one treatment option is reasonably in the patient's best interests, the practitioner must, in consultation with the patient or the patient's surrogate, choose the option that least restricts the patient's future choices."

¹⁰⁶ *Clarke v Hurst NO* 1992 (4) SA 630 (D).

¹⁰⁷ HPCSA *Guidelines for Withholding and Withdrawing of Treatment*, Booklet 7 (2016).

¹⁰⁸ Outside of cases where patients are clinically dead.

¹⁰⁹ "7.1.1 Where a patient is competent to participate in decision-making, health care practitioners must discuss with the patient their conclusions about diagnosis, prognosis and which options they consider may be in the patient's best interests. *It is for the patient to judge what might be acceptable*; what weight or priority to give to any burden or risks; and to decide which of the options would be in his or her best interests.

wishes regarding treatment options, those are followed,¹¹⁰ but where such prior or advanced direction has not been given, there are guidelines for substituted decision-making, which can include a decision to withdraw treatment knowing that it will hasten death. This power vests in a proxy decision-maker (a guardian, next of kin, a senior clinician, or the court)¹¹¹ to decide what is in the patient's best interests.¹¹²

In light of the ethical principles of beneficence and non-maleficence, and the ethical guidelines above, where patients lack capacity and competency, it would be ethical to hasten their deaths, despite a lack of personal capacity and competency if "further treatment is futile, or if it is no longer in the patient's best interests (e.g. when treatment merely prolongs the dying process)."¹¹³ Harris notes that

"End of life decisions, whether they amount to euthanasia as it is usually understood...- for example, as involving a positive act intended to result in a merciful death or, more simply but no less certainly, involving decisions to withhold or withdraw treatment – are often taken about individuals whose consent is either unavailable or problematic".¹¹⁴

7.1.2 Health care practitioners should bear in mind that the *decisions of competent adult patients* to refuse a particular medical intervention *must be respected*, even where this would result in serious harm to them or in their own death."

¹¹⁰ Booklet 7 op cit note 107 at paras 8.1.1 – 8.1.3:

"8.1.1 In most cases where the dying process itself affects the patient's mental capacity, the correct course of action for the patient should have been decided previously. Where no such advance management plan had been agreed, or the plan has not been reviewed recently, or is not relevant to the patient's current condition, health care practitioners are advised as follows:

8.1.2 Where patients have difficulty retaining information, communicating their views, or are only intermittently competent, health care practitioners should provide any assistance a patient might need to enable him or her to reach and communicate a decision.

8.1.3 Where there are doubts about a patient's capacity at making a decision, health care practitioners should consult with the relevant health care practitioner taking into account any legal tests of capacity."

¹¹¹ Bolton 'Informed consent' op cit note 88 at 110:

"The standard used in the case of an incapacitated adult, who was previously competent, is that of substituted judgement. In this process, the next-of-kin are usually called on to give surrogate consent. They are asked to act in a way that they believe that the patient would have acted had he/she been competent...In each case, the substituted judgement standard requires that the surrogate decision-maker (whether a guardian, a family member, or the court) determine whether the patient, if competent, would have consented to the proposed health care."

¹¹² Booklet 7 op cit note 107 at paras 8.2.2.1 – 8.2.2.4:

"8.2.2.1 The senior clinician should consult the patient's authorised representative *if* such a person was appointed.

8.2.2.2 The clinician should also consult the health care team and the patient's authorised representative and, wherever possible, those close to the patient. The latter may be able to provide insights into the patient's preferences, and be able to offer an opinion on what would be in the patient's best interests...

8.2.2.4 If the patient is new to the health care practitioner at the time decisions are needed, the health care practitioner must satisfy himself or herself whether or not such consultations have previously been carried out and if so, find out what had been agreed."

¹¹³ Booklet 17 op cit note 76 at para 8.2.3.

¹¹⁴ J Harris 'Consent and end of life decisions' (2003) 29 *J Med Ethics* 10-15.

And yet, in South African law, problematic consent does not bar PE practices from being rendered lawful and ethical, even in cases where a patient lacks competency. This is

“because of the relative frequency of circumstances in which valid consents are unobtainable the law has contrived...various fictional consents to protect well intentioned practitioners from the guilt of unlawful conduct.”¹¹⁵

Either consent matters or it does not. If it does, there must be some kind of justification for the course of action intended to be embarked on. In its truest sense, consent must and can only be given by the person whom the course of action is meant to affect, and so in circumstances where patients are unable to consent personally, proxy consent can be referred to.

While “the chief concern of the criminal law is to prohibit behaviour that represents a serious wrong against an individual or against some fundamental social value or institution,” it is clear that the act of withdrawing and withholding treatment which, even though it hastens death, does not represent a wrong that is worthy of criminal prohibition and sanction.¹¹⁶ The real reason why patients can consent to death in PE cases and not in VAE ones, therefore is that PE is socially acceptable while VAE is not.¹¹⁷

3.4 VULNERABILITIES, CONSENT AND END-OF-LIFE DECISION MAKING

A concern is that patients consenting in VAE cases do not give real consent because they are vulnerable, even when they have been presented with the relevant information. The counter-argument is that patients consenting in PE cases are no less vulnerable than those in VAE.¹¹⁸ The current medical ethical guidelines cater for considerations of vulnerability, decisional or otherwise. This was argued and examined in *Carter v Canada*:¹¹⁹ that patients might be making

¹¹⁵ Harris ‘Consent and end of life decisions’ op cit note 114 at 11.

¹¹⁶ Carstens & Pearmain op cit note 1 at 936-937:

“*Clarke* is not authority for legal recognition of the so-called Living Will. Taitz states that it is interesting to note the evidence led in *Clarke* to the effect that the patient (a qualified medical practitioner) was a life member of SAVES (the South African Voluntary Euthanasia Society). He had signed a ‘living will’: a document directing that should he in the future contract a terminal illness with no hope of recovery or become permanently unconscious, he must not be kept alive by artificial means but be allowed to die. Taitz points out that Thirion J stated that these statements undoubtedly stemmed from a settled, informed and firmly held conviction on the patient’s part that should he ever be in the condition in which he has been since the cardiac arrest no effort should be made to sustain his life by artificial means. None the less the judge placed no emphasis on these directions neither did he rule on the validity of the “living will”. The reason for this, says Taitz, probably lies in the fact that as yet the “living will has not yet been recognized in South African law.”

¹¹⁷ MLJ Koenane ‘Euthanasia in South Africa: Philosophical and theological considerations’ (2017) 38(1) *Verbatum et Ecclesia* a1549, available at http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S2074-77052017000100004, accessed on 6 June 2022. Koenane notes that there is no distinction between PE and VAE in the causation context when viewed in the light of any difference between acts and omissions, but rather solely on the basis of a moral argument for what forms of causing death are morally (socially) accepted.

¹¹⁸ *Carter v Canada (Attorney General)* 2015 (SCC) 5; [2015] 1 SCR 331.

¹¹⁹ *Carter v Canada* supra note 118.

decisions under conditions of emotional pressure which meant that they were vulnerable and therefore not competent to make decisions; therefore, the blanket prohibition on consent to death should be maintained.¹²⁰ In other words, because patients might be making decisions in emotional circumstances which may also include severe pain, may mean that their capacity to consent is impaired where a concern is that these factors affect the quality of their consent. One must also be vigilant that in relation to pain and requests for VAE, a criteria is that a patient must be in severe pain to qualify for it.¹²¹

In *Carter v Canada* the applicant was diagnosed with fatal neurodegenerative disease, which, as the disease progressed would affect her ability to chew, swallow, speak, and eventually breathe. In the main, the application she brought was for a court to permit her to consent to a medically assisted death. At the time, assisted suicide was criminalised under s 14 of the Criminal Code. The result would be that any physician who assisted her to die would be criminally prosecuted, and would not be able to rely on her consent as a defence. Specifically, on the issue of the quality of consent and vulnerability, the arguments raised by the State were:

“there are many possible sources of error and many factors that can render a patient “decisionally vulnerable” and thereby give rise to the risk that persons without a rational and considered desire for death will in fact end up dead. It points to cognitive impairment, depression or other mental illness, coercion, undue influence, psychological or emotional manipulation, systemic prejudice (against the elderly or people with disabilities), and the possibility of ambivalence or misdiagnosis as factors that may escape detection or give rise to errors in capacity assessment”.¹²²

These concerns were by no means trivial, and it was further argued that “given the breadth of this list, there is no reliable way to identify those who are vulnerable and those who are not. As a result...a blanket prohibition is necessary”¹²³ as it was the only guaranteed way of ensuring that all patients are protected. Rejecting the argument, the court concluded that “vulnerability

¹²⁰ *Carter v Canada* supra note 118 at para 114. See also Y Kamisar ‘Some non-religious views against proposed ‘mercy-killing’ legislation Part 1’ (1976) 2(2) *Hum Life Rev* 71-114.

¹²¹ *Carter v Canada* supra note 118 at para 68:

“...it is clear that anyone who seeks physician-assisted dying because they are suffering intolerably as a result of a grievous and irremediable medical condition ‘does so out of a deeply personal and fundamental belief about how they wish to live, or cease to live. The trial judge, too, described this as a decision that, for some people, is ‘very important to their sense of dignity and personal integrity, that is consistent with their lifelong values and that reflects their life's experiences’. This is a decision that is rooted in their control over their bodily integrity; it represents their deeply personal response to serious pain and suffering.”

See also B Chan and M Somerville ‘Converting the “right to life” to the “right to physician-assisted suicide and euthanasia”: An analysis of *Carter v Canada* (Attorney General), *Supreme Court of Canada*’ (2016) *The Medical Law Review* 24(2) 143-175.

¹²² *Carter v Canada* supra note 118 at para 114.

¹²³ *Carter v Canada* supra note 118 at para 114.

can be assessed on an individual basis, using the procedures that physicians apply in their assessment of informed consent and decisional capacity in the context of medical decision-making more generally”.¹²⁴ The court drew an analogy with the assessment of decision-making capacity of patients who consented to PE, and noted that:

“Logically speaking, there is no reason to think that the injured, ill, and disabled who have the option to refuse or to request withdrawal of lifesaving treatment, or who seek palliative sedation, are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying. The risks that Canada describes are already part and parcel of our medical system”.¹²⁵

In South Africa, just as in Canada, adult patients have capacity and are presumed to be competent to consent to treatment in the form of PE, unless proven otherwise.¹²⁶ Their consent is not rendered invalid due to nature of their illness nor the pain levels they are experiencing. In relation to assessing vulnerability and decision-making particularly in relation to PE, the HPCSA guidelines recognise that

“Discussions about the possibility of withholding or withdrawing a potentially life-prolonging treatment may be difficult and distressing. However, this does not mean that such discussions should be avoided. Instead, the discussions should be handled sensitively and with appropriate support being provided to the patient. Health care practitioners should also consult with those close to the patient about the best means of withholding or withdrawing treatment where this is appropriate”.¹²⁷

Further, the guidelines recognise that patients “faced with life-threatening illnesses, are likely to be vulnerable and anxious”¹²⁸ but regardless, if they make an informed decision regarding treatment that can hasten their deaths, their decision is still valid and competent despite such vulnerability. It is submitted that patients who consent to PE are equally as “vulnerable” as those who request VAE. Where a concern raised is that patients make decisions based on the level of pain they are enduring, a way to mitigate this would be if discussions about pain management and more acutely end-of-life care and planning, were to occur earlier rather than later. It is clear that the HPCSA acknowledges that patients who are faced with making decisions about PE may be encountering emotional and other pressures, but this alone does not mean that patients lack decision-making competence. In an effort to deal with concerns of decisional vulnerability, continued counselling and discussion between the doctor and the

¹²⁴ *Carter v Canada* supra note 118 at para 115.

¹²⁵ *Carter v Canada* supra note 118 at para 115.

¹²⁶ Op cit note 121.

¹²⁷ Booklet 4 op cit note 93 at para 7.1.5.

¹²⁸ Booklet 17 op cit note 76 at para 6.2.

patient is encouraged. As long as the patient has legal capacity and demonstrates understanding, rationality and acquiescence, even after these discussions, there is no presumption in PE cases that the patient has made an incompetent decision or that they were ‘decisionally’ vulnerable. However, there is a difference between undue influence and decisional vulnerability and:

“It should be noted that these situations are different from cases concerning competence. The doctrine of undue influence does not question the person's ability to understand the choice that they made. Rather it looks at the issue of whether the decision was made freely, to the extent that it reflects the exercise of the person's autonomy”.¹²⁹

The court in *Carter v Canada* considered how the law and medical practice assess voluntariness, coercion and undue influence.¹³⁰ Similarly, in South Africa, the existing requirements for assessing the quality and genuineness of consent are currently effective for assessing the quality of consent and for detecting coercion in all medical decision-making.¹³¹ There is no indication that they are not, as the requirements for consent as they currently exist are being used and relied upon in life-and-death decision-making in PE. As such, as was proposed in *Carter v Canada*,¹³² the same assessment protocols and guidelines would be effective and applicable to VAE and could further be bolstered by additional requirements, for example further psychological assessments. Currently, for all other medical decisions, where a physician suspects that a patient lacks decision-making capacity because they appear confused or ambivalent,¹³³ mechanisms and processes are engaged to assess these. This has been the route adopted by permissive jurisdictions as well.¹³⁴

¹²⁹ C Stewart and A Lynch ‘Undue influence, consent and medical treatment’ (2003) 96(12) *J R Soc Med* 598-601 at 598.

¹³⁰ *Carter v Canada* 2015 SCC 5 at paras 26 and 106:

“The trial judge then considered the risks of a permissive regime and the feasibility of implementing safeguards to address those risks. After reviewing the evidence tendered by physicians and experts in patient assessment, she concluded that physicians were (currently) capable of reliably assessing patient competence, including in the context of life-and-death decisions... She found that it was possible to detect coercion, undue influence, and ambivalence as part of this assessment process... She also found that the informed consent standard could be applied in the context of physician-assisted death, so long as care was taken to ‘ensure a patient is properly informed of her diagnosis and prognosis’ and the treatment options described included all reasonable palliative care interventions... Ultimately, she concluded that the risks of physician-assisted death “can be identified and very substantially minimized through a carefully-designed system” that imposes strict limits that are scrupulously monitored and enforced...”

¹³¹ Booklet 4 op cit note 93 at para 3.4.2.9:

“Consent will not be informed if it was given as a result of duress, coercion, manipulation, misrepresentation or mental impairment (e.g. under the influence of alcohol, drugs, including premedication in the theatre).”

Health care practitioners are required to report unprofessional, illegal or unethical conduct – HPCSA Guidelines Booklet 2 *Ethical and Professional Rules of the Health Professions Council of South Africa* (2016) at para 25(1)(c).

¹³² *Carter v Canada* 2015 SCC 5.

¹³³ See Kamisar op cit note 120.

¹³⁴ Canada’s Medical Assistance in Dying Act, Oregon’s Death with Dignity Act: all require stricter informed consent requirements as well as reporting and documenting protocols. Which are more stringent than the current

The South African Law Reform Commission (SALRC) considered some of the reasons for not accepting consent in VAE in its report on *Euthanasia and the Artificial Preservation of Life*¹³⁵ and noted that patient anxiety and vulnerability could impact on the quality of consent:¹³⁶

“Labuschagne explains that the problem in this case is that the consent to euthanasia given by the patient while he is in pain, suffering and facing death, and accordingly in a state of anxiety and depression, may be questionable. Can it really be regarded as voluntary?”¹³⁷

However, Labuschagne answered his own question and posited that the concern raised could be mitigated through proper supervision and continuous consultation. This would be a way of gauging whether a patient has made a request for an assisted death under conditions of undue influence or duress.¹³⁸ The same question raised by Labuschagne applies in relation to patients who give consent in PE cases. However, as has been explained, matters of pain, suffering, depression or anxiety do not on their own mean that a patient in these circumstances has made an irrational or incompetent decision, or has succumbed to undue influence or coercion.

The court in *Clarke v Hurst NO* considered pain levels and consent, and noted that “It is indeed difficult to appreciate a situation, save where the patient is suffering unbearable pain or is in a vegetative state, where it would be in his best interests not to exist at all. The patient in the present case has, however, passed beyond the point where he could be said to have an interest in the matter. But just as a living person has an interest in the disposal of his body, so I think the patient’s wishes as expressed when he was in good health should be given effect to.”¹³⁹

The court was referring to the living will which the patient had made. In that document, the patient had expressed that he did not wish to be kept alive by artificial means. Although the court did not make a ruling on the validity or otherwise of such advance directives, and as such, the wishes expressed by the patient could only be respected if in the light of the legal convictions of society, hastening his death would be reasonable. In this case, although the court

guidelines on palliative care and withdrawing and withholding treatment. These options are discussed below here in.

¹³⁵ SALRC Issue Paper 71 (Project 86) *Euthanasia and the Artificial Preservation of Life* (1998).

¹³⁶ SALRC op cit note 133, paras 4.6 and 4.7. You can consent to real harm, provided that the harm is ‘minimal’. You cannot consent to ‘real’ harm if the harm is ‘serious’.

¹³⁷ SALRC op cit note 135 at page 87.

¹³⁸ SALRC op cit note 135 at page 87:

“Although Labuschagne concedes that since factors such as pain, illness, drugs and a range of other circumstances may have an effect of a person’s mental state, the patient should be evaluated throughout.” Labuschagne was in favour of legalising euthanasia provided that a patient has exercised autonomy and has given informed consent.

¹³⁹ *Clarke v Hurst NO* supra note 106 at 660.

permitted as lawful the cessation of the artificial feeding regimen which was serving to sustain the patient, it did so based not on consent or apparent consent, but rather on the social utility of keeping such patients in a state of stasis – suspended between life and death. What we can conclude is that PE, where a patient lacks capacity and competency to consent to the withdrawal or withholding of treatment and life sustaining measures, would be permissible if a patient had expressed this previously, or if they had not, the medical treatment was offering no therapeutic benefits. It is submitted that this PE practice has been properly decriminalised by placing it outside of the ambit of criminal law, through application of the consent doctrine on the one hand, and on arguments of social utility (where consent has not been given) on the other. Such conduct is permissible, provided that consent was given by the patient or his proxy and the decision to withhold and withdraw treatment which would hasten death is in the patient's best interests.¹⁴⁰

In relation to deaths hastened through the administration of palliative care, the court in *Clarke v Hurst NO*¹⁴¹ noted by way of an obiter remark that it would not be unreasonable or against the legal convictions of society for a doctor to prescribe pain-relieving drugs, even if the side-effect is that death would be hastened.¹⁴² For example, in cases where patients are conscious and require increasing amounts of pain-relieving medication, the risk of death resulting due to these increased doses must be explained to the patient. If the patient understands and accepts the risk then the doctor can administer or prescribe treatments which carry the risk of causing death. Although the court did not expressly state that the patient's consent would be required in cases of palliative care deaths, Thirion J did say that it would be lawful (justified/justifiable) if done “while following the precepts and ethics of his profession.”¹⁴³ The ethical precepts of the profession require that a patient gives informed consent to any treatment, including passive euthanasia practices like palliative/terminal

¹⁴⁰ J Horder *Ashworth's Principles of Criminal Law* 9 ed (2019) at 4:

“... they cannot prosecute unless the offence charged is actually laid down by statute or at common law. So we must consider the interaction between the law itself and the practical operation of the criminal process if we are to understand the social reality of the criminal law.”

¹⁴¹ *Clarke v Hurst NO* supra note 106.

¹⁴² *Clarke v Hurst NO* supra note 106 at 656.

¹⁴³ B Sneiderman and D McQuoid-Mason ‘Decision-making at the end of life: The termination of life-prolonging treatment, euthanasia (mercy-killing), and assisted suicide in Canada and South Africa’ (2000) 33 *CILSA* 193-209, at 199:

“Therefore whenever the family requests the termination of life-prolonging treatment on quality-of-life grounds, the physician cannot legally comply if he or she believes that such decision does not accord either with the wishes, or the best interests of the patient. This is very different from the situation when a mentally competent patient asks that life-prolonging treatment be terminated. When this happens, the patient is in effect terminating the physician's duty to treat.”

sedation which is acknowledged as a form of treatment which hastens death. While the patient in *Clarke* clearly lacked decision-making capacity at the relevant time, his wishes had been previously stated. What the applicant asked of the court was to be given decision-making powers which would permit her to be appointed as a proxy decision-maker, with the power to lawfully make a decision which would hasten the patient's death. The court ruled in her favour as the conduct she intended to undertake which would hasten the patient's death would be in his best interests.

Of palliative care and terminal sedation (palliative sedation), Cantor notes that both are formalised and accepted forms of medical treatment which do in fact hasten death.¹⁴⁴ With respect to patients that have the capacity to consent, for a physician to escape criminal liability in these situations would require consent on the part of the patient.¹⁴⁵

3.5 BONI MORES, CONSENT AND VOLUNTARY ACTIVE EUTHANASIA

The first barrier to allowing patients to access VAE is the *boni mores* issue. Our law is clear and settled that consent is never a defence to murder,¹⁴⁶ not even in cases of VAE.¹⁴⁷ In the context of VAE the blanket prohibition against consent as a ground of justification places a limit on patient autonomy and means categorically that a physician will never be able to escape criminal liability for death caused despite a patient having requested and consented to an assisted death.¹⁴⁸ The current formulation of the principle expressed in *Hartmann*, includes all persons, and does not readily imply that "person" means anyone other than a physician, or that in the particular context of VAE, consent avails as a defence.¹⁴⁹ In *Hartmann* the accused, a physician, was charged with murder in that he administered a lethal dose of Pentothal to the deceased, his father. The deceased was in the last stages of cancer and had been described as moribund. The accused stated in his statement to the police that the patient had requested, and

¹⁴⁴ N Cantor 'On hastening death without violating legal and moral prohibitions' (2006) 37(2) *Loyola Univ Chicago LJ* 407-431 at 418: "Another contemporary medical practice that offers a way to hasten death is called terminal sedation".

¹⁴⁵ *Airedale National Health Trust v Bland* (1993) 1 All ER 858 (HL) where the House of Lords held that medical treatment may be lawfully withheld from a patient with no hope of recovery even if it is known that the result will be that the patient will shortly thereafter die (at 871, 873-4, 876-7): Provided that responsible and competent medical opinion is of the view that it would be in the patient's best interests not to prolong his or her life by continuing with medical treatment which will be futile and will not confer any benefit on the patient (at 861, 866, 868, 870, 872, 876).

¹⁴⁶ *S v Peverett* 1940 AD 213 and *S v Robinson and Others* 1968 (1) SA 666 (AD).

¹⁴⁷ *S v Hartmann* 1975 (3) SA 532 (C) at 534.

¹⁴⁸ *Hartmann* supra note 147.

¹⁴⁹ Doctor and physician are used interchangeably throughout. See National Health Act op cit note 8 re definition. of Health Care Provider. 'Doctor' is used most frequently in the HPCSA guidelines.

thereby consented to being killed. However, as the act perpetrated by the accused was murder, the court would not be able to accept consent of the deceased as a defence:

“Be that as it may, it would not constitute a defence to the charge that the deceased had consented to the administration of pentothal. It has more than once been held in the Appellate Division that the fact that the deceased wished to be killed does not exclude the criminal responsibility of him who gratifies the deceased's wish. See, for instance, *S. v Peverett* 1940 AD 213, and *S. v Robinson and Others*, 1968 (1) SA 666 (AD).”¹⁵⁰

The law does not as yet draw a distinction between deaths caused in the context of VAE (even in a mercy killing-type situation)¹⁵¹ and those commonly understood as murder.¹⁵² This does not even entertain the notion that patients may be competent to make these types of decisions.

The case of *Grotjohn* dealt with an act of assisted suicide. In that case, the deceased had instructed the accused (the husband of the deceased) to give her a gun so that she could kill herself, pursuant to an argument she was having with him. Although the decision of the Appellate Division was based on the element of causation, the conclusion is that even where a person requests assistance to commit suicide and thereby consents, such consent would not avail as a defence for the accused. It was clear in that case that the deceased had in fact asked for assistance to commit suicide. The assistance rendered was the provision of a loaded gun. The court ruled that in such cases, where assistance to commit suicide is rendered, the accused person could be guilty of murder. Categorically consent is never a defence to murder, and so where the elements of intention and causation have been proved, the fact that the deceased requested assistance to commit suicide would never be a defence. It is important to note though that the court did not address whether the victim had truly consented to being assisted in committing suicide. Be that as it may, it is submitted that in the light of the current position of the law, even if the consent of the victim was real, genuine and informed, such consent would

¹⁵⁰ *Hartmann* supra note 147 at 534.

¹⁵¹ *Hartmann* supra note 147 at 535:

“The accused's action in this case falls into the category of what is popularly known as “mercy-killing.” The attitude of the law towards such actions has long been the subject of public debate – sometimes heated. It is thought by some that the law as stated above is unfeeling and harsh, more particularly with reference to the medical man who in the course of his profession is sometimes exposed to the lonely dilemma of whether or not actively to assist or refrain from preventing his already doomed and suffering patient's demise. The law as stated above is to the best of our knowledge substantially similar in all western countries. Attempts have been made to have it legislatively altered, more particularly in the United Kingdom and certain of the American States. All these attempts have foundered. There are undoubtedly strongly held views both religious and sectarian that to allow mercy-killing even when hedged about with innumerable safeguards would pave the way for abuses which would be damaging to the community. Our only reason for referring to these circumstances is to emphasise that the change in the law lies solely within the competence of the Legislature. The Courts, in appropriate circumstances, can mitigate but they cannot legislate. For the foregoing reasons we accordingly find the accused guilty as charged.”

¹⁵² *S v Agliotti* 2011 (2) SACR 437 (GSJ).

not avail as a defence simply because consent is never a defence to murder, which the court in its final summation ruled that assisted suicide was.

In *S v Nkwanyana*,¹⁵³ the deceased was suffering from depression and anorexia and wanted to kill herself. She had tried to commit suicide on several occasions but was unsuccessful. She then asked the accused, her friend, to kill her. He refused, but the deceased became insistent and even said that if he did not kill her she would ask a stranger to do so. He finally agreed, and killed the deceased by shooting her. The accused was charged with murder and he pleaded guilty. The court accepted his plea and he was convicted. Regarding the consent of the victim as a possible defence, the court referred to *Hartmann* and noted that:

“there is no doubt in my mind that the crimes of which the accused has been found guilty by the court are very serious crimes, especially the count relating to murder, and for this he must be on the receiving end of the full wrath of the law. The fact that the deceased consented in her demise is irrelevant for the purposes of the conviction.”¹⁵⁴

As stated, it is clear that the court did not question the quality of the consent of the victim, nor that she lacked capacity and competency to give consent. This is simply because of the seriousness with which society views the intentional causing of the death of another human being. It would only be open to a court to consider the quality of consent if in fact consent could be a defence to murder. As it was not, the fact that the victim had consented did not affect the finding of guilt. The court, however, did rely on the fact that the victim had specifically asked to be killed, and thereby consented to her own death as compelling and exceptional circumstances which could be deferred to as a reason for imposing a light sentence – five years’ imprisonment which was wholly suspended for five years.¹⁵⁵ In this case, the accused was not a physician, and the act of euthanasia was performed outside of the context of terminal illness. The current position of the law in South Africa is that consent on the part of a patient will not absolve any person, not even a physician of such criminal liability where the conduct is intended to cause the death of the patient.¹⁵⁶

¹⁵³ *S v Nkwanyana* 2002 JOL 10119 (W).

¹⁵⁴ *Nkwanyana* supra note 153 at p 9.

¹⁵⁵ *Nkwanyana* supra note 153 at p 13.

¹⁵⁶ SALRC Issue Paper 71 (Project 86) *Euthanasia and the Artificial Preservation of Life* (1998) at page 60 para 4.58. Without placing VAE outside of the ambit of the criminal law through fair labelling, the definition of murder is broad enough to bring the practices within its purview. At present, VAE is not a lawful form of causing death, while PE is. All elements for criminal liability remain provable, but the practice of PE is lawful because the law says it is: “In our law the position is that the person who knowingly supplies a drug to a patient for use in suicide is guilty of aiding and abetting a suicide and can accordingly be found guilty of murder.” The arguments made regarding the sanctity of life are discussed in chapter five herein.

In contrast to the factual scenarios that presented in *Grotjohn* and *Nkwanyana*, the applicant in *Stransham-Ford* was suffering from cancer and was in the final stages of the disease. He brought an application to the High Court where he stated that he voluntarily and autonomously was requesting medical assistance to die, either through PAS or PAE. The relief he sought was to absolve a physician of criminal liability based on the fact that the applicant consented to being killed. The application was granted by the High Court, but the decision was taken on appeal to the Supreme Court of Appeal. The appeal was successful and the High Court's decision was overturned. Regarding whether one could ever consent to being killed, the SCA in *Stransham-Ford*¹⁵⁷ unequivocally stated that "insofar as the crime of murder is concerned, consent is not a defence available to the person who brings about¹⁵⁸ the death of the deceased. Nor does the fact of consent justify a conviction on the lesser charge of culpable homicide."¹⁵⁹ The SCA noted particularly that arguments surrounding the right to life and the sanctity of life had not been addressed by the High Court,¹⁶⁰ and linked this issue to that of the right to dignity.¹⁶¹

The SCA in *Stransham-Ford* turned to the question of consent and whether it would ever act as a defence excluding unlawfulness generally and more specifically in relation to VAE. This would only be possible if VAE is deemed to no longer be *contra bonos mores*. Referring to *Peeverett*,¹⁶² the SCA confirmed that "consent is no defence to criminal responsibility for intentionally killing another person."¹⁶³ Thus, where a perpetrator is proved to have had intention, he could not raise the consent of the victim as a defence. But should the law change? The SCA¹⁶⁴ deemed it prudent to deal with this question as it was part of the application brought by *Stransham-Ford* in the court a quo. If granted, the relief sought would

¹⁵⁷ *Stransham-Ford* (SCA) supra note 13.

¹⁵⁸ This refers to the actor being both the legal and factual cause of the death, but also refers to the *mens rea* requirement, evidenced by the court referring to culpable homicide, which elementally from murder in that it requires negligence instead of intention. Includes both PAS and PAE – because causally, VAE *brings about death* meaning that death is caused.

¹⁵⁹ *Stransham-Ford* (SCA) supra note 13 at para 38.

¹⁶⁰ *Stransham-Ford* (SCA) supra note 13 at para 74.

¹⁶¹ *Stransham-Ford* (SCA) supra note 13 at para 69:

"Does the guarantee of the right to life includes a right to die, or does it stand in opposition to it and support the criminalisation of PAE? Does the right to dignity extend beyond dignity in the process leading up to our inevitable death, so as to encompass a right to die when and in the manner we choose? When we are in reality concerned with the implications of the criminal law for the medical profession, do the rights of patients warrant a change in existing criminal law as it affects doctors? Does the right to health care extend to the provision and possible administration of lethal agents or does it by necessary implication exclude this? What are the implications of palliative care for the question whether a person's dignity is infringed by their inability to terminate their own life or have it terminated?"

¹⁶² *R v Peeverett* 1940 AD 213.

¹⁶³ *Stransham-Ford* (SCA) supra note 13 at para 39. Emphasis added.

¹⁶⁴ *Stransham-Ford* (SCA) supra note 13 at para 41.

mean that a doctor assisting Stransham-Ford to end his life would be exempted from criminal liability because he (the patient) would have consented to an assisted death. The relief sought was a challenge to the principle firmly established in *Peeverett*¹⁶⁵ and re-affirmed in *Robinson*.¹⁶⁶ The SCA noted that a flaw in the arguments raised in the High Court and subsequently a flaw for the ratio was that the principle was not challenged or directly raised by the applicant. Without hearing arguments or considering the principles of the applicability of consent, the High Court simply accepted consent as a defence. Having overturned the judgment of the court a quo on the point of mootness, the SCA offered a final blow by stating that “an order making such a profound change to our law of murder, without any consideration of applicable principles, should not have been made and it must now be set aside”¹⁶⁷ and that as the law stands, consent by a patient would “make(s) no difference to the legal consequences of the medical practitioner’s conduct.”¹⁶⁸ Although the court here was referring to PAE, it did go further to say that “insofar as the crime of murder is concerned, consent is not a defence available to the person who brings about¹⁶⁹ the death of the deceased”¹⁷⁰ and this means that consent is not a defence even in the narrow construct of VAE performed by a physician at the patient’s earnest and informed request. This would include PAS. The SCA was dealing specifically with a case of VAE, and the conclusion is that currently in South African law, for as long as VAE is viewed as murder, consent will never be a defence.

If a medical doctor is proved to have had intention and his conduct caused the patient’s death, he must and will be convicted of murder, and nothing less because consent is not a defence to murder, which VAE is categorised as being.¹⁷¹ It follows then that as VAE is the

¹⁶⁵ *Peeverett* supra note 162.

¹⁶⁶ *S v Robinson* 1968 (1) SA 666 (AD).

¹⁶⁷ *Stransham-Ford* (SCA) supra note 13 at para 41.

¹⁶⁸ *Stransham-Ford* (SCA) supra note 13 at para 38.

¹⁶⁹ This refers to the actor being both the legal and factual cause of the death, but also refers to the *mens rea* requirement, evidenced by the court referring to culpable homicide, which elementally from murder in that it requires negligence instead of intention. Includes PAS and PAE – because causally, PAS *brings about death*.

¹⁷⁰ *Stransham-Ford* (SCA) supra note 13 at para 38:

“Neither of these cases, nor *Marengo*, which was also cited by Fabricius J, had anything to do with either assisted suicide (PAS) or active voluntary euthanasia (PAE). They were all cases of euthanasia of the kind usually referred to as ‘mercy killing’. They did not involve suicide and in none of them had the person who died asked to have their life ended. They are only relevant in identifying the issue arising from PAE, which is whether the consent of the patient makes any difference to the legal consequences of the medical practitioner’s conduct. The answer, as the law stands, is that it does not. Insofar as the crime of murder is concerned, consent is not a defence available to the person who brings about the death of the deceased. Nor does the fact of consent justify a conviction on the lesser charge of culpable homicide.”

¹⁷¹ Discussed in Chapters Two and Three. The problem of intention and consent was noted in *Carter v Canada*, and the proposal was that accepting consent as a defence in situations of VAE would mitigate against imperfect and unscientific regard to intention and causation in homicide cases. See *Carter v Canada (Attorney General)*, 2015 SCC 5, at para 328:

crime of murder, consent is not a defence, regardless of the quality of the consent. The SCA in *Stransham-Ford* appeared to have drawn a distinction between an assisted death and a physician-assisted death. Having relied on *Grotjohn* and the factual matrix of that case, the court stated that the case before it could perhaps be distinguished from *Grotjohn*,¹⁷² suggesting that there could be a permissibility distinction applicable to physicians who assist patients to commit suicide by PAS, and lay persons who assist people to commit suicide. But the court was also cautious about drawing such a distinction when it noted that there was no certainty of how it ought to apply the *Grotjohn*¹⁷³ principle to physicians and patients¹⁷⁴ and justify why they do not apply to laypersons. The rule established in *Grotjohn* is broad enough to include PAS, and so any deviation or exemption to the rule would need to be clear as to when and why such exemption applies.

3.5.1 *The gravity of the harm*

Murder criminalises the act of causing death, unlawfully and intentionally. Undoubtedly, there is no harm graver than to kill another human being. Acts of PE and VAE have been shown to cause the death of patients, yet in PE matters, the consent of the patient or proxy can render the conduct of the physician lawful. In contrast to murder, the crime of assault criminalises the unlawful and intentional “applying (of) force to the person of another”¹⁷⁵ with no requirement or indication regarding the gravity of the force or the harm/injury occasioned. In fact, assault is also committed if the accused inspires the belief in the other person that force is to be applied.¹⁷⁶ Thus assault can be committed even where no actual physical harm has occurred to the victim. An assault may be lawful if the person consented to the assault and the circumstances under which the assault occurred are legally permissible.¹⁷⁷ Thus, the gravity of

“...in particular its focus on implications of the requirement for informed consent to medical treatment and on the legality of existing end-of-life practices, may explain why the majority’s comments about intention do not perfectly track criminal law doctrine regarding intention and causation in homicide cases.”

¹⁷² *Stransham-Ford* (SCA) supra note 13 at para 50.

¹⁷³ Referring to *Ex Parte Die Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355.

¹⁷⁴ *Stransham-Ford* (SCA) supra note 13 at para 52.

¹⁷⁵ Burchell *Principles of Criminal Law* 5ed op cit note 8 at 591.

¹⁷⁶ Burchell *Principles of Criminal Law* 5ed op cit note 8 at 685:

“Following the English law, South African law regards the mere inspiring of an apprehension in the mind of a person that he or she is about to be touched or beaten is in itself an assault for which punishment may be imposed. The gist of this form of assault is the creation of the apprehension in the mind of the victim of the assault. An assault is thus any act or gesture (or words?) that induces in the mind of another an apprehension that he or she is about to suffer a battery.”

See also *S v Miya* 1996 (4) SA 274 (N).

¹⁷⁷ *Boshoff v Boshoff* 1987 (2) SA 659 (O); *Roux v Hatting* 2012 (6) SA 428 (SCA); Burchell *Principles of Criminal Law* 5ed op cit note 8 at 682:

“Since human beings are gregarious creatures who live together in communities and together engage in a myriad of activities that involve the touching of others, human society would be impossible in every

the harm on its own does not automatically mean that consent is invalidated. Public policy permits assault in particular circumstances and under particular conditions, even if the assault results in death; provided of course that the conduct is in fact not *contra bonos mores* and that there is an acceptable ground for justification.¹⁷⁸ As we have seen, the law permits death caused through PE because the conduct is justifiable as a form of medical treatment which serves a social and individual purpose.¹⁷⁹ As such, the gravity of the harm alone is not decisive for whether consent avails as a defence.¹⁸⁰ According to Labuschagne,¹⁸¹ the position of the law on consent in relation to the gravity of harm is that one can consent to death implicitly (but not directly or explicitly) when the circumstances under which the death resulted were not *contra bonos mores*, and the perpetrator did not directly intend to cause harm.¹⁸²

Intentional harm (even death) caused in medical treatment is justifiable through consent because the conduct is not *contra bonos mores*.¹⁸³ Regardless of the gravity of the harm, a person's consent in PE cases is valid and no criminal liability will follow in these cases because the conduct is not *contra bonos mores*. The State has an interest in preventing and punishing harms which are *contra bonos mores*, regardless of the gravity. So, if the reason for the prohibition on consent is that VAE causes a grave and fatal harm, this reason alone cannot prevail as a justification for maintaining the limitation on consent.

There is, however, a stronger motivation for restricting the applicability of consent to VAE specifically. The argument is that the State has an interest in protecting the vulnerable from abuse, particularly where there may be concerns regarding the genuineness and quality of the consent. So the State's interest in maintaining the blanket prohibition on the applicability of consent is more refined: it is not to preserve life at *all* costs and in *all* circumstances but rather that "it is more specifically to protect vulnerable persons from being induced to commit

touching that might occur in the home, the workplace, schools, hospitals, the street, the playing fields, and on the dance-floor were to be punishable as an assault. Not surprisingly, therefore, there are a number of circumstances in which the assault is justified or treated by the law as not unlawful."

¹⁷⁸ Burchell *Principles of Criminal Law* 5ed op cit note 8 at 334:

"However, in addition to the patient's consent, the purpose of the operation is relevant. If the purpose is curative or therapeutic the operation will be lawful unless the law provides otherwise. Where a serious risk to life, health or person is involved, it seems that the accused would have to be professionally qualified and licensed."

¹⁷⁹ *Clarke v Hurst NO* supra note 106.

¹⁸⁰ Burchell *Principles of Criminal Law* (2016) op cit note 12 at 333:

"A surgical operation may involve serious injury and yet, because of its therapeutic purpose, it is lawful if consented to. The role of public policy in determining the ultimate legality or illegality of the conduct is paramount."

¹⁸¹ Labuschagne "Violence" in sport and the *volenti non fit iniuria* defence: A perspective on the death of the cricket player Phil Hughes' op cit note 5.

¹⁸² *R v Donovan* [1934] All ER 207 (CCA).

¹⁸³ *Clarke v Hurst NO* supra note 106.

suicide at a time of weakness”.¹⁸⁴ It is submitted that this involves an assessment of whether the person purporting to consent has the capacity (including competency) to do so, whether the consent is real, and whether the person identifies as vulnerable and needing the type of protection that the blanket prohibition on consent offers. The arguments regarding the State’s interests are discussed in a later chapter, but purely in the context of the quality of consent, this is where determining whether the consent given by a person was real or whether the person was unduly coerced and manipulated into consenting becomes relevant. This would assist in determining which patients require the type of protection that the limit on autonomy and consent aims to provide. I turn now to assess vulnerability and its effect on consent.

3.6 CAN INFORMED CONSENT PRINCIPLES APPLY TO VOLUNTARY ACTIVE EUTHANASIA?

Collectively the body of jurisprudence seeks to protect patient autonomy and self-determination from interference as it is “a component of the right to be left alone in the sense of being allowed to live the life one chooses”.¹⁸⁵ This accords with the constitutional imperative and guarantee of affording respect to persons and personhood through the acknowledgement of dignity by treating persons “as ends in themselves and not merely instrumentally as means to ends or objectives chosen by others”,¹⁸⁶ including the state. And even if the decision taken by a patient is objectively unreasonable, it must still be respected, as long as the patient was competent to make the decision – having legal capacity and having been informed of all the possible options, risks and benefits.

It does not follow that just because the patient has made an objectively unreasonable decision that they are vulnerable, unless of course there are other factors which might point to that conclusion. Where a patient has, with capacity and competency, made a decision (that is lawful), it must be respected. In the absence of such an indication, the doctor is required to administer the treatment elected by the patient, even if they subjectively believe that another option would be more efficacious. In this case, all they can do is counsel the patient further, but if the patient holds steadfast, the doctor must oblige, or withdraw as the treating physician; they cannot impose.

However, Hart argues that

¹⁸⁴ *Carter v Canada* 2015 SCC 5.

¹⁸⁵ I Currie & J De Waal *Bill of Rights Handbook* (2013) at 287.

¹⁸⁶ Harris ‘Consent and end of life decisions’ op cit note 114.

“Choices may be made or consent given without adequate reflection or appreciation of the consequences; or in pursuit of merely transitory desires... or in various predicaments when the judgement is likely to be clouded; or under inner psychological compulsion; or under pressure by others of a kind too subtle to be susceptible of proof in a law court”.¹⁸⁷

Hart’s argument is based on an assessment of the quality of consent and too readily generalises that people act without proper thought. He was defending the position that consent is not a defence to murder through the consideration of the state’s interest in preventing such harms, regardless of how they occur. However, the argument is narrow, and does not consider the permissibility of consented-to or invited harms. Kleinig rejects Hart’s argument for “its less than candid appeal to our ignorance”.¹⁸⁸ I agree with Kleinig, in that while some people *may* consent without adequate reflection, it does not mean that for a particular set of circumstances, *that* person did *not* adequately reflect, and for that reason in *all* cases no one should be allowed to consent. If Hart’s assessment is true, then the doctrine of informed consent cannot prevail, and we ought rather to return to a state of medical paternalism. Competency and capacity must be, as they are currently, assessed on an individual basis. For reasons explained, it is clear that it is possible to assess the quality of consent in all medical matters, even those involving bodily harm and the risk of death. But to maintain the prohibition on acceptability of the *volenti* maxim because *generally* it is not possible to gauge the quality of the consent, must be rejected, because, generally it is possible to assess the quality of consent. Doctors do it all the time, and we trust that doctors are trained to gauge the quality of consent and act accordingly. The slippery-slope concerns regarding the quality of consent can be mitigated through added consent-gauging measures.¹⁸⁹

I do, however, agree with Hart, that those who consent to death may be subject to psychological, emotional and other pressures, but, with a regulated and safe-guarded form of VAE, which includes early discussion of end-of-life care and planning, the quality of consent of such patients can be reliably gauged, as is the case in other medical contexts. It is, however, presumptive of Hart¹⁹⁰ to assume that outside of VAE, where medical decisions are taken,

¹⁸⁷ HLA Hart *Law, Liberty and Morality* (1963) 32-33. Here, Hart was defending the position that consent is not defence to murder.

¹⁸⁸ J Kleinig ‘Consent as a defence in criminal law’ (1979) 65(3) *Archives for Philos Law & Social Philos* 329 at 341.

¹⁸⁹ As discussed in Chapter Six and is evidenced through the various sections in the proposed legislation that appears as appendix A.

¹⁹⁰ Hart discusses a range of social and legal issues, including euthanasia, homosexuality and abortion, and argues specifically in relation to murder and assault that for the vast majority of cases, those who consent to severe bodily harm only do so ‘apparently’; the risks associated with gauging the quality of consent is too great to legitimise the validity of consent:

patients are not under psychological or emotional pressure. The argument for rejecting the validity of consent and applicability of the *volenti* maxim on this basis is diminished, if safeguards against abuse are proven to already exist generally.

Admittedly, the purpose of limiting autonomy and rendering consent inapplicable where the purpose is to protect the weak and the vulnerable from abuse, is certainly strong enough to maintain the prohibition, but not if patients have personally exhibited capacity and competency, and do not identify as requiring the type of protection offered by the prohibition on consent. The argument raised in *Carter v Canada*¹⁹¹ was that although the broad purpose of the prohibition was legitimate and defensible, it was overly broad as it unjustifiably limited the rights of those who did not identify as being weak and vulnerable.¹⁹²

Specifically related to the concern of undue influence in the South African context, the Supreme Court of Appeal in *Stransham-Ford*¹⁹³ considered the reasoning followed in *Carter v Canada*: that the reason why the criminal prohibition was declared as being overly broad in Canada was because the purpose could *actually* be achieved by placing and implementing measures which would mitigate against the abuse feared, but noted that

“in the situation prevailing in Canada, it was practicable to put in place measures that would have permitted PAD¹⁹⁴ while safeguarding vulnerable people against coercion or any other form of inducement to ask for PAD”.¹⁹⁵

“Many hope that the Suicide Act may be followed by further measures of reform, and that certain forms of abortion, homosexual behavior between consenting adults in private, and certain forms of euthanasia will cease to be criminal offences; for they think that here, as in the case of suicide, the misery caused directly and indirectly by legal punishment outweighs any conceivable harm these practices may do.” - (supra, preface).

Specifically, regarding the morality of suicide, Hart notes in the preface of the first edition published by Oxford University Press, that:

“The suicide Act 1961, though it may directly affect the lives of few people, is something of a landmark in our legal history. It is the first Act of Parliament for at least a century to remove altogether the penalties of the criminal law from a practice both clearly condemned by conventional Christian morality and punishable by law”.

¹⁹¹ *Carter v Canada* 2015 SCC 5.

¹⁹² *Carter v Canada* supra note 184 at para 107:

“As to the risk to vulnerable populations (such as the elderly and disabled), the trial judge found that there was no evidence from permissive jurisdictions that people with disabilities are at heightened risk of accessing physician-assisted dying (paras. 852 and 1242). She thus rejected the contention that unconscious bias by physicians would undermine the assessment process (para. 1129). The trial judge found there was no evidence of inordinate impact on socially vulnerable populations in the permissive jurisdictions, and that in some cases palliative care actually improved post-legalization (para. 731). She also found that while the evidence suggested that the law had both negative and positive impacts on physicians, it did support the conclusion that physicians were better able to provide overall end-of-life treatment once assisted death was legalized (para. 1271). Finally, she found no compelling evidence that a permissive regime in Canada would result in a ‘practical slippery slope’ (para. 1241)”

¹⁹³ *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA).

¹⁹⁴ Physician Aid in Dying.

¹⁹⁵ *Stransham-Ford* (SCA) supra note 193 at para 67.

So the real issue for South Africa is the practical implementation of established and endorsed informed consent requirements,¹⁹⁶ which evidence was not before the High Court nor the Supreme Court of Appeal.¹⁹⁷ Thus, while theoretically an individual could consent to his own death in cases of VAE, it would only be possible to permit such consent if it was possible to safeguard against abuse, including satisfaction that the medical practitioners had properly obtained it.¹⁹⁸ It is submitted that the principles of informed consent which apply to PE can apply to VAE, but whether they should, is a different question and requires an analysis of whether the blanket prohibition on consent to VAE is constitutional.¹⁹⁹

3.7 CONCLUSION

Harris²⁰⁰ opines that

“[p]ersons who want to live are wronged by being killed because they are thereby deprived of something they value. Persons who do not want to live are not on this account harmed by having their wish to die granted, for example, through voluntary euthanasia”.²⁰¹

Perhaps this is an over-simplification of the issue, but it does cut straight to the jugular: Can one be “harmed” if one who no longer wants to live consents and even welcomes such ‘harm’? From the above discourse, barring the fact that the current state of the law and medical practice do not see VAE as lawful, but as murder, if the objection is only that the quality of the consent is not gaugeable, then the informed consent principles can apply to VAE.

In relation to the court’s²⁰² observation that development of the common-law in relation to consent would only be possible if the intricacies of consent are first debated, I have shown

¹⁹⁶ SC Chima PHD thesis (2018) *An investigation of informed consent in clinical practice in South Africa*.

¹⁹⁷ *Stransham-Ford* supra note 193 at para 72:

“Whether a South African court faced with the same issue would arrive at the same conclusion would need to be determined in the light of the very different circumstances in this country; the availability of medical care and especially palliative care; the wide diversity of our society in its cultures and belief systems; our sense of the need to protect the poor, the weak and the vulnerable and the value attached to providing such protection. The high court’s too ready adoption of the reasoning in *Carter* ignored the very different context in which that case was decided.”

¹⁹⁸ Chima op cit note 194 at 594 recommends the specific recruitment and of interpreters

“as part of medical teams in South African Hospitals, to assist in improving the quality of doctor-patient communications, informed consent, confidentiality, and healthcare service delivery in public hospitals. It would also be useful to modify the current universal hospital consent form to better reflect current teaching in medico-legal practice, by including translations in local languages, or options specific for consent for certain procedures or mandatory disclosures as required by law. It would also be useful for patient information leaflets to be produced in local languages to enhance patient education and understanding prior to providing consent. Finally, continuing education for doctors and other healthcare professionals in ethics and medical law will go a long way towards improving the overall quality of healthcare service delivery in South African hospitals.”

¹⁹⁹ Discussed in the next chapter.

²⁰⁰ Harris ‘Consent and end of life decisions’ op cit note 114.

²⁰¹ Harris ‘Consent and end of life decisions’ op cit note 114 at 13.

²⁰² *Stransham-Ford* (SCA) supra note 193.

that even only on the current and existing requirements for legal consent, which is in fact informed consent, it is possible to gauge whether a patient is in law capable of consenting. The limits to what a person can consent to is determined through *boni mores*. Despite the concern raised by the court in *Stransham-Ford*²⁰³ that a framework and system for evaluating consent in medical contexts *may* not be adequate in South Africa, it is important to remember that the decision in *Carter v Canada*²⁰⁴ was made on universal assessments of informed consent as they existed in Canada at the time, and which currently exist and are enforced in South Africa. Those same principles, even as they were, currently apply in South Africa, and without definitive proof that the principles are currently ineffective for gauging consent for all and other medical decision-making, it is incorrect to conclude that the principles are inadequate in South Africa in the context of VAE. This will have to be fully argued before a competent court. If, however, definitive proof is tendered or the allegation is made that the current extant principles are generally inadequate, this would require engagement on that issue of consent, not necessarily or primarily focussed on VAE, but generalised medical practice *in toto*.

The concerns raised in both *Carter v Canada*²⁰⁵ and *Stransham-Ford*²⁰⁶ that adopting a permissive policy could place vulnerable individuals at risk of abuse, would benefit from fuller investigation into the practical challenges faced by physicians when obtaining consent.²⁰⁷ Permissive jurisdictions like Canada have added competency assessment processes for patients who seek VAE. These included additional psychological and other counselling, which serve to more actively monitor and assess patient competence in end-of-life decision-making. The Supreme Court of Appeal in *Stransham-Ford* correctly noted that this issue had not been raised, nor had it been argued in the High Court, and so the conclusion of the High Court that the common-law should develop did not explain why it should develop, or how it should develop.

It is evident and has been shown that medical practitioners are able to determine whether consent is real, and that they even use proxy-consent when it is not possible for a patient to personally consent to death through passive euthanasia. Physicians are permitted to make decisions on behalf of patients even if the decision hastens death, in consultation with proxy-decision makers. They can also make these decisions where proxy-decision makers are not available. Where proxy-decision makers have a conflicting decision to physicians, our courts have been enlisted to make a decision that is in the patient's best interests, even to rule

²⁰³ *Stransham-Ford* (SCA) supra note 193.

²⁰⁴ *Carter v Canada* 2015 SCC 5.

²⁰⁵ *Carter v Canada* supra note 204.

²⁰⁶ *Stransham-Ford* (SCA) supra note 193.

²⁰⁷ Chima op cit note 196.

that the patient's death should be hastened.²⁰⁸ This decision is lawful if it is in the patient's best interests. And so, the argument for rejecting consent as a defence because there are no reliable ways of ensuring that consent was not given in a state of "decisional vulnerability" must fail. While the possibility of obtaining consent, and the reliability of consent in situations of PE where patients lack capacity have been noted as being challenging, it is not impossible, and is certainly not a bar to accepting consent as a defence to PE.²⁰⁹ Engaging the principles of proxy-consent and the protocols affixed thereto, proxy and substitute consent are ethically sanctioned as real consent and therefore effective to render the conduct of the physician lawful when acting in PE scenarios.²¹⁰

Following this line of reasoning, and drawing an analogy with *Carter v Canada*,²¹¹ I clearly substantiate that theoretically the current informed consent principles already apply practically to PE and similarly, there is no reason to conclude that they cannot also practically apply to VAE.

Consent is not a defence to murder, but could it be a defence to VAE? The short answer is no for as long as VAE is categorised as murder. If death consented to and caused by VAE attracts no "social need to punish the accused for the performance in question,"²¹² then the consent requirements as they currently exist would avail. But this is a matter of policy. If the first hurdle is surmounted, then can the quality of the consent be assessed? Theoretically consent can be a defence in VAE cases, but the question is should it be? To answer this question requires consideration of the rights to dignity, autonomy, life and bodily and psychological integrity as enshrined in the Constitution and whether the limits placed on autonomy is justifiable in the light thereof.

²⁰⁸ *Clarke v Hurst NO* supra note 106.

²⁰⁹ Harris 'Consent and end of life decisions' (2003) *J Med Ethics* 29 10-15.

²¹⁰ Harris 'Consent and end of life decisions' op cit note 209 at 11:

"Because of the relative frequency of circumstances in which valid consents are unobtainable the law has contrived – and I use this term deliberately - various fictional consents to protect well intentioned practitioners from the guilt of unlawful conduct. And not only practitioners, of course, but all well intentioned people who touch others where consent cannot be obtained.

The moral necessity of obtaining a valid consent where this can be obtained does not require further discussion. To violate the bodily integrity of persons who reject such violation is usually a form of tyranny and should be accepted and treated as such. We must, however, look more closely at those cases where consent or its refusal is problematic, and at the fictionalised consents that are often manufactured in these circumstances.

²¹¹ *Carter v Canada* supra note 204.

²¹² Burchell *South African Criminal Law and Procedure, Vol I* op cit note 2 at 114.

CHAPTER FOUR

INTENTION AND ASSISTED DYING

“There may be little distinction between the intent of a terminally ill patient who decides to remove her life support and one who seeks the assistance of a doctor in ending her life; in both situations, the patient is seeking to hasten a certain, impending death. The doctor’s intent might also be the same in prescribing lethal medication as it is in terminating life support.”

(Washington, et al., Petitioners v. Harold Glucksberg, et al.
521 U.S. 702 (1997), 117 S. Ct. 2258, 117S. CT. 2302, p750)

4.1 INTRODUCTION

When the topic of euthanasia is raised, responses are polarised: to some it is an act of mercy, to others it is murder.¹ In criminal law, the act of unlawfully and intentionally causing another person’s death is murder,² regardless of the perpetrator’s motive. In this chapter I look at intention, and whether development of the common law to permit VAE can be achieved through the element of intention.

I look at the general principles of criminal law and the criteria for assessing intention and compare that with how intention is assessed in terms of medical care. In both respects, the relationship between intention and motive is considered, and whether the latter has any bearing on the law’s assessment of the former. Essentially, the discussion turns on how and why intention in law is determined differently from intention in medical practice, and whether in law and medical practice, the permissibility distinction between PE and VAE when based on the law’s application of intention is legally sound and sustainable for maintaining the criminal prohibition.³

¹ SALRC Issue Paper 71 (Project 86) *Euthanasia and the Artificial Preservation of Life* (1998) pp 84-86. Proponents argue that euthanasia practices ought to be permissible based on the legal convictions of society; a consideration of whether as adjudged by the *boni mores*, society deems the practice not punishable or not blameworthy. Opponents argue the opposite.

² SV Hoxton *Snyman’s Criminal Law* 7 ed (2020) 387.

³ Cf. *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D); *Airedale NHS Trust v Bland* [1993] AC 789; *R v Adams* [1957] Crim LR 365; *R v Cox* [1992] 12 BMLR 38.

4.2 INTENTION IN LAW

*Actus non facit reum nisi mens sit rea*⁴ is the Latin maxim which establishes that to be found guilty, an accused person must have committed some form of unlawful conduct (*actus reus*) and such conduct must be accompanied by a guilty mind (*mens rea*).⁵ *Mens rea*⁶ concerns the state of mind of a person, and involves gauging whether an accused person had the requisite fault⁷ rendering him blameworthy for his conduct. If *mens rea* is lacking an accused person cannot be found guilty of the crime of which he is charged.⁸ As autonomous persons, individuals have the capacity to choose what they do, but the corollary is that they are also liable and responsible for the consequences of their choices. These choices are the manifestation of an intention to bring about an eventuality that is foreseen.⁹

In South African criminal law, intention is assessed in a few forms: *dolus directus*, *dolus indirectus* and *dolus eventualis*. Each of these considers foresight in differing degrees and thus intention in the crime of murder can exhibit directly or indirectly.¹⁰ It is well settled in South African law that *dolus eventualis* suffices for a conviction of murder, and thus the net of criminal liability is cast wide enough to include deaths caused by VAE¹¹ even when motivated by mercy.¹²

⁴ An act does not make a defendant guilty without a guilty mind.

⁵ JM Burchell *Principles of Criminal Law* 5 ed (2016) at 60.

⁶ *Mens rea* is the Latin term which is literally translated as “a guilty mind”, and can further be described as ‘culpability’ or ‘blameworthiness’, and in law, the assessment is of legal culpability, not moral culpability. The assessment considers “whether there are grounds for blaming X personally for his unlawful conduct” (Hoctor *Snyman’s Criminal Law* op cit note 2 at 149). *Mens rea* includes an assessment of fault in the form of intention or negligence. *Mens rea* also includes an assessment of capacity, but that is dealt with in a later chapter in relation to decision-making capacity. As a prerequisite for liability, it is legal culpability and not moral culpability which is assessed. Herein, as the discussion turns to the crimes of murder, the assessment is focused on intention, and not negligence.

⁷ Either intention or negligence. In this thesis I focus only on intention as it is the fault requirement for murder.

⁸ Some crimes require negligence as the *mens rea* requirement, for example culpable homicide. Although intention may be lacking, if an accused person is found to have acted negligently, in the case of an unlawful killing for example, he can be found guilty of culpable homicide, as culpable homicide is a competent verdict to a charge of murder.

⁹ A Ashworth and J Horder *Principles of Criminal Law* 6 ed (2013) at 155.

¹⁰ Burchell *Principles of Criminal Law* 5ed op cit note 5 at 341-342:

“If X has as his or her aim and objective (purpose) the killing of Y and X succeeds in this plan, then few would doubt that a conviction of X for the murder of Y should result, whether his or her form of fault is labeled as ‘deliberate’, ‘actual’, ‘wicked’, malicious or ‘direct’ (*dolus directus*). Many legal systems would also acknowledge that even if X argued that it was not his or her purpose to kill Y, if X realized that the death of Y was certain or virtually certain to follow from his or her conduct (*dolus indirectus*), X still has the *mens rea* for murder. The dispute lies, however in the appropriate label for other killings where the death of Y is merely foreseen (*dolus eventualis*) or recklessly caused”.

¹¹ Arguably, when the intention tests are applied strictly, PE practitioners will also be proved to have intention to hasten a patient’s death.

¹² *S v Hartmann* 1975 (3) SA 532 (C) at 534:

“It is beyond doubt that, in acting as he did, the accused did not desire to end his father’s life. The motive for his action was a compassionate one...Nevertheless to achieve such purpose he was prepared to do an

4.2.1 *Dolus directus*

Dolus directus can be described as the most common understanding of intention. Here the perpetrator has a specific goal or aim in mind and performs an act to realise that specifically desired and intended end result.¹³ For murder, the accused would have such direct intention if they had in mind the specific goal of causing the death of the victim and in turn directed that desire into action and caused the death of the victim – they *intend* the result (the death of the victim) and *cause* it to materialise in the way envisaged (in any way imaginable – shooting, strangulation, poisoning or the administration of a lethal dose of medication).¹⁴

Dolus directus can be understood to mean primary intention.¹⁵ It is “intention in its ordinary and grammatical sense and refers to the accused’s aim and object to perpetrate unlawful conduct or cause the unlawful consequence.”¹⁶

4.2.2 *Dolus indirectus*

Here, the accused’s intention in relation to the criminal act is indirect. The unlawful act under judicial scrutiny is an unavoidable and necessary consequence (side-effect) *en route* to achieving his main goal.¹⁷ *Dolus indirectus* is literally translated as indirect intention, and exists where the accused desires to achieve a particular result but is aware that, in doing so, a secondary - not directly intended (in the sense of *dolus directus*) - result will certainly also result. There is a primary intention to which actions are directed, but there is the certainty that, to achieve the primary aim, an additional result (or side-effect) will inevitably and with certainty occur.¹⁸ The side-effect is unavoidable and accepted as necessary in order to achieve the main objective.¹⁹ As stated, in order to achieve the main purpose, the accused appreciates

act which he was aware would inevitably terminate his father’s life. He therefore clearly entertained that intention which is an essential ingredient of the crime with which he is charged”.

See also Burchell *Principles of Criminal Law* 5ed op cit note 5 at 60: “All forms of intention are assessed subjectively and *dolus eventualis* is a sufficient form of intention for all crimes based on intention. Motive is not equivalent to intention.”

¹³ Burchell *Principles of Criminal Law* 5ed op cit note 5 at 348.

¹⁴ Hoctor *Snyman’s Criminal Law* 7 ed op cit note 2 at 160: “X is certain that he is committing the prohibited act or that he is causing the prohibited result. He does not regard the commission of the act or the causing of the result as a mere possibility.”

¹⁵ *Dolus directus* is relevant for the discussion in relation to *Hartmann*.

¹⁶ Burchell *Principles of Criminal Law* 5ed op cit note 5 at 60.

¹⁷ Hoctor *Snyman’s Criminal Law* 7ed op cit note 2 at 160. “In indirect intention (*dolus indirectus*) the prohibited act or result is not X’s goal, but he realizes that if he wants to achieve his goal, the prohibited act or result **will** occur.” (Emphasis added).

¹⁸ Hoctor *Snyman’s Criminal Law* 7ed op cit note 2 at 160-161.

¹⁹ Burchell *Principles of Criminal Law* 5ed op cit note 5 at 461. Burchell states that:

“*dolus indirectus* exists where, although the unlawful conduct or consequence was not the accused’s aim and object, he or she foresaw the unlawful conduct or consequence as certain, or as ‘substantially certain’, or ‘virtually certain’.”

and accepts that some other consequence *must* necessarily occur in order to achieve his primary objective.²⁰ Thus, *dolus indirectus* is proved when the accused acts with knowledge and appreciation of the *certainty* of the not-directly-intended consequence materialising.²¹ *Dolus indirectus* can be understood to mean secondary intention.

4.2.3 *Dolus eventualis*

Where *dolus directus* and *dolus indirectus* consider certainties, *dolus eventualis* considers possibilities. *Dolus eventualis* exhibits when the accused foresees the *possibility*²² of an act occurring, reconciles himself that there is a possibility of it materialising, and persists nonetheless, with reckless disregard of the said foreseen consequence materialising.²³ Dubbed

See also SV Hoorer 'The concept of *dolus eventualis* in South African law – an historical perspective' (2008) 14(2) *Fundamina* 15. Hoorer notes that *dolus indirectus*

"refers to the accused's state of mind in relation to a prohibited act or consequence which is not his or her main goal, but is recognized by the accused as a *necessary consequence* of the attainment of his or her main goal or object."

See also Hoorer *Snyman's Criminal Law* 7ed op cit note 2 at 160 who offers the following example of *dolus indirectus*:

"X is sitting in his neighbour's (Y's) house. From inside the house he wants to shoot a bird which is outside. He realizes that his shot will of necessity shatter Y's window-pane. Although he is not anxious to bring about this result, he nevertheless decides to go ahead, aims at the bird and shoots the window-pane to pieces. If he is subsequently charged with damaging Y's property, he cannot be heard to say that he meant to shoot only the bird, not to damage the window-pane. It is evident from the example that this form of intention may be present even though X does not desire the prohibited result. The volitional element here consists in the fact that X directs his will towards shooting the bird and decides to go ahead with it knowing full well that he will necessarily also shatter the window-pane."

²⁰ SV Hoorer 'Intention: Introduction' In J J Joubert (ed) *LAWSA* 3 ed (2017) vol 11 at para 88

"*Dolus indirectus*, seldom referred to in case law, exists where a person foresees that a certain consequence will inevitably follow his or her achieving his or her aim (*dolus directus*) and the person nevertheless acts."

²¹ JM Burchell & J Milton *Principles of Criminal Law* 3 ed (2005) at 60: "*Dolus indirectus* is present where the accused foresaw the unlawful conduct or consequence as certain or substantially certain to occur."

²² SV Hoorer 'The degree of foresight in *dolus eventualis*' (2013) 26(2) *SACJ* 131 at 135-165:

"Notwithstanding early dicta where it was stated that the requisite foresight of the 'probability' of harm, or foresight that the act in question was 'likely' to cause the particular result, or foresight of 'some risk to life', it is now firmly established that the accused need only foresee the possibility of harm occurring."

²³ *Snyman's Criminal Law* 7ed op cit note 2 at 161 and *S v Malinga* 1963 (1) SA 692 (A) G-H:

"In considering the issue of intention to kill, the test is whether the *socius* foresaw the possibility that the act in question in the prosecution of the common purpose would have fatal consequence, and was reckless whether death resulted or not."

See also *R v Thibani* 1949 (4) SA 720 (A) 729-730:

"It seems to me to be clear that a man may have the intention to kill even though he does not visualise death as more likely than not to result from his acts. Supposing for instance that he was expressly warned at the time of the danger of death resulting from his act and, while realising that there was such danger, nevertheless did the act, reckless whether death resulted or not, I do not think that it would matter whether he thought that death would very probably result or whether he thought that, though reasonably possible, it would very probably not result ... I shall add that provided the requisite recklessness is present it may even be correct to say that realisation of the possibility of death resulting, even as a remote chance, would suffice, though it is not necessary for present purposes to go to that length."

as legal intention, *dolus eventualis* has at its core considerations of public policy based on the perpetrator's willingness to take the risk of the possibility materialising, even if remote.²⁴

Dolus eventualis is also a form of secondary intention, and requires scrutiny of how foresight of an unlawful consequence is assessed. Properly stated, the inquiry is whether the accused person *subjectively* was *attentive* to the outcome. Once *attentive* to the outcome, a person has the intention to cause it, even if the chance of it materialising is remote.²⁵ There are concerns that foresight of an unqualified possibility may result in unfair convictions, however Hoctor notes that there are in fact safeguards to mitigate against this concern in that *dolus eventualis* requires not only foresight, but also *reconciliation* with the possibility of the eventuality materialising.²⁶ The combined effect of foresight and reconciliation is that the consequence is intended. Regarding reconciliation, where the outcome is so remote so as not to have even been in the perpetrator's contemplation, then the intention is lacking because subjectively the person was not attentive to it so as to say they did not even imagine it as an outcome and so could not have reconciled themselves to its eventuality.²⁷

²⁴ Hoctor 'The degree of foresight in *dolus eventualis*' op cit note 22 at 155 "These policy factors are that someone acting with *dolus eventualis* evidences a 'willingness' to bring about the harm rather than to give up his proposed course of action."

See also Burchell & Milton *Principles of Criminal Law* (2005) op cit note 21 at 60:

"Although there is some debate about whether negligence is a form of fault or an assessment of conduct, it seems to be accepted that failure to measure up to notional standards of reasonableness can be seen as a type of fault or blameworthiness."

²⁵ Hoctor 'The degree of foresight in *dolus eventualis*' op cit at 22 at 154:

"First, the probability of a consequence occurring will be relevant in drawing an inference of actual foresight on the part of the accused. As Loubser and Rabie point out 'the greater the likelihood or probability of death, the stronger would be the inference that he accused foresaw it'. It follows that the more improbable the consequence in question, the more difficult it would be to prove foresight on the part of the accused by way of inferential reasoning. Secondly, the fact of foresight (on its own) does not suffice for *dolus eventualis* liability, the accused *must have reconciled himself to the risk*. It should also be noted that remoteness of the foreseen possibility could be relevant to punishment: if an accused had foresight of a remote possibility of death, but regarded death as 'although possible, extremely unlikely', this could constitute mitigating circumstances in taking the risk of the occurrence of death. Thus even if the remote foreseen possibility founds a conviction, the punishment is likely to be reduced by virtue of the remoteness of the foresight."

See also Burchell & Milton *Principles of Criminal Law* (2005) op cit note 21 at 60-61:

"*Dolus eventualis* is present where the accused foresaw the possibility that the prohibited consequence might occur, in substantially the same manner as that in which it actually does occur, or the accused foresaw the possibility that the prohibited circumstance might exist, and he or she accepted this possibility into the bargain. There has been much debate on whether the foresight of even a *remote* possibility may be sufficient for this type of intention. There is a strong argument and recent case authority for restricting the scope of criminal liability to foresight of a *real/substantial* possibility and regarding foresight of any possibility sort of a real/substantial one as at most satisfying the first part of the test for conscious negligence. However, in 1985, the Appellate Division in *Ngubane* had preferred a different approach: In principle, *dolus eventualis* could extend to foresight of even a remote possibility, but the likelihood of the possibility eventuating would have a bearing on whether the accused accepted the possibility into the bargain (the so-called 'volitional' element of *dolus eventualis*)."

²⁶ Hoctor 'The degree of foresight in *dolus eventualis*' op cit note 22.

²⁷ Hoctor 'The degree of foresight in *dolus eventualis*' op cit note 22 at 153:

4.3 ASSESSING FORESIGHT THROUGH THE CASES

How much foresight of the consequence must be had? Does the law require foresight of all the possibilities or only some of them or only the most likely ones? How real or how certain or how possible the outcome is (however much desired or undesired) becomes relevant in determining what kind of intention the perpetrator has where they foresee the outcome as possible; not that they do not have intention at all. The degree of the possibility materialising is irrelevant. For as long as *an* outcome is subjectively foreseen, and the perpetrator reconciles himself to that possibility, and acts in appreciation of that possibility *possibly* materialising, they intend it.²⁸

Intention is gauged from the causal and factual matrices which relate to subjective foresight of the outcome as informing intention. But subjective foresight is difficult to prove definitively and Hoctor notes that

“Since such subjective foresight on the part of the accused is seldom able to be proved by means of direct evidence, to determine the mental state of the accused a court can rely on proof by means of inferential reasoning, whereby the presence of foresight can be proved by inference drawn from the accused’s conduct and from the circumstance in which the crime was committed”.²⁹

What follows is an analysis of how foresight in intention has been assessed in cases of medically-assisted dying in South African law.

4.3.1 *Voluntary-active euthanasia and foresight*

“Cases dismissing foresight of a remote possibility may be interpreted as, rightly, excluding from the ambit of liability for intention instances where the accused foresaw the possibility of harm occurring, but regarded such possibility as so unlikely as to rule it out entirely.”

In such an instance, intention will not be proved and an accused person would not be criminally liable for a crime that required intention as the *mens rea* requirement for fault. If the accused did not foresee it but ought to have foreseen it because a reasonable person would have foreseen it, then the accused may be found to have *mens rea* in the form of negligence. But negligence is outside of the scope of this thesis.

²⁸ E M Burchell, P M A Hunt & JM Burchell *South African Criminal Law and Procedure* Vol 1 3 ed (1997) at 229-231:

“The difficulty that arises is that, while consequences will occur, the probability of their occurrence may vary. In other words, some consequences of an action will certainly occur; others will probably occur while it is only a possibility that another consequence might occur. The question that must be considered is whether all consequences, *however remote the possibility* of their occurrence is, can be said to have been intended or whether there is some point in the scale of probability at which foresight ceases to qualify as intention.”

²⁹ Hoctor ‘The degree of foresight in *dolus eventualis*’ op cit note 22 at 135.

*S v Hartmann*³⁰ was a case of active euthanasia which was definitive regarding direct intention. This case also rejected motive as having any bearing on intention. In *Hartmann*³¹ the accused was a qualified medical practitioner. He was held to have had an intention to kill his father. The court found that Hartmann "...performed an act, that is, the injection of the Pentothal into the drip connected to the deceased's body, that this act was unlawful, and it led directly to the death of the deceased within a matter of seconds."³²

The patient in this case was suffering from cancer³³ and was suffering intolerable and intractable pain. He was being treated by his son. The disease had progressed to an advanced stage which rendered him bedridden, emaciated and incontinent. He was at this stage only receiving pain medication which was not having the desired effect. He was also being fed intravenously as he was no longer able to swallow food without choking. From his admission to the hospital it was clear that the patient was critical and for all intents and purposes, at death's door, having been described as "moribund."³⁴ The evidence presented to the court was that on the evening of 11 September, the accused instructed a nurse who was on duty to administer an injection of 0.5mg of morphine to his father. She submitted that she was reluctant to do this as the dose was too large, but regardless, she administered the dose at approximately 7.30pm. An hour later, at 8.30pm, Hartmann acquired a further 0.5mg of morphine from the same nurse, and personally administered this to his father. Hartmann remained at his father's bedside. Then

³⁰ *S v Hartmann* 1975 (3) SA 532 (C). Although this case may not directly deal with a VAE scenario, the court did observe at 534 that:

"There is some suggestion in the accused's statement to the police that he asked his father whether he wanted to sleep and that his father vaguely nodded his head in approval. I do not know whether this portion of the statement is intended to indicate that the deceased desired to have administered to him some drug permanently to end his suffering. It seems highly doubtful that the deceased was at that stage able to appreciate what he was being asked, or that he was sufficiently rational to signify his assent to the administration of such a drug, or even whether he in fact did so when he nodded his head. Be that as it may, it would not constitute a defence to the charge that the deceased had consented to the administration of pentothal. It has more than once been held in the Appellate Division that the fact that the deceased wished to be killed does not exclude the criminal responsibility of him who gratifies the deceased's wish. See, for instance, *S v Peeverett*, 1940 A.D. 213, and *S v Robinson and Others*, 1968 (1) SA 666 (AD)."

The discussion here however is confined to the assessment of intention as it too is an element of liability which becomes relevant if an accused person's conduct is *prima facie* unlawful and has not otherwise been justified, by for example, consent.

³¹ Supra note 30.

³² *Hartmann* supra note 30 at 533H.

³³ Carcinoma of the prostate which had spread to his bones and ribs.

³⁴ *Hartmann* supra note 30 at 533F.

at around 11pm he obtained a further dose of 250mg of Pentothal³⁵ from the same nurse and administered it to his father. Seconds after administering this dose, his father died.³⁶

Analysis of Hartmann:

Morphine is primarily a drug prescribed for pain relief, but in higher doses, can be fatal. Pentothal was at the time widely used in anaesthesia, and was also being used in various jurisdictions in the execution of convicted persons who were sentenced to the death penalty.³⁷ It has been used in the Netherlands and in Oregon in cases of assisted suicide.³⁸

Against this backdrop, it is submitted that the actions of the accused in administering a second dose of morphine, and then a further dose of Pentothal, showed that the accused directly and primarily intended to end his father's life.³⁹ It was clear that Hartmann had reconciled himself to the fact that the only way to relieve his father's pain and suffering was to terminate his life. So, although his motive and desire were to alleviate pain and suffering, his intention was *dolus directus* because it was the only way for him to achieve the primary motive.

Hartmann acted with awareness, understanding and reconciliation that the repeated acts of injecting his father would lead directly to his death. He was motivated by compassion and a desire only to relieve his father from enduring further pain and suffering, but in fact "he was prepared to do an act which he was aware would inevitably terminate his father's life".⁴⁰

As regards intention and motive, the court in *Hartmann*⁴¹ turned to the 1940 Appellate Division decision of *Peeverett*.⁴² In that case, it was argued that the accused lacked intention to kill because he had "*no wish or desire*" to cause the death of the victim. Correctly, the court rejected this argument holding that although

"it is true that the accused was reluctant to cause the death of Mrs [S], and in that sense did not desire it, but it does not follow that he did not intend to cause her death. *In law desire must be distinguished from intention*. The consequences which a man contemplates or expects to result from his acts are consequences which he "intends", but (as Austin points out in lecture 19) such

³⁵ The brand name for Thiopentothal: C J Williams 'Maker of anesthetic used in executions is discontinuing drug' *Los Angeles Times* 22 January 2011, available at <https://www.latimes.com/local/la-xpm-2011-jan-22-la-me-execution-drug-20110122-story.html> accessed on 10 July 2022.

³⁶ *Hartmann* supra note 30 at 533G-H.

³⁷ In the form of Pentobarbital, it has been used in 14 states in the United States of America in such executions: S Pappas 'Death and medicine: Why lethal injection is getting harder' *LiveScience* 30 June 2015, available at <https://www.livescience.com/51389-why-lethal-injection-is-getting-harder.html>, accessed on 10 July 2022.

³⁸ *Ibid*.

³⁹ *Hartmann* supra note 30 at 534C.

⁴⁰ *Hartmann* supra note 30 at 534D.

⁴¹ Supra note 30.

⁴² *R v Peeverett* 1940 AD 213.

consequences may not always be desired. Though a desired consequence is usually an intended one, an intended consequence is not always a desired one. In the eyes of the law, therefore, he intended to kill her, however little he may have desired her death”.⁴³

In the same vein, we must assess Hartmann’s intention, absent of his desire (motive). What did he contemplate or expect the result of his administration of morphine and Pentothal to be? One might be swayed to conclude that Hartmann did not have *dolus directus*, but only *dolus eventualis*, due to the court referring to the *desire* of the accused in the same paragraph where it concludes that he did in fact have intention. But, when read in context, it is clear that *desire* relates to his motive only (compassion to relieve pain and suffering) and not his intention.⁴⁴

In *Hartmann*,⁴⁵ it was patently obvious that the accused’s state of mind (*mens rea*) was clearly and absolutely to cause his father’s death, as the court states that he was “*prepared to do an act which he was aware would inevitably terminate his father’s life.*”⁴⁶ “Prepared” thus proves pre-meditation, “aware” shows knowledge and understanding of the consequences of his action, as well as reconciliation with the consequence that death would with absolute certainty, occur as a result of the repeated doses of the fatal medication. Once Hartmann reconciled himself to that consequence as being absolutely certain, his actions (administering repeated doses of morphine and a final fatal dose of Pentothal) were directed and intended specifically, primarily and solely at causing his father’s death. He knowingly directed his will to an unlawful consequence, in appreciation that the consequence *would* result as an *absolute certainty* and not a mere possibility, probability or risk. His father’s death was not merely a risk or a chance he was prepared to endure, it was the outcome he had planned for and directed his actions (and repeated actions) towards. The court noted that the act performed by Hartmann could be classed as a mercy killing but that it was still murder because he had the requisite intention regardless of his motive.⁴⁷

⁴³ *Peeverett* supra note 42 at 219 – drawing the distinction between motive and intention.

⁴⁴ *Hartmann* supra note 30 at 543C-E:

“It is beyond doubt that, in acting as he did, the accused did not desire to end his father’s life. The motive for his action was compassionate...Nevertheless to achieve such relief he was prepared to do an act which he was *aware* would inevitably terminate his father’s life.”

⁴⁵ Supra note 37.

⁴⁶ *Hartmann* supra note 30 at 534.

⁴⁷ *Hartmann* supra note 30 at 535B:

“There are undoubtedly strongly held views both religious and sectarian that to allow mercy-killing even when hedged about with innumerable safeguards would pave the way for abuses which would be damaging to the community. Our only reason for referring to these circumstances is to emphasise that the change in the law lies solely within the competence of the Legislature. The Courts in appropriate circumstances, can mitigate but they cannot legislate.”

Regardless of motive, intention is intention, and whether an accused has *dolus directus*, *dolus indirectus* or *dolus eventualis* is sophistry for purposes of criminal liability.⁴⁸ In applying the principles of intention, the court convicted Hartmann of the crime of murder. However, an interesting point to note is the sentence handed down by the court. It was at this stage that the court took into account Hartmann's motive noting that even though Hartmann's intention was *dolus directus*, which normally ought to attract the most severe sentence for murder, the court showed mercy.⁴⁹

4.3.2 *Passive euthanasia and foresight*

In 1988 the patient, Dr Clarke, had suffered a cardiac arrest. He had been resuscitated but due to prolonged oxygen deprivation was reduced to a persistent vegetative state.⁵⁰ As a result, he had "permanently lost the capacity to induce a physical and mental existence at a level which qualifies as human life."⁵¹ He was however able to breathe spontaneously and was not on ventilator. He was being fed through an artificial feeding tube, and was not brain-dead. His death was not imminent and he would remain *alive* and in this state for as long as he was being fed artificially.⁵² The medical expert evidence confirmed this and also confirmed that Dr Clarke would never regain any cognitive capacity due to the severity and irreversibility of the brain-

⁴⁸ The degree of foresight in intention usually affects the type of sentence and accused person receives. However, this general rule was not applied strictly in *Hartmann*, or any other of the VAE cases that have presented before South African courts – see *S v De Bellocq* 1975 (3) SA 538 (T) and Davison op cit note 4.

⁴⁹ *Hartmann* supra note 30 at 536 F-G:

"This is a case, if ever there was one, in which, without being unfair to society, full measure can be given to the element of mercy. This is a case which in my view calls for a total suspension of the sentence. This however cannot be achieved in law and accordingly the accused is sentenced to a term of imprisonment of one year. The accused will be detained until the rising of the Court and the balance of the sentence is suspended for one year on condition that he does not during that period commit an offence involving the intentional infliction of bodily injury."

⁵⁰ *Clarke v Hurst NO* 1992 (4) SA 630 (D) at 640F-G:

"It would seem to me that the term 'persistent vegetative state' describes not a distinct condition but rather a range of chronically persistent neurological defects which are irreversible; with no cognitive or intellectual function and no self-awareness or awareness of the surroundings and no purposive bodily movement."

⁵¹ *Clarke v Hurst NO* supra note 50 at 659A-B.

⁵² *Clarke v Hurst NO* supra note 50 at 649G-J:

"There is, however, no doubt that legally the patient is still alive; nor is death imminent. His life expectancy is uncertain. The discontinuance of the nasogastric feeding and any other form of nourishment is bound to lead to the termination of such life as the patient still has. According to Ms Duminiet, the period which it would take for the patient to die after the administration of nourishment has ceased is somewhat unpredictable. If the potassium levels were to suddenly rise considerably the patient could suffer a cardiac arrest. If this does not happen the patient would simply 'fade'. He would be totally unaware of what is happening. He would not register anything at all. His blood pressure would drop and his breathing would slow down until cardiac standstill occurs. There would be no dramatic or sudden death. Quiet, shallow breathing would simply turn into no breathing at all and life would be extinguished. This would occur within two or three weeks after nourishment has ceased to be administered."

damage he had endured.⁵³ In 1992, Dr Clarke's wife made an application to the High Court requesting permission to remove the artificial feeding tube in appreciation that doing so would inevitably cause the patient to die, and that if granted, there would be no criminal law repercussions for her intended actions. In her application she noted specifically that "I am of course mindful of the fact that my husband's death *will* follow the removal of the tube from his stomach."⁵⁴ As such, she made the admission that the requirements for intention to cause death would be satisfied, and the court would not be able to sanction an act of intentional killing (murder).⁵⁵

Her application was opposed by the Attorney General⁵⁶ who argued that he was "not prepared to undertake in advance not to prosecute should steps be taken to terminate the patient's life and that he was not prepared to declare in advance what his decision would be in the event of such steps being taken."⁵⁷ The court ultimately ruled in favour of the applicant,

⁵³ *Clarke v Hurst NO* supra note 50 at 645 F-G:

"Awareness is the ability of a person to perceive any aspect of the environment. In an unconscious patient this would be tested by applying some external stimulus and observing whether there is a response. Mr Staub performed several such tests on the patient. In some cases there were responses to the external stimuli. Those were the results of the auditory stimulation test, test of sensation of the face, reactions of pupils, painful stimulation of the limbs and forehead. All these responses, according to Mr Staub, may be mediated through the brainstem or spinal cord and therefore do not prove that the patient is aware of his external environment at any level. In order to prove clinically that the patient is aware of the stimuli one would have to elicit a response from him that was not possibly mediated at brainstem level but rather at cortical level. No such response could be obtained from the patient."

⁵⁴ *Clarke v Hurst NO* supra note 50 at 633C.

⁵⁵ *Clarke v Hurst NO* supra note 50 at 633A-D:

"In her founding affidavit the applicant has expressed it as her intention, if the application should be granted, to have the tube removed which has been introduced into the patient's stomach to provide for his body's nutritional requirements. In effect what the applicant intends doing is to put an end to the artificial feeding regime at present in operation whereby the patient obtains the necessary sustenance for his bodily functions such as they are. The applicant expresses herself as follows:

'If the order is granted I will consult with the medical practitioners with whom my husband will be in custody at the time and give such directions as will ensure that any physical distress which accompanies the removal of the tube is minimised; that being necessary, as I understand it, to preserve the dignity of the relationship between the attending medical staff and my husband and to alleviate the stress on family members. I am of course mindful of the fact that my husband's death will follow the removal of the tube from his stomach. However, I respectfully submit that the removal of the tube will not cause his death. In my respectful submission what will cause my husband's death is the cardiac arrest that occurred on 30 July 1988.'"

⁵⁶ Cited as the third respondent.

⁵⁷ *Clarke v Hurst NO* supra note 50 at 634C-D. Further at 650C-H the court summed up the Attorney General's arguments as follows:

"Counsel who appeared for the Attorney General submitted that: (i) any act which hastens a person's death is a cause of it, even though at the time of the commission of the act which results in his death he may already have been mortally injured or may already have been suffering from some terminal condition: *R v Makali* 1950 (1) SA 340 (N); (ii) if a killing is intentional it is none the less murder, even though the killer may not have harboured any evil motive: *S v Hartmann* 1975 (3) SA 532 (C); *S v De Bellocq* 1975 (3) SA 538 (T); (iii) even an omission to act, if the omission results in the victim's death, would attract liability on the part of the non-doer, if he was under a legal duty to act so as to prevent the victim's death; (iv) consequently, in the instant case, if the applicant were to discontinue the nasogastric feeding and the patient's death were to be accelerated or hastened thereby, the applicant's conduct would

but did so on grounds of lawfulness, not intention. The court held that the discontinuance of the life-sustain measures in these circumstances would not be unlawful as in terms of the legal convictions of society, Mrs Clarke would be acting “reasonably and would be justified in discontinuing the artificial feeding and would therefore not be acting wrongfully.”⁵⁸

The court in *Clarke v Hurst NO*⁵⁹ also noted by way of an obiter remark that the administration of pain-relieving medications which have the side-effect of hastening death that “it has come to be accepted that the doctor may give a terminally ill patient drugs with the object of relieving his pain, even if, to the doctor’s knowledge, the drugs will certainly shorten the patient’s life.”⁶⁰ This part of the judgment refers to palliative care practices, and thus if a patient’s death ensues as a result of such treatment, provided of course that the doctor is found to have acted reasonably, he would not be acting unlawfully. In these circumstances, when conduct is justified, *cadit questio*.

Analysis of Clarke:

In *Clarke v Hurst NO* the court did not base its decision on the intention harboured by the applicant and in fact acknowledged and accepted that the applicant would have *dolus directus*. In other words, the court’s decision must not be understood to mean that people acting in cases of PE act without foresight that death will be the result of their conduct. In the applicant’s founding affidavit, she expressed unequivocally that it was her intention to remove the feeding tube knowing that such discontinuance would inevitably cause the patient’s death.⁶¹ The court concluded that it was unnecessary to consider either causation or intention in this particular case, when in terms of society’s legal convictions, the act of removing such artificial life support was not in fact unlawful in the circumstances. Thus, because the act the applicant intended to undertake was not wrongful it was not a criminal offence. The court in fact set PE apart from the crime of murder making it unnecessary to consider the element of intention. It follows, therefore, that a doctor who genuinely and reasonably attempts to relieve the pain of the patient by administering pain medication, but causes the death of the patient as a consequence, would not be guilty of murder only *if* such conduct is not wrongful, not because

probably be unlawful. Counsel’s argument amounts to this: The discontinuance of the artificial feeding would hasten the patient’s death and would thus be a cause of it and, as the applicant foresees death as a probable result of the discontinuance of the artificial feeding, she would in law be liable for having unlawfully killed the patient.”

⁵⁸ *Clarke v Hurst NO* supra note 50 at 659B-C.

⁵⁹ *Clarke v Hurst NO* supra note 50.

⁶⁰ *Clarke v Hurst NO* supra note 50 at 656-657.

⁶¹ *Clarke v Hurst NO* supra note 50 at 633C “I am of course mindful of the fact that my husband’s death *will* follow the removal of the tube from his stomach.”

he lacks intention.⁶² It relates to the question of wrongfulness and justification of the act itself, not of intention. Intention, however, would be relevant if the physician is alleged to have acted outside of the defined parameters of lawfully accepted conduct.⁶³

4.3.3 A recent case on voluntary active euthanasia and foresight

The *Stransham-Ford*⁶⁴ case, first heard in the North Gauteng High Court, and then on appeal in the Supreme Court of Appeal, placed the issue of the lawfulness of physician-assisted suicide and physician-administered euthanasia squarely before the judiciary. In that case, the applicant was diagnosed with cancer and was in the last stages of the disease. He brought an application asking that the court permit a physician to assist him in dying, either through PAE or PAS. The High Court ruled in his favour, however the decision was overturned chiefly on the issue of mootness, as the applicant had passed away before the court handed down its decision.

The High Court made the following observations regarding *dolus* and foresight in medical cases, particularly PE:

“... life-sustaining treatment may be withdrawn even if this would cause the patient to die from natural causes. I will return to this topic hereunder but I pose the question whether this is not a good example of *dolus eventualis*? 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 may ensue, and he reconciles himself with this possibility.”⁶⁵

And further:

⁶² D F Dorfling “*Genadedood*” in *die Strafreg – ‘n Regsfilosfiese en Regsvergekykende Perspektief* (unpublished LLM thesis, Randse Afrikaanse Universiteit 1991) at 114, in S Strauss *Doctor Patient and the Law* 3 ed (1991) 346.

⁶³ *Clarke v Hurst NO* supra note 50 at 657D-H:

“In my view the distinction between the act of the doctor who, while following the precepts and ethics of his profession, prescribes a drug in a quantity merely sufficient to relieve, and with the object of relieving, the pain of his patient, well knowing that it may also shorten the patient's life, and the act of the doctor who prescribes an overdose of the drug with the object of killing his patient, is that the former acts within the legitimate context and sphere of his professional relationship with his patient while the latter does not act in that context. Consequently, society adjudges the former's conduct justified in accordance with its criterion of reasonableness and therefore not wrongful, while it condemns the conduct of the latter as wrongful. The distinction between what is wrong and what is right cannot always be drawn according to logic. Logic does not dictate the formation of society's legal or moral convictions. The distinction can also be justified on rational grounds. The doctor who brings about the death of his patient by prescribing an overdose of the drug with the object of killing the patient, causes the death of the patient in a manner which is unrelated to his legitimate function as a doctor. He changes not only the course but also the cause of his patient's death. To allow conduct of this nature would open the door to abuse and subject people to the vagaries of unauthorised and autocratic decision-making.”

⁶⁴ *Minister of Justice and Correctional Services v Estate Late James Stransham-Ford* 2017 (3) SA 152 (SCA); *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (4) SA 50 (GP).

⁶⁵ *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (4) SA 50 (GP) at p 14.

“He said that the main intention for the medical practitioner remains to ensure the patient’s quality of life and dignity. The secondary result, namely death or the hastening of death is exactly the same in both instances. I agree that that is so. On behalf of the Applicant it was therefore submitted that where a doctor withdraws life sustaining or life prolonging treatment, he or she knows that the result would be a hastening of the patient’s death, which a doctor could have avoided, yet reconciled himself or herself with the result and still acted accordingly. Is this not a good example of *dolus eventualis*?”⁶⁶

On accepting the common law principles regarding intention and foresight, the High Court ultimately ruled in favour of the applicant, but did so by drawing an analogy with the lawfulness criteria established in *Clarke v Hurst NO*. Thus, the court ruled that the applicant was

“...entitled to be assisted by a qualified medical doctor, who is willing to do so, to end his life, either by administration of a lethal agent or by providing the Applicant with the necessary lethal agent to administer himself...”⁶⁷

and that

“The medical doctor who accedes to the request of the Applicant shall not be acting *unlawfully*, and hence, shall not be subject to prosecution...”⁶⁸

The High Court did not alter or modify the intention criteria as it exists in the common law, nor did it declare that a physician would be acting without the intention to cause the applicant’s death.

The decision was taken on appeal to the Supreme Court of Appeal. The SCA⁶⁹ referred with approval of the dictum in *Clarke* as authority for the position that “a medical practitioner commits *no offence* by prescribing drugs by way of palliative treatment for pain that the doctor *knows* will have the effect of hastening the patient’s death”.⁷⁰ However, the SCA went further by referring to the English law principle of the doctrine of double effect (DDE) as the reason for the decision in *Clarke*, stating that doctors who know that death will be hastened by their actions commit no offence:

“This is referred to as ‘double effect’...It was accepted as the correct position in our law in *Clarke v Hurst NO*, citing Devlin J’s charge to the jury in *R v Adams*: ‘If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor

⁶⁶ *Stransham-Ford* (HC) supra note 65 at p 31.

⁶⁷ *Stransham-Ford* (HC) supra note 65 at p 35.

⁶⁸ *Stransham-Ford* (HC) supra note 65 at p 35.

⁶⁹ *Minister of Justice and Correctional Services v Estate Late James Stransham-Ford* 2017 (3) SA 152 (SCA).

⁷⁰ *Stransham-Ford* (SCA) supra note 69 at para 34.

to do, and *he is entitled to do all that is proper and necessary to relieve pain and suffering, even if measures he takes may incidentally shorten life*’.”⁷¹

A concern is that hereby, the SCA implies that in cases like these, the only form of intention to be scrutinised is *dolus directus*.

Analysis of Stransham-Ford:

It is submitted that the SCA decision in *Stransham-Ford* must not be understood to mean that the court in *Clarke v Hurst NO*⁷² endorsed the DDE as having any influence on intention. The court in *Clarke v Hurst NO* noted that “on the principles of our law the doctor would in each of the above examples be exempt from liability *if, judged by the legal convictions of society, his conduct is reasonable*”.⁷³ This speaks directly to *boni mores* and grounds for justification. In South African law, at best, the DDE is used to determine lawfulness and justification, where the other elements of criminal liability have been proved, including intention. In medical practice guidelines, the DDE is used to exclude intention in the forms of *dolus indirectus* and *dolus eventualis*.

It is submitted, that the SCA in *Stransham-Ford* incorrectly stated the ratio in *Clarke v Hurst NO* by referring to the DDE as the reason why physicians acting in PE cases are not criminally liable as it inadvertently creates the presumption that the DDE influences intention in law. The problem with this is that while motive has never had a bearing on intention in South African law in relation to the assessment of intention, the SCA appears to endorse this English law principle which inadvertently has the unintended consequence of negating criminal intention as strictly applied in South African law. Where *Clarke v Hurst NO* was clear that the answer is to be found in public policy considerations of lawfulness, the SCA appears to be suggesting that the answer can be found through re-interpreting intention by incorporating motive into the analysis. Passive euthanasia is not wrongful when it is justifiable. If death so caused is not justifiable, a court would turn to consider *mens rea*, which would mean that if the doctor had foreseen and reconciled themselves to the consequences of a hastened death materialising as a result of the treatment undertaken, that doctor would at the very least have intention in the form of *dolus eventualis*. McQuoid-Mason confirms this and notes that

“[d]octors who hasten the termination of the lives of their patients by withholding or withdrawing treatment or prescribing a potentially fatal palliative dose of medication *satisfy the*

⁷¹ *Stransham-Ford* (SCA) supra note 69 at para 34.

⁷² Supra note 50.

⁷³ Supra note 50 at 657 A-B.

elements of intention and causation of a charge of murder against them. However, the courts have held that, *for policy reasons* based on ‘society’s legal convictions’, such conduct is not **unlawful** if the patient consented to it or medical treatment would be futile or palliative treatment may hasten death. Doctors are not held liable for murder because society regards their omissions or acts as lawful – not because they did not have the intention in law to kill or did not cause the death of their patients”.⁷⁴

The SCA did not make any ruling regarding either intention or unlawfulness, except to confirm the position set out in *Clarke v Hurst NO* and *Hartmann*. As such, the dictum and principles confirmed and established in both these cases reflect the current position of the law regarding intention. Why the SCA was not able to decide on lawfulness of VAE is discussed in the next chapter.

4.4 INTENTION THROUGH THE MEDICAL PRACTICE GUIDELINES

To regulate the conduct of members of the medical profession, the Health Professions Council of South Africa (HPCSA) has drafted and published a set of practice guidelines which establish the parameters of ethical conduct relating to end-of-life decisions.⁷⁵ All members of the medical profession ascribe to and are governed by these ethical guidelines, which primarily find its roots in the Hippocratic Oath.⁷⁶

4.4.1 *The ethical guidelines*

⁷⁴ DJ McQuoid-Mason ‘Withholding or withdrawing treatment and palliative treatment hastening death: The real reason why doctors are not held liable for murder’ (2014) 104(2) *SAMJ* 102.

⁷⁵ There are a total of 17 ethical practice guidelines dealing with general matters as well as more specific ones. The booklets are available at https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf, accessed on 21 September 2021.

⁷⁶ The Hippocratic Oath is of ancient Greek origin and was written by Hippocrates. Modern versions of the Oath now exist, but the basic tenets remain, particularly the ethical prescripts of beneficence, non-maleficence and confidentiality. It is still taken by all members of the medical profession and is binding on them, such that physicians who conduct themselves outside of the ethical bounds of the oath can face both legal (civil and criminal) and professional censure and repercussions, including being struck off the role of licensed practitioners. See *The World Medical Association Declaration of Geneva – The “Modern Hippocratic Oath”*, available at <https://www.wma.net/what-we-do/medical-ethics/declaration-of-geneva/>, accessed on 20 September 2021:

“The Declaration of Geneva is one of the World Medical Association’s (WMA) oldest policies adopted by the 2nd General Assembly in Geneva in 1947. It builds on the principles of the Hippocratic Oath, and is now known as its modern version. It also remains one of the most consistent documents of the WMA. With only very few and careful revisions over many decades, it safeguards the ethical principles of the medical profession, relatively uninfluenced by zeitgeist and modernism. The Oath should not be read alone, but in parallel with the more specific and detailed policies of the WMA especially the International Code of Medical Ethics, which followed the Declaration of Geneva as early as 1948.”

Booklet 7 of the HPCSA *Guidelines for the Withholding and Withdrawing of Treatment* (September 2016) offers guidance to medical practitioners regarding the ethical nature of withholding and withdrawing of treatment from consenting⁷⁷ patients. Specifically, in relation to intention, the guidelines state that causing death in these types of cases is permissible because the primary intention⁷⁸ is not to cause a patient's death.⁷⁹ In contrast, the HPCSA maintains that PAS and PAE are impermissible because the primary intention is to cause death.⁸⁰

In 2019 the HPCSA published Booklet 17: *Ethical Guidelines on Palliative care (edited by the Committee⁸¹ for Human Rights, Ethics and Professional Practice of the Health Professions Council of South Africa)*.⁸² The guidelines in Booklet 17 state:

“9.8 When medical treatment relieves suffering - but has the effect of *accelerating the dying process* - the health practitioner providing palliative care must consider whether the palliative benefits justify the shortened life expectancy before pursuing that course of treatment.

⁷⁷ Consent is given by the patient themselves, or by a proxy decision maker.

⁷⁸ Primary intention refers to *dolus directus* and adheres to the declaration published by the *World Medical Association Declaration on Terminal Illness*. Booklet 7 has as an annexure the World Medical Association (WMA) declaration in this regard which endorses the DDE in that death can be justified and is not intended when the primary aim of palliative treatment is aimed at comfort care. WMA 'Declaration of Venice on Terminal Illness', adopted by the 35th World Medical Assembly, Venice, Italy, October 1983 and revised by the 57th WMA General Assembly, Pilansberg, South Africa, 30 October 2006, *World Medical Association* available at <https://www.wma.net/policies-post/wma-declaration-of-venice-on-terminal-illness/> accessed on 22 January 2021. The preamble states that

“The World Medical Association condemns as unethical both euthanasia and physician-assisted suicide. It should be understood that WMA policy on these issues is fully applicable in the context of this Statement on Terminal Illness.” See also ‘WMA Declaration of Venice on Terminal Illness’ op cit note 53 – Principle 3: “The patient’s right to autonomy in decision-making must be respected with regard to decisions in the terminal phase of life. This includes the right to refuse treatment and to request palliative measures to relieve suffering but which may have the additional effect of accelerating the dying process. However, physicians are ethically prohibited from actively assisting patients in suicide. This includes administering any treatments whose palliative benefits, in the opinion of the physician, do not justify the additional effects”.

⁷⁹ Booklet 7 of the HPCSA ‘*Guidelines for the Withholding and Withdrawing of Treatment*’ (2016) at para 1.2: “The guidance which follows is intended to provide an ethical framework of good practice for health care practitioners in circumstances where they are faced with making a decision on whether to withhold or withdraw life-prolonging treatment. It is based on those areas of broad consensus so far established and recognises the need to ensure that patients can die with dignity and that their families and others close to them are appropriately involved in their care. It takes account of existing law in this area, that allowing for withholding and withdrawing of life sustaining treatments and that which prohibits killing, active euthanasia, and assisted suicide. It is, therefore, based on the premise that any medical intervention where the health care professional’s *primary intention* is to end the patient’s life is both contrary to the ethics of health care and unlawful.” (Emphasis added).

⁸⁰ Booklet 7 *ibid*.

⁸¹ Members of the Committee were at that time Dr S Balton (Chairperson), Prof DJ McQuoid-Mason, Dr N Tsotsi, Prof B Pillay, Prof N Gwele, Prof N Mekwa and Prof S Hanekom.

⁸² Booklet 17 *Ethical Guidelines on Palliative Care* (2019), available at https://www.hpcs.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf accessed on 22 February 2021.

- 9.9 Palliative care treatment where life is shortened as a side effect, is not regarded as unlawful or unethical – provided the patient or their surrogate has given informed consent.”

Stated this way, it is clear that physicians know through foresight (*dolus eventualis*) that a course of medical treatment undertaken can cause death, and in “pursuing that course of treatment” they direct their will towards the foreseen, yet undesired side-effect; they in fact have subjective “foresight of (the) consequences and circumstances” of their actions and reconcile themselves to the possibility of death resulting when they persist with their actions.⁸³

Particularly in relation to PAS and PAE, the guidelines note that these practices are inconsistent with the ethical principles of beneficence and non-maleficence. However, palliative care practices, even though they hasten death, do not transgress these principles.⁸⁴ Medical practitioners view intention differently from the way it is viewed by the law, made possible by reliance on the doctrine of double effect (DDE).⁸⁵

4.4.2 *The doctrine of double effect*

⁸³ Burchell *Principles of Criminal Law* 5ed op cit note 5. See also S V Hooror ‘The degree of foresight in *dolus eventualis*’ op cit note 22.

⁸⁴ Booklet 17 op cit note 82 at para 9:

“9.1 Non-maleficence requires health practitioners providing palliative care not to harm their patients and complements beneficence and the balancing of risks and benefits.

9.2 Euthanasia and doctor-assisted suicide are often perceived as inconsistent with the principle of non-maleficence.

9.3 Euthanasia and doctor-assisted suicide are presently prohibited under South African law, and the courts frequently do not distinguish between the two when it comes to culpability.

9.4 Euthanasia is the employment of any medical intervention primarily aimed at ending a patient’s life (e.g. giving a patient lethal drug or injection).

9.5 Doctor-assisted suicide occurs when the health practitioner provides the means necessary to enable the patient to end their own life (e.g. handing a patient a lethal drug or prescribing a lethal drug for a patient).

9.5 At present, South African courts have acknowledged that both euthanasia and doctor-assisted suicide are fundamentally incompatible with a practitioner’s role as a healer, and a practitioner guilty of either is regarded as having acted unethically and unlawfully.

9.6 Due to the stress of extreme pain and the prospect of facing a life-threatening illness, a patient may request a health practitioner providing palliative care to end their life.

9.7 The role of the health practitioner providing palliative care in this instance is to discuss the concerns and fears that have led to the patient’s request, and to provide alternate approaches to address these issues.

9.8 When medical treatment relieves suffering - but has the effect of accelerating the dying process - the health practitioner providing palliative care must consider whether the palliative benefits justify the shortened life expectancy before pursuing that course of treatment.

9.9 Palliative care treatment where life is shortened as a side effect, is not regarded as unlawful or unethical – provided the patient or their surrogate has given informed consent.”

⁸⁵ P F Omonzejele ‘Obligation of non-maleficence: moral dilemma in physician-patient relationship’ (2005) 4 *JMBR* 22-30 at 24:

“The principle of double effect attempts to differentiate intended and non-intended effects of an action. The intended effect is good and primary; however, associated with the intended effect is the necessary but bad and unintended (secondary) effect.”

Motivated by a desire to alleviate pain suffered by their patients, the question is, do physicians have foresight of the possibility of death occurring, given the nature of the treatments involved and the circumstances under which they are administered?

While the ethical principles of beneficence and non-maleficence⁸⁶ require that physicians not cause harm to their patients, the DDE⁸⁷ is invoked to assist in providing care which is ethical to patients suffering from terminal illnesses, where the do-no-harm principle may conflict with palliative care treatments which hasten death. The DDE is invoked “in certain difficult cases, provided that certain conditions are satisfied, to bring about an effect indirectly that they are forbidden to bring about directly.”⁸⁸

The DDE finds its roots in the medieval natural law tradition and has found application through Catholic moral theology.⁸⁹ The operational requirements of the DDE are based on drawing moral distinctions between what is right and what is wrong, ushering in language aimed at assessing the character of the intention for its moral goodness or badness.⁹⁰ In the practice of medicine the DDE is invoked to exclude all forms of intention other than *dolus directus*.⁹¹ The criteria for the DDE which must be met for it to apply are that “the directly intended effect must be a good one; the harmful effect must be foreseen but not directly intended; the harmful effect must not be a way of producing the good effect; and the good

⁸⁶ ‘WMA Declaration of Venice on Terminal Illness’, op cit note 91, principle 4: “The duty of physicians is to heal, where possible, to relieve suffering and to protect the best interests of their patients. There shall be no exception to this principle even in the case of incurable disease”.

⁸⁷ A McIntyre ‘The doctrine of double effect’ in E N Zalta (ed) *Stanford Encyclopedia of Philosophy* (2018), available at <https://plato.stanford.edu/entries/double-effect/> accessed on 14 February 2021:

“The doctrine (or principle) of double effect is often invoked to explain the permissibility of an action that causes a serious harm, such as the death of a human being, as a side effect of promoting some good end. According to the principle of double effect, sometimes it is permissible to cause a harm as a side effect (or “double effect”) of bringing about a good result even though it would not be permissible to cause such a harm as a means to bringing about the same good end... Thomas Aquinas is credited with introducing the principle of double effect in his discussion of the permissibility of self-defense in the *Summa Theologica* (II-II, Qu. 64, Art.7).”.

⁸⁸ R G Frey ‘Some aspects of the doctrine of double effect’ (1975) 5(2) *Can J Philos* 259-283 at 259.

⁸⁹ McIntyre op cit note 87.

⁹⁰ Frey ‘Some aspects to the Doctrine of Double effect’ op cit note 88 at 262:

“In examining DDE, talk of sin serves only to obscure matters. Specifically, it obscures the distinction between the rightness or wrongness of acts and the goodness or badness of agents, and the considerations relevant to each. What is at issue, and this must be stressed, is whether DDE’s use of the distinction between direct and oblique intention can establish a difference in the goodness or badness of our two doctors, one of whom intentionally kills his patient, the other of whom knowingly brings about his patient’s death. The adherent to DDE thinks it can, whereas Hart, rightly, I believe, thinks otherwise. So far as the rightness or wrongness of acts is concerned, we have already seen in connection with Condition One that in order even to consider whether DDE is applicable in a particular case, it is assumed one knows whether or not the proposed act is intrinsically wrong.”

⁹¹ McIntyre op cit note 87: “The distinction between direct and indirect harmful agency is what underlies the moral significance of the distinction between intended and merely foreseen harms.”

effect must outweigh the harmful effect.”⁹² The DDE is firmly placed within the scope of medical practice, and effectively means that the primary intention (*dolus directus*) to provide pain relief outweighs the secondary intention (*dolus eventualis*) of a foreseen death.⁹³ Through the DDE, in terms of medical practice, deaths caused by PE are permissible because physicians do not *primarily* intend to cause their patients’ deaths, while deaths caused by VAE are not permissible because such practices intend to cause death primarily.⁹⁴ Through reliance on the DDE, the HPCSA as well as other international bodies⁹⁵ see death caused through palliative care and the withdrawing and withholding of life-sustaining treatment as unintentional and, therefore as ethical.⁹⁶

4.4.2.1 Analysis of reliance on the doctrine of double effect in medical practice

In this section I will show that where intention is concerned in law, there is no distinction between PE and VAE: for as long as the physician has foresight of the death of the patient, reconciles himself to that possibility, and persists in treatment, death is intended. As such, reliance on the permissibility distinction between PE and VAE through the DDE in medical practice is unsustainable in South African law.

Riisfeld considers the permissibly distinction between deaths caused through palliative care and euthanasia when based on intention and notes that there are a number of “widely

⁹² D Wholihan & E Olson ‘The Doctrine of Double Effect: A review for the bedside nurse providing end-of-life care’ (2017) 19(3) *J Hospice & Palliat Nurs* 205-211 where the authors note that palliative care practitioners “are frequently presented with ethically challenging situations involving the use of palliative sedation and increasing opioids at the end of life. The doctrine of double effect is an ethical principle dating back to the 13th century that explains how the bad consequences of an action can be considered ethically justified if the original intent was for good intention”.

⁹³ Booklet 7 of the HPCSA *Guidelines for the Withholding and Withdrawing of Treatment* op cit note 79.

⁹⁴ G Williams *The Sanctity of Life and the Criminal Law* (1958) at 286:

“It is altogether too artificial to say that a doctor who gives an overdose of a narcotic having in the forefront of his mind the aim of ending his patient's existence is guilty of sin, while a doctor who gives the same overdose in the same circumstances in order to relieve pain is not guilty of sin, provided he keeps his mind off the consequence which his professional training teaches him is inevitable, namely, the death of his patient. ...If [DDE] means that the necessity of making a choice of values can be avoided merely by keeping your mind off one of the consequences, it can only encourage a hypocritical attitude towards moral problems.”

⁹⁵ WHO ‘Palliative care: Symptom management and end-of-life care’ available at <https://www.who.int/hiv/pub/imai/genericpalliativecare082004.pdf> accessed on 14 February 2021.

⁹⁶ Booklet 17 op cit note 82 at para 1.2.2: “Palliative care ...intends neither to hasten or postpone death” And at paras 9.8 and 9.9:

“9.8 When medical treatment relieves suffering - but has the effect of accelerating the dying process - the health practitioner providing palliative care must consider whether the palliative benefits justify the shortened life expectancy before pursuing that course of treatment.

9.9 Palliative care treatment where life is shortened as a side effect, is not regarded as unlawful or unethical – provided the patient or their surrogate has given informed consent.”

accepted practices in the provision of mainstream palliative care”⁹⁷ which are essentially similar to VAE, but ethical and lawful nonetheless, justified by the way the medical profession understands and applies intention through the DDE.⁹⁸ He focuses his argument on the active practices of the administration of opioids and sedatives in palliative care, noting that although they are primarily intended to alleviate pain, they do also hasten death:

“given the nature of the drugs involved, it is at least biologically plausible that—despite their careful titration—the ATAOs⁹⁹ and palliative sedation (particularly CDPS¹⁰⁰) do in fact hasten or bring about death, or in other words, shorten survival time”.¹⁰¹

He submits, and I agree, that the drugs are an active intervention, which although not primarily aimed at or intended to cause death do hasten death. It is, through *dolus eventualis*, intended. Through this knowledge of the mechanics of the drugs prescribed or administered, it is not possible to conclude that a physician does not have within their contemplation the death of the patient, hastened by these drugs. Therefore, in law, death is intended. This confirms that physicians do have intention, at the very least, in the form of *dolus eventualis*. Physicians who administer drugs for palliation and sedation foresee the fatal effects that the drugs can have.¹⁰² In law, *dolus eventualis* is sufficient for proving that an accused intended to cause death. The alleviation of pain and suffering may be the primary intention, but it cannot, without more discount the other forms of intention that apply in South African law, particularly in relation to foresight of death resulting as a possibility from palliative care medications.

⁹⁷ T D Riisfeld ‘Weakening the ethical distinction between euthanasia, palliative opioid use and palliative sedation’ (2019) 45(2) *J Med Ethics* at 125.

⁹⁸ Riisfeld op cit note 97 at 125:

“Palliative care comprises a broad range of pharmacological and non-pharmacological interventions, which can also be divided into ‘active’ practices (eg, the administration of drugs) and ‘passive’ practices (eg, withholding drugs, instituting ‘do not resuscitate’ orders, turning off mechanical ventilators, removing nasogastric feeding tubes)”.

⁹⁹ Appropriately titrated administration of opioids.

¹⁰⁰ Continuous deep palliative sedation.

¹⁰¹ Riisfeld op cit note 97.

¹⁰² However, where drugs are administered in reasonable quantities, the physician may not be liable for murder because his conduct is reasonable and justifiable. J Lynn, J Lynch Schuster & A Kabcenell *Improving Care for the End of Life* (2000) available at <http://www.mywhatever.com/cifwriter/library/66/4367.html> accessed on 10 July 2022:

“Drugs such as morphine and other opioids used in pain relief are often thought to hasten death... Because of this fear, some doctors are concerned that use of effective drugs will be seen as having engaged in active euthanasia (i.e., actively killing a patient via lethal injection).”

See also ‘Law backs doctors who prescribe opioids to the dying’ 3 June 2019, *The University of Queensland, Faculty of Medicine* available at <https://medicine.uq.edu.au/article/2019/06/law-backs-doctors-who-prescribe-opioids-dying> accessed on 25 December 2020:

“Some doctors fear litigation and professional ruin if they are seen to have overprescribed opioids to terminally ill patients, according to a University of Queensland researcher... Some are choosing to abandon end-of-life care altogether rather than risk professional ruin should they persist in the use of any opioid therapy... The fear is that the use of medicines to minimise suffering and distress at the very end of life may hasten death and be construed by critics as euthanasia by stealth.”

This brings us to Riisfeld's¹⁰³ consideration of intention and primary purpose gauged on the basis of what drugs are typically administered in palliative care scenarios.¹⁰⁴ With medical practitioners holding steadfast to the *ethical* distinction between VAE and palliative sedation based on intention, consideration of how intention is assessed in medical practice, proves that the intention distinction is not sound in law. Bodies like the HPCSA and the World Medical Association maintain that VAE is unethical because it aims to cause patients' deaths, but palliative sedation is not because it does not aim to cause death.¹⁰⁵ This distinction is maintained by the profession simply because the medical fraternity will not sanction *euthanasia*, and continues to deceptively and intentionally distort and manipulate words to sanction all other forms of assisted dying, to the explicit exclusion of VAE. It appears that the medical profession takes exception to the word euthanasia itself.¹⁰⁶

Death caused through PE is lawful in certain contexts, but it is foreseen, and if it is foreseen, unless justified, will also be criminally intended. In South African law intention extends beyond the direct aim and, through *dolus indirectus* and *dolus eventualis*, brings both VAE and PE within the ambit of the criminal law understanding of intention, to the categorical exclusion of motive in relation to any effect it may have on intention. Each of these will be discussed below and will illustrate the malalignment of the concept of intention between the law and the practice of medicine in the assisted-dying paradigm.¹⁰⁷

In defining palliative care, the HPCSA states that the provision of palliative care does not *intend* to hasten death¹⁰⁸ despite admitting that the provision of such care could result in serious harm or death. Physicians make a judgment call and decide whether the side effect of death is reasonable in order to achieve the primary aim of pain relief.¹⁰⁹ Palliative care includes

¹⁰³ Riisfeld op cit note 97 at 125.

¹⁰⁴ Ibid

“One fruitful way to explore the ethics of euthanasia is via comparison with already widely accepted practices in the provision of mainstream palliative care, in order to draw similarities and differences between them. Palliative care comprises a broad range of pharmacological and non-pharmacological interventions, which can also be divided into ‘active’ practices (eg, the administration of drugs) and ‘passive’ practices (eg, withholding drugs, instituting ‘do not resuscitate’ orders, turning off mechanical ventilators, removing nasogastric feeding tubes). In this essay, I will focus on two specific active practices: the administration of opioids and sedatives.”

¹⁰⁵ Booklet 17, op cit note 82.

¹⁰⁶ See discussion below regarding terminal sedation now referred to as palliative sedation.

¹⁰⁷ D J J Muckart et al ‘Palliative care: Definition of euthanasia’ (2014) 104(4) *SAMJ* 259-260.

¹⁰⁸ Booklet 17 op cit note 82.

¹⁰⁹ Booklet 17 op cit note 82 at para 9.8:

“When medical treatment relieves suffering – but has the effect of accelerating the dying process – the health practitioner providing palliative care must consider whether the palliative benefits justify the shortened life expectancy before pursuing that course of treatment.”

terminal sedation.¹¹⁰ Palliative care is pain management for patients suffering from life-threatening (and terminal) illness, from the time of diagnosis until death.¹¹¹ As the patient's life draws closer to death, his palliation needs also increase, requiring higher doses to reach the goal of pain relief and comfort.¹¹² Palliative care is most frequently associated with cancer, and understood to be an end-of-life consideration, part of the treatment and management plan between the physician and the patient, driven by the primary purpose of making the last few days, weeks or months of a patient's life as comfortable and as dignified as possible.¹¹³

Research conducted in Finland¹¹⁴ shows that strong opioids are the foundation of effective pain management in cancer for patients in the end-stages of life, and further shows that the frequency of doses increases, as does the amount of the dose, as the patient draws closer to death. It is well documented that high and frequent doses of opioids (eg, morphine, tramadol, oxycodone and methadone commonly used for advanced or higher-level pain management)¹¹⁵ will result in death. The World Health Organization (WHO) documents that these drugs can cause death¹¹⁶ but are nonetheless recommended for use in palliative care to alleviate distress.¹¹⁷ The WHO notes further that people who used prescription opioids and who were prescribed higher doses were at particular risk of death as a result of the need for increasing dosage levels.¹¹⁸ This is significant for the consideration of the legal intention of a physician who prescribes or administers such palliation medication to his patients as it clearly proves foresight of the possibility of death resulting pursuant to such drug administration.¹¹⁹

¹¹⁰ J Rietjens et al 'Terminal sedation and euthanasia: A comparison of clinical practices' (2006) 166(7) *Arch Intern Med* 749-753: "Terminal sedation, defined as bringing the patient into deep sedation while forgoing artificial nutrition or hydration."

¹¹¹ Palliative care is used in non-terminal cases as well, but for the purposes of this discussion, will be confined to and focused on patients with terminal conditions.

¹¹² L Koivu, T Polonen, T Stormi & E Salminen 'End-of-life pain medication among cancer patients in hospice settings' (2014) 34(11) *Anticancer Res* 6581-6584: "As the disease became more advanced the focus on pain management changed towards more frequent use of opioids."

¹¹³ World Health Organization 'Guidelines on Palliative Care' available at <https://www.who.int/news-room/fact-sheets/detail/palliative-care>, accessed on 27 July 2021.

¹¹⁴ Koivu et al op cit note 112.

¹¹⁵ 'Opioid Overdose' (Fact sheet) *World Health Organization* 28 August 2018, available at https://www.who.int/substance_abuse/information-sheet/en/:

"Pharmaceutical opioids, in particular strong opioids of the type that are typically involved in opioid overdoses, have been restricted in the past to the management of acute pain and cancer pain, such as is recommended in the WHO Cancer Pain Ladder." And "due to their effect on the part of the brain which regulates breathing, opioids in high doses can cause respiratory depression and death."

¹¹⁶ 'Opioid Overdose' op cit note 115.

¹¹⁷ World Health Organization 'Guidelines on Palliative Care' op cit note 126: "Opioids are essential for managing pain. Opioids can also alleviate other common distressing physical symptoms including breathlessness."

¹¹⁸ 'Opioid Overdose' op cit note 115.

¹¹⁹ See McQuoid-Mason op cit note 74.

Terminal sedation as a tool of palliative care was first introduced in 1991.¹²⁰ As a treatment option in palliative care, terminal sedation is aimed at patients who are in extreme pain and for whom other methods of pain alleviation have proved to be ineffective. In practice, it is meant to serve as a last resort.¹²¹ The medication is administered induces sleep or unconsciousness, until such time as death occurs. Debate ensued around whether the practice of terminal sedation was ethical¹²² particularly whether it was euthanasia in disguise¹²³ and in either case, what the repercussions would be for medical practitioners who terminally sedated their patients.¹²⁴ “Terminal sedation has been defined as the intention of deliberately inducing and maintaining deep sleep, but not *deliberately* causing death in specific intractable circumstances”.¹²⁵ As such, the distinction between terminal sedation and VAE from within the medical profession lies in its understanding of intention that does not necessarily align with the law’s contemplation of it particularly as relates to *dolus eventualis*. The legally indefensible result is that as long as physicians maintain that their primary intention is to alleviate pain and suffering, then they are not criminally liable for the death of the patient, even though in these palliative care circumstances causing death is foreseen as an eventuality.

Critics (ethicists and medical practitioners) took exception to the practice being called *terminal* sedation in that it “revealed (that) the real purpose of the intervention...is to *terminate* the patient’s life”.¹²⁶ Eventually, use of the phrase terminal sedation was abandoned and was replaced with *palliative* sedation.¹²⁷ However, the practice, mechanisms, procedure, drug combinations, impact, effect and end-result still remained the same.

This semantic shift shows that although there is no procedural or effective distinction between palliative sedation and euthanasia, there is an *ethical* one based on motive and primary purpose as applied under the DDE. Riisfeld considers the operational principles of the DDE, and concludes that there is at the very least reason to “doubt ... the often-claimed ethical

¹²⁰ R E Enck ‘Drug-induced terminal sedation for symptom control’ (1991) 8 *Am J Hosp Palliat Care* 3-5.

¹²¹ *Ibid.*

¹²² S Simon et al ‘Attitudes towards terminal sedation: an empirical survey among experts in the field of medical ethics’ (2007) 16 *BMC Palliat Care* 4.

¹²³ J A Billings and S D Block ‘Slow euthanasia’ (1996) 12 *J Palliat Care* 1996 31-37. See also J Howland ‘Questions about palliative sedation: an act of mercy or mercy killing?’ (2005) 30 *Ethics Medics* 1-2.

¹²⁴ J Rietjens et al ‘Terminal sedation and euthanasia: A comparison of clinical practices’ (2006) 166(7) *Arch Intern Med* 749-753.

¹²⁵ R L Fainsinger et al ‘Sedation for uncontrolled symptoms in a South African hospice’ (1998) 16(3) *J Pain & Symptom Man* 145-152.

¹²⁶ H Ten Have & J V M Weillie ‘Palliative sedation versus euthanasia: An ethical assessment’ (2014) 47(1) *J Pain & Symptom Man* 123 at 124, 132.

¹²⁷ B Broeckaert ‘Palliative sedation defined or why and when terminal sedation is not euthanasia’ (2000) 20(6) *J Pain Symptom Man* s 58. See also N Broeckaert, J Olarte & J Manuel ‘Sedation in palliative care: facts and concepts’ in H ten Have & D Clark (eds) *The Ethics of Palliative Care. European Perspectives* (2002) 166-180.

distinction between euthanasia and palliative opioid/sedative use.”¹²⁸ In reaching this conclusion, he considers the nature of the medications used in standard palliative sedation practice – the same cocktail used in euthanasia - and concludes that “given the nature of the drugs involved, it is at least biologically plausible that (even) appropriately titrated administered opioids and palliative sedation do in fact hasten or bring about death”.¹²⁹ Riisfeld notes that palliative sedation involves the administration of medication (a combination of opioids and barbiturates)¹³⁰ to a patient which induces deep sedation coupled with the withholding of artificial nutrition and hydration.¹³¹ And if death was foreseen as a result of the drug combination and the withholding of artificial nutrition and hydration by the administering physician, then death is intended.

In cases of palliative sedation, the possibility of death and therefore the degree of foresight increases, such that it is not merely a possibility, but an eventuality; a certainty. Adherents to the DDE would hold that even a physician who more than *merely* foresees a patient’s death resulting from their actions would not be criminally responsible for the patients’ death because the physician did not have *dolus directus* to cause it. The legally indefensible result is that as long as physicians maintain that their direct intention was to alleviate pain and suffering, foresight of death as a side effect is irrelevant as *dolus eventualis* simply does not apply to physicians.

In *Hartmann*, the court noted that “the law is clear that it nonetheless constitutes the crime of murder even if all that an accused has done is to hasten the death of a human being who was due to die in any event”¹³² and where such action is done with foresight, it is intended.¹³³ The distinction between the scenario in *Hartmann* and the palliative care scenario is only that in *Hartmann* the dose was given as a bolus,¹³⁴ while in palliative care practice it is

¹²⁸ Riisfeld op cit note 97 at 125.

¹²⁹ Riisfeld op cit note 97 at 125.

¹³⁰ Riisfeld op cit note 97 at 125.

¹³¹ Rietjens et al ‘Terminal sedation and euthanasia: A comparison of clinical practices’ op cit note 137.

¹³² *Hartmann* supra note 30 at 534E

“It is true that the deceased was in a dying condition when this dose of pentothal was administered and that there is evidence that he may very well have died as little as a few hours later. But the law is clear that it nonetheless constitutes the crime of murder even if all that an accused has done is to hasten the death of a human being who was due to die in any event. See *R v Makali*, 1950 (1) SA 340 (N). Here the State has proved that but for the accused’s action the deceased would not have died when he did. That such action, if wilfully undertaken, constitutes murder is also the law of England, as appears from a number of decisions in the English Court, cited by Hart and Honoré in their work *Causation in the Law* at pp. 307 - 8.”

¹³³ *Hartmann* supra note 30.

¹³⁴ A bolus is a single dose of a drug given with the intention that the effect is fast acting and immediate, as opposed to smaller doses which are titrated over longer periods of time.

titrated.¹³⁵ This not only assists with the causation inquiry but also with the law's treatment of foresight as part of intention. If causing death was not justified, a physician acting in PE type scenarios would be found to have the requisite *mens rea* for causing death unlawfully. If this understanding is adopted by bodies like the HPCSA then we will find that both the law and medical practitioners will be on the same page regarding the real reason why death caused in these circumstances may be justifiable. If it is not justifiable, then a court would have to assess whether the harm caused was intended. This would certainly help to focus the legalisation arguments to the issue of lawfulness and justification through the Constitution and *boni mores*.

4.4.2.2 *Intention and voluntary active euthanasia*

Medical ethics are aligned with the law's interpretation of intention for VAE. In VAE where a physician (or anyone for that matter) administers a lethal dose to a patient, with the direct intention of killing the patient, that person will be guilty of the crime of murder, despite the consent of the patient.¹³⁶ This was definitively held in *Hartmann* and was applied in subsequent cases involving active euthanasia. The guidelines state emphatically that "killing, active euthanasia and assisted suicide"¹³⁷ are prohibited on the premise that in such instance a physician has *dolus directus* to end a patient's life. To harbour such intention is both contrary to the ethical guidelines and the law.¹³⁸

The DDE is not invoked in cases of VAE for the specific reason that the intentional (direct) causing of death of a patient is unethical and contrary to the principle of non-maleficence.¹³⁹

4.5 SHOULD WE BE RE-THINKING THE ROLE OF MOTIVE IN ASSESSING INTENTION?

¹³⁵ Drug titration is the process of continuously measuring and adjusting the balance of the drugs or treatment administered to gauge whether the dose is effective to meet the pain palliation needs of a patient.

¹³⁶ Active euthanasia.

¹³⁷ Booklet 7 op cit note 79 at para 1.2.

¹³⁸ Booklet 7 op cit note 79 at para 1.2:

"It takes account of existing law in this area, that allowing for withholding and withdrawing of life sustaining treatments and that which prohibits killing, active euthanasia, and assisted suicide. It is, therefore, based on the premise that any medical intervention where the health care professional's primary intention is to end the patient's life is both contrary to the ethics of health care and unlawful."

¹³⁹ Booklet 17 op cit note 82 at para 9.2: "Euthanasia and doctor-assisted suicide are often perceived as inconsistent with the principle of non-maleficence" and at para 9.5:

"At present, South African courts have acknowledged that both euthanasia and doctor-assisted suicide are fundamentally incompatible with a practitioner's role as a healer, and a practitioner guilty of either is regarded as having acted unethically and unlawfully."

The SCA in *Stransham-Ford* noted that

“Assuming that a matter reached the stage where a court thought that a development of the common law was required in relation to PAS, it would then have to decide whether that should take the form of a different view of causation, or of intention (*mens rea*), or of unlawfulness.”¹⁴⁰

Both medical ethics and the law, permit some forms of intentional killing in medical practice, to the exclusion of others. However, the reason for permissibility in law is different from the reason in medical practice. The law’s reason has not been based on the absence of intention. Cases like *Hartmann* are no doubt difficult matters to adjudicate when motives clearly appear to be compassionate,¹⁴¹ but South African law is well settled that motive does not and should not infiltrate the intention inquiry. Good motive was rejected as a means of negating intention long before *Hartmann* which simply restated the principle which separates motive from intention.¹⁴²

Hoor, ¹⁴³ writing in relation to the crime of malicious injury to property, also cautions against the infiltration of motive on intention:

“if it is indeed the purpose of the courts or the legislature to adjust the description of the crime for the sake of clarity, as well as to accord with modern discourse, then the qualifier “malicious” ought to be dispensed with. *In signifying that the crime can only be committed where the accused acts out of ill-will or some improper motive, it only serves as a possible source of confusion, and a violation of the principle of fair labelling*, which requires that offences are so labelled so as to “ensure that the stigma (label) attaching to the accused by virtue of his conviction is a fair and accurate reflection of his guilt”. The word “malicious” offers no guidance to the court, which simply assesses whether the conduct is intentional”.¹⁴⁴

¹⁴⁰ *Stransham-Ford* (SCA) supra note 69 at para 56.

¹⁴¹ See K Naidoo ‘Reconsidering motive’s irrelevance and secondary role in criminal law’ (2017) 2 *TSAR* 337, who discusses hate crimes “as a specific category of criminal conduct in the United States of America and the proliferation of hate-crime laws in that country an apparent exception to the maxim that motive is irrelevant and plays a secondary role seems to exist.” But it exists as sound because the motive is a definitional element of that crime.

¹⁴² *Hartmann* supra at 534:

“It is beyond doubt that, in acting as he did, the accused did not desire to end his father’s life. The motive for his action was a compassionate one...Nevertheless to achieve such purpose he was prepared to do an act which he was aware would inevitably terminate his father’s life. He therefore clearly entertained that intention which is an essential ingredient of the crime with which he is charged” and *R v Peverett* supra at 219: “In law desire must be distinguished from intention. The consequences which a man contemplates or expects to result from his act are the consequences he ‘intends’, but (as Austin points out in lecture 19) such consequences may not always be desired. Though a desired consequence is usually an intended one, an intended consequence is not always a desired one... In the eyes of the law, therefore, he intended to kill her, however little he may have desired her death.”

¹⁴³ SV Hoor ‘Criminalisation of damage to property by South African common-law crimes’ (2019) 25(2) *Fundamina* 35-67.

¹⁴⁴ Hoor ‘Criminalisation of damage to property by South African common-law crimes’ op cit note 143 at 38.

Despite the allusion to motive as part of the definitional elements of the crime of malicious injury to property, courts in South Africa must still disregard motive in examining intention. The intention inquiry is intended to establish legal culpability and not moral culpability,¹⁴⁵ which means that whether an accused person has intention is to be determined with no reference to his motives, however noble or malicious, even when the word malicious appears as a definitional element of the crime. In contrast, the DDE negates culpability on moral grounds.¹⁴⁶

McQuoid-Mason explains in relation to foresight of the possibility of death resulting in medical matters that

“A doctor who withholds or withdraws treatment or prescribes palliative treatment that hastens death may have a good motive – not to engage in futile treatment or to lessen the pain of the patient – but legally has the eventual intention to kill the patient.”¹⁴⁷

Questions of moral ‘goodness’ or moral ‘badness’ require insight into a person’s motive/s for causing unlawful consequences and would be contrary to “the principle of legality (which) militates against assigning liability on the basis of *personal* and *individual* ethics and motivation”.¹⁴⁸ Notably, the reason for the exclusion of motive in the intention analysis is that it is near impossible to determine what a person’s motives are.¹⁴⁹ The law on intention is a blunt instrument because it must be. And where motive must not be used to ascribe liability, similarly it must not be used to negate it.¹⁵⁰ Burchell notes that

“Logically, motive precedes the formation of the intention to engage in conduct. It is something separate and distinct from intention. In most systems of criminal law, motive is considered to

¹⁴⁵ Hooro *Snyman’s Criminal Law* 7ed op cit note 2 at 150.

¹⁴⁶ Omonzejele ‘Obligation of non-maleficence: moral dilemma in physician-patient relationship’ op cit note 98 at 25:

“The duty and responsibility physicians owe to patients and society is to do well (beneficence) and not to inflict harm (maleficence). Ironically, Kantian ethics could also be used the other way round to support the principle of double effect (infliction of harm) if one focused on just duty or act and ignored the consequences in line with deontological ethical theories. This is because (and according to Kant) our actions have moral worth in themselves, in which case it would seem that only physicians’ intended actions should be morally evaluated in double effect treatments and the unintended consequence (e.g., hastened death) should be ignored as of no moral consequence or even relevance.”

¹⁴⁷ DJ McQuoid-Mason ‘Withholding or withdrawing treatment and palliative treatment hastening death: The real reason why doctors are not held liable for murder’ (2014) 104 (4) *SAMJ* 102-103 at 102. While withdrawing and withholding of treatment which hastens death is not classed as an unlawful killing, and neither is the administration of drugs in the palliative care and palliative sedation scenarios, this does not mean that the physician does not have intention.”

¹⁴⁸ Burchell *Principles of Criminal Law* 5ed op cit note 5 at 354.

¹⁴⁹ Burchell *Principles of Criminal Law* 5ed op cit note 5 at 354:

“The reason for ignoring motive in the matter for determining criminal liability is that individual motives are too complex and obscure to provide a reliable basis for determining liability for punishment.”

¹⁵⁰ Burchell *Principles of Criminal Law* 5ed op cit note 5 at 353:

“In most systems of criminal law, motive is considered to be irrelevant to the determination of liability. The general rule is that a person’s motives, whether good or bad, are irrelevant to criminal intent.”

be irrelevant to the determination of liability. The general rule is that a person's motives, whether good or bad, are irrelevant to criminal intent."¹⁵¹

The criminal law is only concerned with motive in as much as it is "a force inducing intention and action. Ulterior intention entails a rephrasing of this meaning of motive so that instead of talking of the motive to alleviate pain and suffering of the patient that caused the doctor to act, "we talk of his ulterior intention ...which is directly linked to the intention to satisfy his"¹⁵² motive. Norrie notes that "it is this link between social causes and individual motives that lies behind the exclusion of motive from consideration of legal fault and responsibility. The attitude that motive is irrelevant to responsibility and the guilty mind has deep roots within the common law tradition, and is linked to the social conflicts of the period in which the law was developed"¹⁵³ premised on a breach of universal social interests.

As in South Africa, the fault requirement for murder in England is intention, and the English courts' adoption of the DDE to negate intention has been severely criticised by English writers.¹⁵⁴ Ashworth notes that courts in England prefer a narrow definition of intention in order to justify decisions made on motive rather than legal principles.¹⁵⁵ He and Norrie¹⁵⁶ both criticise the English courts' willingness to include moral issues in the intention inquiry.¹⁵⁷ Williams¹⁵⁸ notes that courts in England incorrectly conclude that "doctors are not *normally* presumed to *intend* all the foreseen consequences of their actions,"¹⁵⁹ because of the motive

¹⁵¹ Burchell *Principles of Criminal Law* (2016) op cit note 8 at 353.

¹⁵² A Norrie *Crime, Reason and History: A Critical Introduction to Criminal Law* 3 ed (2014) at 43.

¹⁵³ Norrie op cit note 165 at 44.

¹⁵⁴ R Huxtable 'Get out of jail free? The doctrine of double effect in English law' *Palliative Medicine* (2004) 18(1) 62-68; J Bennett 'Foreseen Side Effects versus Intended Consequences' In *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle*, edited by P. A. WOODWARD, 85-118 (2001); H Faris, B Dewar, C Dyason, et al. 'Goods, causes and intentions: problems with applying the doctrine of double effect to palliative sedation' *BMC Med Ethics* 22, 141 (2021); S Kershner and R Kelley 'The right-based criticism of the doctrine of double effect' (2020) *International Journal of Applied Philosophy* 34(2) 215-233; C Kendall 'A double dose of double effect' (2000) *Journal of Medical Ethics* 26 204-206; F Woollard 'Double effect, doing and allowing, and the relaxed nonconsequentialist' (2017) *Philosophical Explorations* 20(2) 145-158; A Saemi 'The intention principle and the doctrine of double effect' (2019) *Analysis* 79(1), 91-99; WJ FitzPatrick 'The doctrine of double effect Intention and permissibility' (2012) *Philosophy Compass* 7(3) 183-196; WS Quinn 'Actions, intentions, and consequences: The doctrine of double effect' (1989) *Philosophy & Public Affairs* 18(4) 334-351.

¹⁵⁵ A Ashworth and J Horder *Principles of Criminal Law* 6 ed (2013) at 176:

"Judges in the appellate courts are fond of referring to 'ordinary language' as a justification for their decisions, but this often appears to be camouflage for moral judgements."

¹⁵⁶ Norrie op cit note 152 at 58:

"courts sometimes regard the defendant's motive as a reason for concluding that the result was not 'intended'... and sometimes do not...contemporary criminal law is trapped by a set of concepts stemming from a desire to separate 'legal judgment from substantive moral issues' which means that in difficult cases the courts find themselves 'excluding and re-admitting substantive moral issues into a technically conceived set of fault categories'."

¹⁵⁷ Ashworth op cit note 155 at 176 (case references excluded).

¹⁵⁸ G Williams *Intention and Causation in Medical Non-Killing* (2007).

¹⁵⁹ Williams *Intention and Causation in Medical Non-Killing* op cit note 158 at 41.

behind their conduct. Ashworth similarly concludes disapprovingly of the courts' approach that "when faced with a strong moral pull towards exculpation the courts have sometimes...manipulated the concept of intention rather than developing a defence to criminal liability."¹⁶⁰ The courts in England inappropriately rely on the DDE to exclude intention, when, as Ashworth correctly notes, it is better suited for a determination of unlawfulness and whether some forms of conduct ought to be decriminalised and justified. I agree with Ashworth. Unlawfulness is a separate and distinct policy issue from intention. The DDE and how it construes motive as relevant for intention does not and should not have a bearing on intention in law.

Equally critical of the English courts' reliance on the DDE in medical cases, Norrie opines that medical cases provide

"a good illustration of the law being manoeuvred to produce what Ashworth and Horder (2013. 174) calls 'moral elbow-room' in a case of good motive where otherwise the standard formulation of the law of intention would lead to a guilty verdict...How the law potentially delivers this through the failure to provide a precise definition of intention is (that)... 'the intent formed was not *criminal* intent'."¹⁶¹

Referring to *Re (A) (Children)*¹⁶² Norrie concludes that the presence of the DDE in English law

"echoes the sense of an uneasy and persistent tug of war between legal and moral conceptions of intention reflected in Fletcher's view that criminal law is caught between a desire for value-free (i.e non-moral) rules and concepts and the 'the reality of judgement, blame and punishment [which] generates the contrary pressure and insures that the quest for a value free science of law cannot succeed'."¹⁶³

Grubb notes that

"The philosophical doctrine of "double effect" has no place in the English criminal law. The doctrine asserts that a defendant who acts intending to achieve a primary effect which is good (relieve pain) does not intend an secondary effect which is bad (death). Whatever the philosophical propriety of this doctrine, the English criminal law does not distinguish between

¹⁶⁰ Ashworth op cit note 155 at 177:

"when faced with a strong moral pull towards exculpation the courts have sometimes, as in *Steane* and in *Gillick*, manipulated the concept of intention rather than developing a defence to criminal liability."

See also Lord Mustill in *Airedale N.H.S. Trust v Bland* [1993] 2 WLR 316 (HL) at 396:

"the argument seems to me to require not manipulation of the law so much as its application in an entirely new and illogical way."

¹⁶¹ Norrie op cit note 152 at 48. See also previous discussion regarding 'malicious' intent per Hoctor.

¹⁶² [2000] 4 All ER 961.

¹⁶³ Norrie op cit note 152 at 49.

the desired result of a defendant's action (the primary effect) and the undesired but inevitable consequences of his action (the secondary effect). Both are, in law, intended.”¹⁶⁴

Baker¹⁶⁵ explains why the law looks at intention and not motive and notes that

“To say that a person did the *actus reus* with *mens rea* does not mean that he acted immorally. One who breaks the law with a good motive, or for conscientious reasons, or from religious belief, still commits a crime.”¹⁶⁶

Thus, where conduct is unlawful, intention must be assessed in all forms to the exclusion of motive. Baker posits the following question: “Isn’t the desire of a consequence the motive for acting, rather than intention?”¹⁶⁷ In answering this question he notes that motive has no bearing on intention, but it may have an influence on justification. Thus, in the active euthanasia context

“if a doctor decides to overdose his patient to kill him because the patient only has weeks to live and is in immense pain, he has no defence since Parliament has not recognized mercy killing as a defence. Since ‘mercy’¹⁶⁸ is not recognized as lawful justification for killing, it is irrelevant that the doctor acted with mercy in mind.”¹⁶⁹

Yet motive is used in English law to negate intention for PE-related deaths. In this light it certainly appears disingenuous to conclude that motive negates intention in PE cases but not in VAE cases, where arguably the motive behind the conduct is the same; both PE and VAE are motivated by a desire to end the pain and suffering of a patient.¹⁷⁰ Thus, in English law, intention ought to be applied and understood as it is in South African law, absent of motive, regardless of the factual matrix or circumstances. Grubb’s criticism of the applicability of the DDE in English law relates to misplacement by the courts in concluding that motive serves to negate intention in medical cases, when rather it has an effect on the lawfulness of death intentionally caused – it is a ground for justification, not a factor which negates intention.

¹⁶⁴ A Grubb ‘Attempted murder of terminally ill patient: R v Cox (United Kingdom)’ (1993) 1(2) *Med Law Rev* 232 at 233.

¹⁶⁵ D J Baker *Glanville Williams Textbook of Criminal Law* 3 ed (2012).

¹⁶⁶ Baker op cit note 165 at 97-98.

¹⁶⁷ Baker op cit note 165 at 100.

¹⁶⁸ Baker op cit note 165 at 100: “Courts should always try to fit the conduct within one of the recognized justificatory defences since a system of judge-made defences would be too unpredictable.”

¹⁶⁹ Baker op cit note 165 at 102.

¹⁷⁰ Frey ‘Some aspects of the doctrine of double effect’ op cit note 88 at 264-265:

“So far as our doctor who knowingly brings about the death of his patient is concerned, then, even if he is described as ‘administering a drug’ or ‘relieving pain’, responsibility for bringing about that particular set of consequences which includes the patient’s death is his. In short, I think we are entitled to conclude that these three attempts to forge a difference in the goodness of our two doctors through establishing a difference between them in respect of the responsibility each bears for the death of his patient come to nothing.”

A further criticism of the English law approach is that it offers a narrow interpretation of intention only to physicians, and so the general principles do not in fact apply generally.¹⁷¹ Intention in medical practice is assessed differently from intention in criminal law. Williams¹⁷² refers to Pellegrino¹⁷³ who states in this regard that from the perspective of a medical practitioner “[i]ntentions cannot be assessed in isolation from the other components of moral events. They must be related to the nature of the act in question, the circumstances under which it is performed, and its consequences”.¹⁷⁴

However,

“While there is a conscious feeling that although the conclusions in these cases are exactly what we would desire them to be, the methods used to reach them are based on considerations such as social acceptability, motive, intuition, and the patient’s condition, none of which have anything at all to do with intention.”¹⁷⁵

South African law is clear: only physicians act lawfully when they cause death in PE-type cases and then too under certain circumstances; the rule does not apply to laypersons, even if they act with the same motive.¹⁷⁶

In South Africa, the DDE cannot be used to prove that the accused (physician or lay person) acted without intent. Voluntary active euthanasia is classed as murder, and in South Africa, the case of *Hartmann*¹⁷⁷ is authority for the principle that motive never proves that an accused lacks intention to commit murder, even where patients are terminally ill, are suffering intractably and death is imminent, and even where the perpetrator is a physician. In the current state of our law, compassionate motive through the DDE does not result in the conclusion that the accused acted without intention; nor does it offer an accused person a defence excluding unlawfulness in VAE cases. It does, however, render deaths intended and caused in PE cases justifiable and lawful through the overarching policy consideration of what forms of conduct ought to be so. Currently motive has some utility in South African law and has been used as a factor in argument for mitigation and aggravation of sentences in VAE cases, where the

¹⁷¹ G Williams *Intention and Causation in Medical Non-Killing* (2007) at 17: “despite contentions that the law in the UK does not differentiate between doctors and non-doctors and despite claims that they are not treated in any way differently to any other class of persons...the narrow interpretation of intention in medical cases shows discrepancies between law as applied to doctors on the one hand and lay persons on the other.”

¹⁷² Williams op cit note 171 at 8.

¹⁷³ ED Pellegrino ‘Doctors must not kill’ (1992) 3(2) *J Clin Ethics* 95.

¹⁷⁴ Ibid.

¹⁷⁵ Williams op cit note 171 at 17.

¹⁷⁶ *Clarke v Hurst NO* supra; *Stransham-Ford* (SCA) supra; *Hartmann* supra.

¹⁷⁷ Supra note 12.

circumstances are deemed to be extenuating, regardless of whether the perpetrator was a physician or a layperson.¹⁷⁸

The analysis of fault in law is a blunt instrument and as such, in the intention analysis, once an actor has appreciated the consequences of his conduct, no matter how much he may not have desired it, he will possess the requisite *criminal* intent to bring about the unlawful consequence. As a blunt instrument, the intention inquiry is unyieldingly scientific, and admittedly causes problems within the discourse where social interests have changed such that VAE is viewed as an act of mercy and compassion. It is submitted, that unless and until there is such re-categorisation, the intention analysis will always prove that an accused physician who assists a patient to die, criminally intended to cause death. The hands of the courts are tied. Legal principles for assessing intention give no quarter to motive, except perhaps in as much as it may have a bearing on sentencing as possibly indicative of a shift in universal interests and legal convictions.¹⁷⁹

So, the answer to the question is: No, we should not allow motive to form part of the intention inquiry. In fact, in South Africa we do not. We should rather be looking at motive in relation to the overarching inquiry into unlawfulness and grounds for justification in terms of society's legal convictions, as has been the case with deaths intended and caused through PE practices.¹⁸⁰

4.6 CONCLUSION

Foreseen consequences are intended consequences, no matter how undesired those consequences¹⁸¹ may be, or what motivated the accused to act. Ascribing to and applying the ordinary common law principles of criminal liability attendant to intention, will categorically result in the conclusion that the physician who perpetrates an act of either PE or VAE has intention to cause the death of his patient. To do otherwise is not only contradictory, but also judicially unsound and inconsistent as to create confusion and lack of certainty of the basic principles of legality for the established intention assessment criteria, particularly foresight.

¹⁷⁸ Hartmann supra note 12.

¹⁷⁹ Hartmann supra note 12 at 534.

¹⁸⁰ A Van der Merwe *An Analysis of Assisted Dying and the Practical Implementation thereof in South African Criminal Law* (unpublished LLM, University of Pretoria 2017) at 56:

“It would seem the courts have gone out of their way over the years to protect the medical profession from the *legal* repercussions of the double effect. But to name this practice would shed light on it and force various sectors to acknowledge it and consider how it should be regulated.”

¹⁸¹ See Hoorntje ‘The degree of foresight in *dolus eventualis*’ op cit note 22.

But for the fact that PE may in certain circumstances be justifiable, the submission is that practitioners in PE cases would in fact otherwise have intention to cause the deaths of their patients. On application of common-law principles of liability, unless justified, a physician would be found to have the necessary intention to cause a patient's death. The SCA in *Stransham-Ford* was correct in confirming that "a medical practitioner *commits no offence* by prescribing drugs by way of palliative treatment for pain that the doctor knows will have the effect of hastening the patient's death",¹⁸² but was incorrect in attributing this to the DDE for the possible effect it may have on motive in relation to intention. As discussed, in terms of the ratio in *Clarke v Hurst NO*, the correct principle in law established that the answer was to be found in overall lawfulness, and not the element of intention. In so doing, the law sets some forms of PE apart from the common law homicide crimes, and it is a practice that might be lawful, if justified. In justifiable circumstances it attracts no consideration of intention in criminal law, when the treatment is in line with treatment protocols for the provision of palliative care and withdrawing or withholding treatment, which undeniably hasten death.¹⁸³

The medical assessment of intention weighs heavily on motive, circumstance and what course of action is believed to be in the best interests of the patient. In criminal law, motive may have some bearing on overall unlawfulness, but not in the sense articulated and applied in medical practice; it certainly has no bearing on intention.

There is a misalignment of ideologies and principles regarding intention in criminal law and the practice of medicine. However, no one is above the law, not even medical doctors, and so, when VAE cases appear before a court, they are inevitably judged in accordance with the letter of the law. The medical practitioner concerned will be accused of the crime of murder, and his criminal liability will be considered in terms of the definitional elements of the crime, in this instance, the element of intention. As submitted, in South Africa, the courts have not based their decisions on the DDE in relation to intention, but rather that PE practices are not wrongful for policy reasons. That is an enquiry quite apart from intention. Side-effects are intended consequences when they are foreseen, but those side effects are not unlawful in the context of PE because they are justified.¹⁸⁴

¹⁸² *Stransham-Ford* (SCA) supra at para 34.

¹⁸³ See Chapter Four on consent for a discussion in this regard.

¹⁸⁴ SALRC report op cit at para 4.39: Strauss in his submissions to the SALRC in relation to the legality of VAE in contrast to PE states that:

"the administration of the pain-alleviating method can be qualified as an act with double effect. It must not be defined according to its side-effect, the unavoidable shortening of life, but according to its aim, which is to combat pain of which the patient is suffering. Many medical acts and drugs have side-effects, but nobody will define them from the viewpoint of these side-effects. The same is true for pain killing."

As yet, our courts have not accepted that a noble motive justifies murder.¹⁸⁵ Motive does not have a bearing on intention in criminal law.¹⁸⁶ For that reason in determining criminal liability in cases of VAE, the proper question is whether intentionally causing death is wrongful within the definition of VAE. As long as VAE is categorised as murder, a principled and categorical application of the common law principles of criminal liability in relation to intention and foresight will prove guilt.

Williams posits that

“The criminal law errs, not only in applying a criminal standard to doctors when they are making end-of-life decisions, but also in ignoring the context in which such decisions are made. A doctor is required by law to act in his patient’s best interests and it is both inappropriate and contradictory to confuse that role with the criminal intent required to satisfy the *mens rea* for murder”.¹⁸⁷

While I agree with her position that medical contexts are different from criminal contexts, it must be stressed that courts must persist in applying criminal tests and standards in cases that present before criminal courts for adjudication. And as long as VAE is prosecutable as the currently categorised homicide offences, the criminal standards and tests must be applied, including the tests for intention. The criminal law does not err in applying the criminal tests because the acts are categorically criminal;¹⁸⁸ the criminal law would err if it did not. However, the test for unlawfulness is also a criminal standard, and it is only in this sense that a criminal court could consider a defence excluding unlawfulness if raised by an accused person.

It is submitted that the general rule that applies where the doctor has acted with propriety and in accordance with the standards of accepted medical practice is that PE practices are not wrongful practices *per se*. When conduct is not wrongful, it is not criminal, and as has been submitted, there is no recourse to consideration of any of the other elements of criminal liability (including intention), unlike where the act itself is a crime. *Clarke v Hurst NO*¹⁸⁹ placed some forms of PE outside of the ambit of the criminal law when it noted that some forms of medical interventions which hasten death may be justifiable. The consideration of criminal liability for the act would thus only present itself if the doctor is alleged to have acted unjustifiably in the administration of doses, frequency thereof, amounts thereof, and the class

¹⁸⁵ *Hartmann* supra note 12.

¹⁸⁶ See *Hartmann* supra note 12.

¹⁸⁷ Williams *Intention and Causation in Medical Non-Killing* op cit note 171 at 8.

¹⁸⁸ *Ex Parte Die Minister van Justisie: In Re S v Grotjohn* 1970 (2) SA 355 (A); *Hartmann* supra note 12.

¹⁸⁹ *Supra*.

of drug used. This will then necessitate an inquiry into intention (and the other elements of criminal liability *inter alia* causation).

Confirming that “motive is separate from the inquiry into intention” thereby rejecting any effect that the DDE can have on intention in South African law, Burchell notes that motive may have a bearing on overall lawfulness and posits that

“the possible lawfulness of assisting a person, who is suffering from an incurable and painful disease, to die with dignity *may* involve taking into account the motive of the assistant as a *factor* in determining the *overall* lawfulness¹⁹⁰ of the conduct”.¹⁹¹

He does not mean that motive proves or disproves intention, only that it may have a bearing on lawfulness if appropriately considered in the light of the legal convictions of the community. Under the present discussion, motive does not offer any assistance in deciding that the physician does not harbour intention to cause death, and this was confirmed in *Hartmann*.¹⁹²

Proper and honest consideration of whether intention exists will always prove that it did, regardless of motive, as appreciating and contemplating the possibility of an outcome and persisting with conduct as acceptance than an unlawful outcome could materialise, secures that death was intended because it was foreseen. The DDE has no defensible place in purporting to draw distinctions between *dolus directus*, *dolus indirectus* and *dolus eventualis* so as to negate foresight in South African law. It may however bear on the overarching consideration of whether VAE is *prima facie* unlawful - as has transpired in the declaration that in certain circumstances death caused through PE is justifiable. The appropriate question is thus whether death caused through VAE could ever be justifiable. This is a question that must be answered through an assessment of *boni mores* as gauged through the Constitution.

¹⁹⁰ Regarding whether Burchell regards motive as an indicator for determining whether conduct is justifiable as appropriately addressed through considerations of *boni mores*.

¹⁹¹ Burchell *Principles of Criminal Law* 5ed op cit note 5 at 35.

¹⁹² Discussed below.

CHAPTER FIVE

LAWFULNESS, THE LEGAL CONVICTIONS OF SOCIETY AND THE CONSTITUTION - DEVELOPING THE SOUTH AFRICAN COMMON LAW

5.1 INTRODUCTION

In the previous chapters it has been shown that acts of passive euthanasia (PE) are justifiable when performed within certain parameters. Resort to the legal convictions of society¹ allows for consideration of justification beyond the established defences which exclude it. At its core, this is the issue which must be examined – whether society’s legal convictions recognise VAE as conduct which is justifiable. It is an exercise which requires the balancing of competing interests – that of the state and that of the individual through the constitutional lens.

The cases which confirmed the common law position were all decided before the advent of the 1996 Constitution, but even then the common law was not static.² Prior to the advent of the Constitution, courts were empowered to develop the common law such that it reflected and met the needs of society.³ However, what has not yet been discussed in great detail is what these convictions are or how they are gauged. All we do know is that these convictions are a reflection of society’s sense of fairness and justice and thus in the context of PE it is fair, just and reasonable to permit the causing (or hastening) of the death of patients even when such is intentional.⁴

¹ Also referred to as ‘the legal convictions of the community’ and ‘*boni mores*’. These terms have been used interchangeably by the courts and writers, but all mean the same thing.

² *Pearl Assurance Co Ltd v Union Government* 1934 (AD) 560 at 563 where the court noted that the common law “is a virile living system of law, ever seeking, as every system must, to adapt itself consistently with its inherent basic principles to deal effectively with the increasing complexities of organized society.”

³ *Amod v Multilateral Motor Vehicle Accidents Fund* 1998 (4) SA 753 (C) at para 22 where the Constitutional Court noted that

“The Supreme Court of Appeal has always had an inherent jurisdiction to develop the common law to meet the needs of a changing society. The circumstances in which it elects to do so and the manner in which it develops the law form part of this jurisdiction. With the coming into force of the interim Constitution, and later the 1996 Constitution, this power must now be exercised in accordance with the “spirit, purport and objects” of the Bill of Rights.”

See also *Pearl Assurance Co Ltd v Union Government* supra note 2.

⁴ *Clarke v Hurst NO* 1992 (4) SA 620 (D). See also AE Storde, J Toohey, P Singh and CM Slack ‘Boni mores and consent for child research in South Africa’ (2015) *SAJBL* 8(1) 22- 25 where the authors discuss the voracity if

In an effort to explain what society's legal convictions are, the court in *Clarke v Hurst NO* referred to several authoritative sources, and explained that the legal convictions of society are an objective measure of reasonableness and fairness, which is a "value judgment based on considerations of morality and policy – a balancing of interests followed by the law's decision to protect one kind of interest against one kind of invasion and not another."⁵

Decades later, the Supreme Court of Appeal in *Stransham-Ford*⁶ was faced with the question of whether the common law ought to be developed to accommodate for the permissibility of VAE. Essentially, based on *Clarke v Hurst NO* and *Hartmann*, this would require consideration of whether society's legal convictions would deem the practice reasonable and justifiable. However, in the decades since these decisions, South Africa saw the implementation of the Constitution of the Republic of South Africa 1996, which caters for the development of the law without reference to the phrase the legal convictions of society. The

any of public opinion or community morals in the determination of whether and how the law ought to be developed. They note at 24 that legal convictions of the community do not equate with public opinion:

"For example, even though public opinion may be opposed to terminations of pregnancy (TOP) below the age of 18, this would not necessarily mean that research into TOP would be inconsistent with public policy. Likewise, research per se into illegal or 'immoral' behaviours is not necessarily against public policy – even though the community may disapprove of the behaviour. For example, research exploring factors that impact on risky sexual practices of adolescents might be frowned upon by some stakeholders but this would not mean that research on the topic would be against public policy if conducted in accordance with the legal framework."

S v Makwanyane 1995 (3) SA 391 (CC) at paras 87-89:

"The Attorney General argued that what is cruel, inhuman or degrading depends to a large extent upon contemporary attitudes within society, and that South African society does not regard the death sentence for extreme cases of murder as a cruel, inhuman or degrading form of punishment. It was disputed whether public opinion, properly informed of the different considerations, would in fact favour the death penalty. I am, however, prepared to assume that it does and that the majority of South Africans agree that the death sentence should be imposed in extreme cases of murder. The question before us, however, is not what the majority of South Africans believe a proper sentence for murder should be. It is whether the Constitution allows the sentence.

Public opinion may have some relevance to the enquiry, but in itself, it is no substitute for the duty vested in the Courts to interpret the Constitution and to uphold its provisions without fear or favour. If public opinion were to be decisive there would be no need for constitutional adjudication. The protection of rights could then be left to Parliament, which has a mandate from the public, and is answerable to the public for the way its mandate is exercised, but this would be a return to parliamentary sovereignty, and a retreat from the new legal order established by the 1993 Constitution. By the same token the issue of the constitutionality of capital punishment cannot be referred to a referendum, in which a majority view would prevail over the wishes of any minority. The very reason for establishing the new legal order, and for vesting the power of judicial review of all legislation in the courts, was to protect the rights of minorities and others who cannot protect their rights adequately through the democratic process. Those who are entitled to claim this protection include the social outcasts and marginalised people of our society. It is only if there is a willingness to protect the worst and the weakest amongst us, that all of us can be secure that our own rights will be protected.

This Court cannot allow itself to be diverted from its duty to act as an independent arbiter of the Constitution by making choices on the basis that they will find favour with the public."

⁵ *Clarke v Hurst NO* supra note 4 at 657.

⁶ *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA). The decision of the lower court in *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (6) BCLR 737 (GP) was brought on appeal to the Supreme Court of Appeals.

respondent (Estate Late Stransham-Ford) argued that equating VAE with the common law crime of murder, was an unjustifiable limitation on a patient's right to human dignity⁷ and as a result, the common law prohibition on consent to an assisted death was overly-broad as it conflicted with the rights enshrined in the Constitution.⁸ The court acknowledged that the development of the common law was possible through the courts via the Constitution,⁹ but because the case presented before it and the High Court was improperly argued on the issue of development, development was not possible.¹⁰

In *Clarke v Hurst NO*¹¹ the court ruled, based on the legal convictions of society, that it would not be unlawful to hasten the death of a patient through the withdrawal of life-supporting measures.¹² Similarly, in relation to palliative care which has been shown to hasten death, the same court considered the principle established in the English case of *R v Adams*,¹³ with the notable distinction being that the South African court based its decision on unlawfulness while the court in *Adams* drew a liability distinction between *dolus directus* and other forms of intention which rely on varying degrees of foresight.¹⁴ The court in *Clarke v Hurst NO* ruled ultimately that in terms of the legal convictions of society it would be reasonable, justifiable and therefore lawful, to hasten a patient's death by means of the withdrawal and withholding of life-sustaining mechanisms, or by the provision of palliative care.¹⁵ And so, what the court did in fact do was develop the common law in relation to the

⁷ Section 10 of the Constitution of the Republic of South Africa, 1996.

⁸ *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) at para 4.

⁹ Sections 8, 39 and 172.

¹⁰ *Ibid* at para 5:

“there was no full and proper examination of the present state of our law in this difficult area, in the light of authority, both local and international, and the constitutional injunctions in relation to the interpretation of the Bill of Rights and the development of the common law.”

¹¹ *Clarke v Hurst* supra note 4.

¹² *Clarke v Hurst* supra note 4 at 653:

“the decision whether the discontinuance of the artificial nutritioning of the patient and his resultant death would be wrongful, depends on whether, judged by the legal convictions of our society, its boni mores, it would be reasonable to discontinue the artificial nutritioning of the patient.”

¹³ *R v Adams* 1957 *Crim LR* 365:

“the distinction between the act of a doctor who, while following the precepts and ethics of his profession, prescribed a drug in a quantity merely sufficient to relieve, and with the object of relieving, the pain of the patient, well knowing that it may also shorten the patient's life, and the act of the doctor who prescribes an overdose of the drug with the object of killing his patient, is that the former acts within the legitimate context and sphere of his professional relationship with his patient while the latter does not act in that context. Consequently, society adjudges the former's conduct justified in accordance with its criterion of reasonableness and therefore not wrongful, while it condemns the conduct of the latter as wrongful.”

¹⁴ *Clarke v Hurst NO* supra note 4 at 657. It is important to clarify that South African courts have not used the *Adams* principle to negate the elements of intention or causation, but rather its applicability in gauging acceptability (or justifiability) of conduct through the legal convictions of society.

¹⁵ *Clarke v Hurst* supra note 4 at 656. Here the court referred to the case of *S v Hartmann* 1975 (3) SA 532 (C). In that case the physician gave the patient a lethal dose of pentothal causing the death of the patient.

element of unlawfulness - when is causing death within particular medical context, justifiable. The question remains: whether society's legal convictions can now be relied on to similarly justify deaths caused through VAE.¹⁶

The SCA in *Stransham-Ford*¹⁷ noted that the question of development of the common law requires courts to give effect to the spirit, purport and objects of the Bill of Rights¹⁸ by considering whether the common law position infringes a right in the Bill of Rights, what the current common law position and purpose is, and then whether the limitation (if there is one) is reasonable and justifiable in an open and democratic society.¹⁹ Only after these issues have been thoroughly canvassed would it be possible to determine whether it would be reasonable and necessary to implement a remedy, for example, by developing the common law so that it is brought into harmony with the spirit, purport and objects of the Bill of Rights, and does not violate against identified rights in the constitutionality challenge. What an appropriate remedy would be in such a case will be discussed later herein.²⁰ It is thus evident that under a constitutional dispensation, the common law must develop to reflect the spirit, purport and objects of the Bill of Rights and that in this era, the legal convictions of society properly mean the spirit, purport and objects of the Bill of Rights.

The common law position on VAE has been thoroughly canvassed in the preceding chapters, and what is left for consideration is the issue of lawfulness and justifiability viewed through the legal convictions of society as determined through the Constitution. In this chapter I explain what the legal convictions of society are under a constitutional dispensation, under what circumstances the common law must develop, and what development could entail, based on the argument that the common law prohibition infringes the right to human dignity. This is done with a view to determining whether, in this constitutional era, VAE is conduct which would be understood as being reasonable and justifiable in South Africa.

The Chapter on consent analysed it as a defence, and concluded that it is possible to reliably gauge the genuineness of consent so as to be acceptable as a defence, but also noted that for consent to have this effect, the conduct consented to must be one for which the law (through *boni mores*) permits consent. It is society's legal convictions which determine what forms of conduct can be consented to.

¹⁶ *Stransham-Ford* (SCA) supra note 8; *Hartmann* supra note 15.

¹⁷ *Stransham-Ford* (SCA) supra note 8.

¹⁸ *Stransham-Ford* (SCA) supra note 8 at para 55.

¹⁹ *Stransham-Ford* (SCA) supra note 8.

²⁰ For example, developing the common law by accepting consent as a defence in the specific circumstances of VAE, or whether in addition thereto there should be a legislative enactment.

This chapter aims to do a number of things. First, I will draw an analogy between the phrases “the legal convictions of society” and “the spirit, purport and objects of the Bill of Rights.” This is necessary because the key cases which drew a distinction between PE and VAE²¹ for their lawfulness were all decided prior to the advent of the Constitution, but drew a permissibility distinction based on “the legal convictions of society”. I will then turn to consider whether “the legal convictions of society” are relevant for the development of the common law under constitutionalism, and subsequently what the phrase means in a constitutional era. I will then consider the Bill of Rights as a tool for development of the common law - how and under what circumstances the common law is ripe for development. And finally, in the next chapter, I will consider what an appropriate remedy would be, if through the discussion in this chapter, it is shown that the common law in South Africa should develop to accommodate for VAE.

5.2 THE LEGAL CONVICTIONS OF SOCIETY – PRE- AND POST-CONSTITUTIONALISM

Thus far the cases under discussion of justifiability of PE and VAE have occurred in the pre-constitutional era,²² and so when considering unlawfulness and the development of the common law, the courts have relied on the legal convictions of society as they existed and were understood at that time to make that determination. In relation hereto, Hoctor²³ notes that there are various criteria that help determine unlawfulness, and although the criteria are admittedly vague, they should be understood as meaning “conduct which is contrary to the community’s perception of justice or with the legal convictions of society.”²⁴

Living communally and socially requires rules (even unwritten rules) of conduct which facilitate day-to-day interactions. These rules have emerged as a social contract²⁵ informed by

²¹ Barring *Stransham-Ford* (SCA) supra note 8 because the effect of that judgement was to re-state the law as determined prior to the advent of the Constitution.

²² *Hartmann* supra note 15; *Ex Parte Die Minister van Justisie: In Re S v Grotjohn* 1970 (2) SA 355 (A).

²³ S V Hoctor *Snyman’s Criminal Law* 7 ed (2020) at 81:

“Among the criteria suggested are that unlawfulness consists of the following: a violation of certain legally protected interests or values; conduct which does not accord with the *boni mores* (literally “good morals”); conduct which violates the community’s perception of justice or equity; conduct which is at variance with public or legal policy; conduct which is contrary to the legal notions or the legal convictions of society; conduct which is contrary to the requirement of objective reasonableness; conduct which causes more harm than benefit; or conduct which is not ‘socially adequate’.”

²⁴ Hoctor *Snyman’s Criminal Law* 7ed op cit note 23 at 81.

²⁵ T M Scanlon *What We Owe to Each Other* (2000); F J M Feldbrugge *The Law’s Beginnings* (2003); A S Diamond *Primitive Law: Past and Present* (1971). Several philosophers have been credited for championing the notion of the social contract, most notably John Locke (*Two Treatises of Government* 1689), Thomas Hobbes (*Leviathan* 1651) and Jean Jacques Rousseau (*The Social Contract* 1762).

a common understanding of what types of conduct are good or bad and therefore socially acceptable or unacceptable. This system of rules is “designed to preserve our individual financial and physical security”²⁶ and as individual members of society we “each (have) an interest in maintaining the State”²⁷ and its institutions, because each member of society benefits from civilization.”²⁸ So the law, and more specifically criminal law, can be understood as being legal recognition and demarcation of socially accepted norms of behaviour for which transgression is punished, and through which society is benefitted. The socially accepted norms of behaviour are reflective of the legal convictions of society and its sense of justice, fairness and reasonableness.

“Society” thus means communal living regulated, maintained and promoted through a system of laws that are designed to reflect and protect society’s shared sense of justice and fairness. While the common law tradition stems from the pre-constitutional era, it was not confined to stasis, and has developed in line with the legal convictions of society which has seen the common law develop through time to meet the ever-changing needs and demands of the society that these laws are meant to serve.²⁹ While the pre-constitutional legal convictions of society shaped and developed the common law, under a constitutional dispensation, the values which underpin the Constitution must now be used to shape and develop it further.

The constitutionality of the common law crime of murder is not being contested, rather the subject matter of this thesis and this chapter is whether VAE ought to continue to fall within the ambit of the definition of murder and thereby whether the blanket prohibition on consent to medical assistance in dying under very specific conditions is unreasonable when viewed in terms of the requirements for development under the Constitution. The fundamental question is whether VAE could ever be justifiable? If that is a possibility, then we can ask when and under what conditions. Of necessity, both these questions engage scrutiny of the legal convictions of society as gauged through the spirit, purport and objects of the Bill of Rights. Under the Constitution, the development of the law is done in terms of criteria which are meant to be less vague than “the legal convictions of society.” Ultimately it still requires the courts to draw a distinction between murder and VAE when viewed in the light of reasonableness and fairness by balancing competing interests, purposes and objectives. These competing factors

²⁶ D J Baker *Glanville Williams Textbook of Criminal Law* 3 ed (2012) at 32.

²⁷ A society of individuals who are governed by a set of agreed norms.

²⁸ Baker *Glanville Williams Textbook of Criminal Law* 3ed op cit note 26 at 33.

²⁹ An excellent example is as occurred in *Ex parte Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A) where the AD explained the historico-legal development of the law related to the decriminalisation of suicide and attempted suicide.

are inter alia the state's interests, individual interests and societal interests which in relation to murder and VAE are purported to be protected through the common law. However none of these interests are superior to the Constitution, and all of them, including the common law, must be evaluated and re-evaluated through the consideration of reasonableness and fairness as ascertained through the Constitution and the spirit, purport and objects of the Bill of Rights; not mere sentiment, which academics and courts have concluded is vague and prone to bias.

In 2001, the Constitutional Court in *Carmichele v Minister of Safety and Security and Another*³⁰ noted that prior to the enactment of the Constitution, the development of the common law was in the hands of the courts and dependent on the criteria of the legal convictions of society as the gauge for whether development was needed. However, a criticism of pre-constitutional development was that reliance on the legal convictions of society was prone to arbitrariness and bias.³¹ This does not mean, however, that the courts are not, under constitutionalism, empowered to develop the common law. In fact, they are. In *Thebus and Another v S*,³² the court confirmed this developmental power noting that judges through the courts, are (and always have been) the custodians of the common law. Prior to constitutionalism, the courts were empowered to develop the common law such that it reflected the changing needs of the very society these laws were meant to govern, serve and protect. Thus, then and now courts, although they are custodial in their function, must not leave the law in a state of stasis. This custodial responsibility also mandates development. Under a constitutional dispensation, courts must "refashion and develop the common law in order to reflect the changing social, moral and economic make-up of society"³³ by balancing purposes, objectives and means in the light of the rights enshrined in the Constitution itself. This, formerly common law, duty is now enshrined in s 8,³⁴ s 39 and s 173 of the Constitution. In the

³⁰ *Carmichele v Minister of Safety and Security and Another* 2001 (4) SA 938 (CC).

³¹ *Carmichele* supra note 30 at para 56:

"Before the advent of the interim Constitution, the refashioning of the common law ... entailed "policy decisions and value judgments" which had to "reflect the wishes, often unspoken, and the perceptions, often but dimly discerned, of the people". A balance had to be struck between the interests of the parties and the conflicting interests of the community according to what "the court conceives to be society's notions of what justice demands. Under section 39(2) of the Constitution concepts such as 'policy decisions and value judgements' reflecting 'the wishes...and the perceptions...of the people' and 'society's notions of what justice demands' might well have to be replaced, or supplemented and enriched by the appropriate norms of the objective value system embodied in the Constitution."

³² *Thebus and Another v S* 2003 (6) SA 505 (CC).

³³ *Thebus* supra note 32 at para 31.

³⁴ "S8

- (1) The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state.
- (2) A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.

light of these provisions, being constitutionally bound also means that in developing the law, the courts ensure that development brings the law into harmony with the spirit, purport and objects of the Bill of Rights in the Constitution. In the section which follows, I intend to show that under constitutionalism, “the legal convictions of society” means “the spirit, purport and objects of the Bill of Rights in the Constitution”. Neethling and Potgieter state emphatically that a consequence of the *Carmichele* judgment is that, when interpreting the common law with a view to development

“the values underpinning the Bill of Rights, ie, the values underlying an open and democratic society based on human dignity, equality and freedom must take precedence over existing *mores*.”³⁵

5.2.1 *From legal convictions of society to society’s constitutional convictions*

At this point, it is necessary to clarify what is meant by the phrase “the legal convictions of society” by considering the phrase prior to and post the advent of the constitutional era. In *DE v RH*³⁶ the Constitutional Court noted that the legal convictions of society are not based on public sentiment or religious conviction, but public policy which is infused with constitutional norms and values.³⁷ This case dealt with the issue of adultery and whether the non-adulterous spouse could make a claim for damages against the third-party adulterer based on the *actio injuriarum* founded on *contumelia* and consortium. The court concluded

“that in the light of the changing *mores* of our society, the delictual action based on adultery... has become outdated and can no longer be sustained; that the time for its abolition has come.”³⁸

The focus was on the determination of wrongfulness as determined by the legal convictions of society informed by the Constitution. The court noted that the legal convictions of society mean

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- (3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court -
a. in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and
b. may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36(1).”

³⁵ J Neethling and J M Potgieter *Law of delict* 8 ed (2020) at p 43. Although the authors were writing in relation to the law of delict, the requirement regarding development of the common law applies to criminal law as well – *Masiya v Director of Public Prosecutions and Another* 2007 (8) BCLR 827; *Minister of Justice and Constitutional Development and Others v Prince (Clarke and Others Intervening)* 2019 (1) SACR 14 (CC); *S v Kampher* 1997 (2) SACR 418 C; *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1998 (2) SACR 556 CC.

³⁶ *DE v RH* [2015] ZACC 18.

³⁷ *DE v RH* supra note 36 at para 7. I Currie & J De Waal *Bill of Rights Handbook* (2013) at 7-8 note that the Constitution “shapes the ordinary law and must inform the way legislation is drafted by the legislatures and interpreted by the courts and the way the courts develop the common law.”

³⁸ *DE v RH* supra note 36 at para 4.

“the community’s general sense of justice”³⁹ and is synonymous with the term *boni mores*. The court referred with approval to an earlier decision of the same court in *Barkhuizen v Napier*⁴⁰ where it was held that

“Public policy represents the legal convictions of the community; it represents those values that are held most dear by the society. Determining the content of public policy was once fraught with difficulties. That is no longer the case. Since the advent of our constitutional democracy, public policy is now deeply rooted in our Constitution and the values which underlie it...

What public policy is . . . must now be determined by reference to the values that underlie our constitutional democracy as given expression by the provisions of the Bill of Rights.”⁴¹

Thus, while establishing that the legal convictions of society in a pre-constitutional era was “fraught with difficulties”, under a constitutional dispensation, the legal convictions of society are informed by the principles of reasonableness and fairness as gauged through the Constitution, and the values held most dear in the Constitution itself – the spirit, purport and objects of the Bill of Rights in the Constitution. The difficulties in relying on the pre-constitutional gauge of the legal convictions of society have evidenced a bias informed by religious doctrine or public sentiment - in this case, the notion of the sanctity of marriage. The court set aside religious doctrine and followed constitutional doctrine, noting that “we have come a long way from those strictures and gymnastics. That is because times are changing, and the law – though still recognising the sanctity of marriage – has moved with the times both in its conception of the institution of marriage and the punitive extremes to which it will go to protect it.”⁴²

In the light of the above, the court summarised the issue before it as “Does public policy – a notion that is now informed by our constitutional values – tell us that a delictual claim founded on adultery must still be part of our law? Put differently, in this context, is it reasonable to impose delictual liability?”⁴³ Similarly, in relation to criminal law, we would ask generally in relation to crimes that came under constitutional scrutiny *whether public policy as informed by constitutional values can determine when it would be reasonable to impose criminal liability and when it would not?*⁴⁴

³⁹ *DE v RH* supra note 36 at para 51.

⁴⁰ *Barkhuizen v Napier* 2007 (5) SA 323 (CC).

⁴¹ *Barkhuizen v Napier* supra note 40 at paras 28-29.

⁴² *DE v RH* supra note 36 at para 27. Here the court was commenting on divorce as being lawful despite Roman Catholic/Christian religious doctrine which held the contrary.

⁴³ *DE v RH* supra note 36 at para 51.

⁴⁴ *Masiya v Director of Public Prosecutions and Another* 2007 (8) BCLR 827 - developed the common law crime of rape to include anal penetration; *S v Kampher* 1997 (2) SACR 418 C – declared that the common law crime of sodomy was an unconstitutional violation of a persons right to privacy and dignity as unfair

Ackermann notes that use of the phrases the legal convictions of society and public policy, although still favoured by the courts, can lead to confusion which could subconsciously result in a perceived bias in favour of less than constitutional *mores*, and prefers, under a constitutional dispensation, that we refer rather to “constitutional policy”.⁴⁵ In this vein, it is preferred that we refer to and understand that the legal convictions of society as the *constitutional convictions* of society. As such, when deciding whether the common law requires development, the issue is whether the provision is aligned with constitutional convictions, and not public sentiment, religious doctrine or other non-constitutional notions of morality which the phrase “the legal convictions of society” may invoke.

5.2.2 *Development of the common law through constitutional convictions*

For a court to reach the stage of considering whether to develop the law and how development should occur, it would first have to be apprised of what the current law actually is. In relation to the subject matter of this thesis, this means that a court would have to consider what the common law position is regarding murder and VAE as a species of murder. It would then have to consider the social purpose for criminalising both murder and VAE and more specifically the purpose of criminalising VAE as murder.

What are the public or social goals that the criminalisation of VAE is aimed at achieving (what is the public good)? After the court has identified the public or social goals, it will have to determine whether they are legitimate in a constitutional democracy based on human dignity, equality and freedom. If the public or social goals are legitimate, then the court will have to determine whether the criminalisation of VAE is rationally related to those goals. Or, to put it another way, the court will have to determine if the criminalisation of VAE will actually achieve those goals. If the criminalisation of VAE is rational (i.e. it will achieve its goals), then the court must go on to determine whether the criminalisation of VAE promotes the spirit, purport and objects of the Bill of Rights. This usually involves identifying a specific right that is relevant, which in the case of VAE, is the right to dignity.

After identifying and defining the relevant right, the court must now engage in the balancing and weighing up exercise. As a part of this exercise, it can ask whether there are other less restrictive means of achieving the objectives sought by criminalising VAE. The

discrimination on the ground of sexual orientation; *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1998 (2) SACR 556 CC – confirmed the position in *Kampher*.

⁴⁵ L Ackermann *Human Dignity: Lodestar for Equality in South Africa* (2012) at 288.

balancing exercise is between the legitimate goals of criminalising VAE and the spirit, purport and objects of the Bill of Rights (e.g. dignity or more specifically autonomy). Finally, if the court finds that the common law principles criminalising VAE do not promote the spirit, purport and object of the Bill of Rights, then it must develop the common law, which it can do in various ways.

In relation to the purpose of the prohibition on VAE, this also means engaging in a rationality analysis between the purpose and the means to achieve the purpose. If there is a way of achieving the purpose through less restrictive means, then there is room to argue that the common law should be developed to accommodate for the lawfulness and justifiability of VAE. Strictly speaking, before a court engages in this balancing exercise, it should first determine:

- (a) whether the criminalisation of VAE serves a legitimate purpose in an open and democratic society; and
- (b) if it does serve a legitimate purpose whether there is a rational connection between the criminalisation of VAE and its purpose.

If the criminalisation of VAE does not satisfy either of these threshold questions, then these common law principles are irrational and arbitrary. They will be unreasonable or unjustifiable if they fail the balancing test. If there is no rational connection between the law and the purpose it means that the law or provision under scrutiny is unconstitutional and the court would be bound to develop the common law rules. If there is a rational connection, the court must now move to the balancing exercise. It must weigh the legitimate goals of VAE against the spirit, purport and objects of the Bill of Rights. As regards whether VAE ought to be decriminalised and set apart from murder, the right to autonomy and the goals and values that autonomy serves are measured on one side of the scale; on the other would be the legitimate goals of maintaining the prohibition on VAE. So, the question is: *do the goals and values of autonomy and dignity outweigh the goals of criminalising VAE?* In this process, the court can take into account whether there are less restrictive means. The court would then further consider whether it is possible to achieve the purpose through these less restrictive means. If that is possible, then the law must be developed to bring it in line with the spirit, purport and objects of the Bill of Rights, namely society's constitutional convictions.

The Constitution has two avenues which cater for the development of the common law, depending on the nature of the challenge. Section 8 explains the process when the challenge is focused on a direct application of the Bill of Rights to a common law provision, and s 39

explains the process when there is an indirect challenge.⁴⁶ The focus in this chapter is on the development of the common law in terms of the process and requirements identified in s 39 as this is the method preferred and relied upon by courts in relation to indirect application of the Bill of Rights.⁴⁷

It is the Constitution and its values which must be relied upon to determine lawfulness - whether, when and under what circumstances the common law should develop. The process described above is exactly what the Constitutional Court in *MEC, Health and Social Development, Gauteng v DZ*⁴⁸ did. The court explained what was required when deciding whether the common law should develop, and noted that in terms of s 36 read with s 39 of the Constitution, a court must

“(1) determine what the existing common law position is; (2) consider its underlying rationale; (3) enquire whether the rule offends section 39(2) of the Constitution; (4) if it does so offend, consider how development in accordance with section 39(2) ought to take place, and (5) consider the wider consequence of the proposed change on the relevant area of law.”⁴⁹

After working through these questions, a court will conclude either that the common law does promote the spirit, purport or objects of the Bill of Rights, or that it does not. If the court concludes that it does not, it must now develop the common law. This is what questions (4) and (5) focus on. In this respect, the common law can be developed by giving a new meaning to the concept of the legal convictions of the society by focusing on the spirit, purport and objects of the Bill of Rights (constitutional convictions) as the new benchmark. The common law can be developed by changing the legal principles and rules governing the common law,

⁴⁶ P De Vos & W Freedman (eds) *South African Constitutional Law in Context* (2014) at 323 explain direct and indirect application as follows:

“When the Bill of Rights applies directly, the purpose is to determine whether the ordinary rules of law (legislation, common law and customary law) are consistent with the Bill of Rights. If they are not, the Bill of Rights overrides the ordinary rules. In these cases, the Bill of Rights also generates its own set of special remedies, for example declaratory orders, structural interdicts, constitutional damages and meaningful engagement. When the Bill of Rights applies indirectly, the purpose is to determine whether the ordinary rules of law promote the values of the Bill of Rights. If they do not, the Bill of Rights does not override the ordinary law nor does it generate its own special remedies. Instead, the court uses the Bill of Rights to develop the rules and remedies of the ordinary law to avoid any inconsistency between the ordinary law and the Bill of Rights.”

⁴⁷ I Currie & J De Waal *Bill of Rights Handbook* (2013) at 46 where the authors note that

“indirect horizontal application has proved to be extremely robust and remains the preferred judicial method for dealing with rights claims in the horizontal dimension. In the subsequent *Thebus* decision the Constitutional Court, without reference to *Khumalo* and without reference to any academic literature on the issue, said nothing about the difficult relationship between s8 and s39, but hinted that s39 (indirect application) was the default mode for considering challenges to the common law.”

In relation hereto, see *S v Thebus* supra note 32 at paras 24-32.

⁴⁸ *Member of the Executive Council for Health and Social Development, Gauteng v DZ obo WZ* 2018 (1) SA 335 (CC).

⁴⁹ *Member of the Executive Council for Health and Social Development, Gauteng v DZ obo WZ* supra note 48 at para 31.

by extending their application to new circumstances, or by narrowing their application, or even by abolishing the common law principles and rules. In the case of VAE, we would seek to redefine or narrow the application of the unlawfulness element by arguing that the legal convictions of society have changed under the influence of the Constitution and, consequently that the criminalisation of VAE no longer reflects the constitutionally-inspired legal convictions of society.

Concerning constitutional convictions and common law crimes, in *National Coalition for Gay and Lesbian Equality v Minister of Justice*⁵⁰ the Constitutional Court declared that the continued criminalisation of sodomy in both the common law and s 20A of the Sexual Offences Act⁵¹ was an unconstitutional violation and unjustifiable infringement of the fundamental human rights to equality, privacy and dignity, when viewed in the light of the spirit, purport and objects of the Constitution. In coming to this conclusion, the court noted that taking into account the purpose behind the criminal law prohibition was a necessary part of the consideration of whether the common law should develop, or whether the criminal sanction should remain. Accepting that criminal laws serve a purpose, the court noted that, despite an infringement of a constitutionally enshrined right,

“The law may continue to proscribe what is acceptable and what is unacceptable...and may, within justifiable limits, penalise what is harmful and regulate what is offensive. What is crucial for present purposes is that whatever limits are established they do not offend the Constitution.”⁵²

In this light then, it becomes clear that the law can continue to place limits on enshrined rights which affect autonomy and conduct, but those limits must also withstand constitutional muster – the limitation must be reasonable and justifiable, and must not offend constitutional convictions.

5.3 DEVELOPMENT THROUGH THE CONSTITUTION – THE STEPS

Returning to the case of *DE v RH*,⁵³ I have thus far only explained what the legal convictions of society are under constitutionalism and confirmed that these constitutional convictions

⁵⁰ *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA (6) (CC). See also *Masiya v Director of Public Prosecutions Pretoria and Another* 2007 (8) BCLR 827 where the court purported to develop the common law crime of rape by extending the scope of its definition to include anal penetration. So, in this case, instead of narrowing the definition, the court extended the ambit of the crime.

⁵¹ The Sexual Offences Act 23 of 1957.

⁵² *National Coalition for Gay and Lesbian Equality v Minister of Justice* supra note 50 at para 119.

⁵³ Supra note 36.

together with rationalisation between purposes and means dictate whether and how the common law must be developed. Before any court reaches this step, it would have to:

- (a) first determine exactly what the common law rule is;
- (b) then consider the underlying reasons for the common law rule;
- (c) then arrive at a conclusion about whether the existing common law rule does or does not promote the spirit, purport and object of the Bill of Rights; and
- (d) then in the light of (c) above, if a common law rule does not promote the spirit, purport and objects of the Bill of rights, the courts must develop the common law by narrowing the application or scope of the unlawfulness element of murder to exclude VAE so that the definition of murder more accurately reflects the legal convictions of society, which have evolved under the influence of the Constitution.⁵⁴

Effectively, these steps expand and give body to the imperative created by s 39. The court in *Thebus* explained that the common law is ripe for development in two instances:

“The first would be when a rule of the common law is inconsistent with a constitutional provision. Repugnancy of this kind would compel an adaptation of the common law to resolve the inconsistency. The second possibility arises even when a rule of the common law is not inconsistent with a specific constitutional provision but may fall short of its spirit, purport and objects. Then, the common law must be adapted so that it grows in harmony with the ‘objective normative value system’ found in the Constitution.”⁵⁵

The first instance applies when the Bill of Rights applies directly to the common law in terms of s 8. Or, to put it another way, it applies when the common law is tested directly against the rights in the Bill of Rights. When the common law is tested directly against the Bill of Rights, the courts follow the normal two-stage approach to constitutional litigation.

The second instance applies when the Bill of Rights is applied indirectly to the common law in terms of s 39(2). Or, to put it another way, it applies when the common law has to be developed by the courts so that it promotes the spirit, purport and objects of the Bill of Rights. The courts prefer to follow this approach and there are many cases in which the Constitutional Court has done so, including *Thebus*⁵⁶ itself.

When the courts follow the second approach, they also apply a two-stage enquiry. At the first stage, the courts ask whether the common law promotes the spirit, purport and objects

⁵⁴ This step also includes consideration of remedies that the court could apply and are discussed more fully in the next chapter. Remedies are considered in Chapter Six herein.

⁵⁵ *Thebus* supra note 32 at para 28.

⁵⁶ *Thebus* supra note 32 at paras 24-32. See also see S Woolman ‘The amazing, vanishing Bill of Rights’ (2007) 124(1) *SALJ* 762 wherein Woolman is critical of the Constitutional Court’s preference to apply the Bill of Rights indirectly to the common law, rather than directly.

of the Bill of Rights. If it does, that is the end of the enquiry. If it does not, then at the second stage the courts must develop the common law. This can include abolishing a common law rule, or amending a common law rule or creating a new common law rule.

However, the Constitution itself does not define what is meant by the phrase “spirit, purport and objects” which unarguably are the drivers for determining whether the law in its current state “promotes” that purpose. So, an important question is how do the courts go about determining whether the common law promotes the spirit, purport and objects of the Bill of Rights? I turn now to look more closely at s 39 of the Constitution.

Section 39 of the Constitution reads as follows:

“39. (1) When interpreting the Bill of Rights, a court, tribunal or forum—

- (a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
 - (b) must consider international law; and
 - (c) may consider foreign law.
- (2) When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.
- (3) The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.”

What this means is that the common law must be developed by the courts if the common law does not align with the values which underpin the Constitution. So, although I have explained in brief what the legal convictions of society are and how these are determined under constitutionalism, logically, a court will only have to consider this aspect after first having determined what the common law rule is and what the underlying reasons for, or purpose of, such rule is. While s 39 of the Constitution places the court under a duty to develop the common law, jurists are left wanting when it comes to determining what the spirit, purport and objects are for the purposes of the imperative created by this section. Some direction can be found in s 36, and through the case law, which shows how the courts have put to practical effect and demonstrated how this driver for reform operates. Strictly speaking, s 36 applies to development as per the directive in s 8, but our courts have used s 36 as a basis for development under s 39.⁵⁷ Even without resorting to s 36, it is clear that at the very least, when considering

⁵⁷ F Moosa ‘Understanding the “Sprit, Purport and Objects” of South Africa’s Bill of Rights’ (2018) 4 *J Forensic Legal & Investigative Sci*, available at <https://www.heraldopenaccess.us/openaccess/understanding-the-spirit-purport-and-objects-of-south-africa-s-bill-of-rights>. Accessed on 8 June 2022.

development of the law under s 39, the courts must (a) determine exactly what the common law position is; (b) then consider the underlying reasons for it; and (c) determine whether the rule infringes the spirit, purport and object of the Bill of Rights. Section 36 deals with the limitation of rights and is invoked to assess whether a right has been unjustifiably limited by either the common law or statute, in which case development must occur. These determinative factors form the core of s 36, which have demonstrably been invoked, albeit indirectly, for their applicability in relation to s 39.

Even when courts apply the Bill of Rights indirectly to the common law, they rely heavily on s 36(1) and engage with it as if the Bill of Rights was being applied directly to the common law. An excellent example is the *Stransham-Ford*⁵⁸ case itself. Strictly speaking, however, the direct application of s 36 in this way is not entirely correct and is different from the explanation I have set out above, yet in practice the direct application method finds favour.⁵⁹ Following the lead of the SCA, therefore, that is the approach I am going to follow.

I turn now to consider the requirements of s 36, and its impact as a guide for development in terms of s 39.

⁵⁸ *Stransham-Ford* (SCA) supra note 8 at para 57 the SCA notes in terms of the High Court decision that:

“On the facts the erroneous approach to the law rendered it impossible to consider whether any limitation of a constitutional right was reasonable and justifiable in terms of s 36 of the Constitution. The approach adopted was unsuited to the consideration of the complex legal issues that arise in the context of these debates about the manner and means of dying.”

Further at paras 70-71 the SCA describes the mechanics of s 36 of the Constitution which would have been appropriate had the court a quo properly dealt with the law:

“[70] At the outset the high court misstated the present situation in South African law. It then failed to consider precisely what development was being sought. It treated PAE and PAS as clear and simple concepts capable of easy application, when they are nothing of the sort. It did not recognise the distinction between the two. It paid little regard to international jurisprudence or to the answers to the constitutional questions posed in the previous paragraph. It claimed that the relief it was granting was ‘case dependent and certainly not a precedent for a general “free for all”’, without any indication of how its effects could be so limited.

[71] The next question that was not considered by the high court was the issue of justification in terms of s 36 of the Constitution. All the foreign jurisprudence to which I have referred makes it clear that the state has a legitimate interest in imposing constraints on the application of PAE, PAS and other forms of aiding and abetting suicide. The facts of *Grotjohn*, *Hibbert* and *Robinson* illuminate why that is also necessary in South Africa. Some constraint is plainly reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. The question is what? And that requires a court to consider the nature of any right that is infringed by the present state of the law; the importance and purpose of the limitation; its nature and extent; the relation between the limitation and its purpose and less restrictive means to achieve that purpose.”

⁵⁹ *Governing Body of the Juma Masjid Primary School & Others v Essay NO and Others* 2011 (8) BCLR 761 (CC); *Khumalo and Others v Holomisa* 2002 (8) BCLR 771; *S v Ntuli* 1996 (1) SA 1207 (CC); *Brink v Kitshoff NO* 1996 (4) SA 197 (CC); *Fraser v Children’s Court, Pretoria North* 1997 (2) SA 261 (CC). P de Vos ‘Pious Wishes or Directly Enforceable Human Rights? Social and Economic Rights in South Africa’s 1996 Constitution’ (1997) 13 *SAJHR* 67; I M Rautenbach ‘The Limitation of Rights in Terms of Provisions of the Bill of Rights Other than the General Limitations Clause’ (2001) *TSAR* 617.

5.4 CONSTITUTIONAL CONVICTIONS AND DEVELOPMENT – SECTION 36 OF THE CONSTITUTION

Section 36 of the Constitution holds as follows:

“36. Limitation of rights.-

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

The Constitution has been described as a living document “that judges have to interpret and apply in an ever-changing political, economic and social environment”⁶⁰ and it is on this basis that judges must apply the Constitution to the common law in order to develop it to bring it into harmony with the objective, normative values enshrined in the Constitution. The core value which underpins and establishes the constitutional imperative is human dignity,⁶¹ and so in developing the common law, the courts must take into account whether and how a common law provision infringes this value, which is the overarching purpose of the Constitution.⁶² Laws which infringe the values underpinned by the Constitution must be developed. This involves consideration of what rights are infringed by the criminal law prohibition, the purpose that the limitation serves, and further whether the purpose can be achieved through less restrictive mechanisms.⁶³ Laws which do not align with constitutional convictions cause harm in that they

⁶⁰ De Vos & Freedman op cit note 46 at 4.

⁶¹ Section 1 of the Constitution 1996.

⁶² Section 1(a) of the Constitution:

“The Republic of South Africa is one, sovereign, democratic state founded on the following values: (a) Human dignity, the achievement of equality and the advancement of human rights and freedoms.” Section 7(1) of the Constitution: “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.”

⁶³ Section 36 of the Constitution, 1996. See also *Loureiro and Others v iMvula Quality Protection (Pty) Ltd* [2014] ZACC 4 at para 53 where Van der Westuizen J states emphatically that

“the wrongfulness enquiry focusses on the conduct and goes to whether the policy and legal convictions of the community, constitutionally understood, regard it as acceptable. It is based on the duty not to cause harm – indeed to respect rights – and questions the reasonableness of imposing liability.”

infringe enshrined rights and may be found to be unconstitutional if imposing liability is constitutionally unreasonable.

5.4.1 *Law of general application*

The preceding chapters have already described what the common law position is regarding VAE. VAE in the forms of physician-assisted suicide and physician-administered euthanasia are both categorised as murder.⁶⁴ It is a law of general application as understood by s 36(1) of the Constitution because the common law crime of murder and the conduct which amounts to murder is “precise enough to enable individuals to conform their conduct to its dictates.”⁶⁵ In other words, the definition is clear enough that people know and understand at a basic level what murder means and can conduct themselves with a level of certainty to ensure that they do not (or do) commit murder. As such, there is nothing vague or imprecise about what murder is, and the result of this law of general application is that the consent of the patient does not offer the physician, or anyone else a defence against unlawfulness if they assist the patient to die. This rule applies generally regardless of the circumstances and means that no one, not even a patient, can validly consent to their own death. Although there are a number of arguments in favour of decriminalising VAE, the most prominent is that it limits patient autonomy and thus does not promote the constitutional value of human dignity, which is one of the foundational values on which the Constitution is based. This was the key argument made by the applicant in *Stransham-Ford*.⁶⁶ Proponents thus argue that the development of the common law in relation to VAE promotes the right to dignity through autonomy.

The SCA in *Stransham-Ford*⁶⁷ noted that developing the common law in relation to VAE posed a number of difficult questions which would require consideration in terms of s 36. These questions related particularly to whether the criminal prohibition on VAE through prosecution as the common law crime of murder, violates constitutionally enshrined rights and thus, whether continued criminalisation and categorisation of VAE as murder is contrary to the spirit, purport and objects of the Bill of Rights.⁶⁸ The court did not answer any of these

⁶⁴ *Ex Parte Die Minister van Justisie: In Re S v Grotjohn* 1970 (2) SA 355 (A); *S v Hartmann* 1975 (3) SA 532 (C).

⁶⁵ S Woolman & M Bishop *Constitutional Law of South Africa* 2 ed (2014) at 34.7 (a). See also *De Reuck v Director of Public Prosecutions, Witwatersrand Local Division, & Others* 2004 (1) SA 46 (CC) at para 57.

⁶⁶ *Stransham-Ford* (SCA) supra note 8 at paras 4, 7, 14, 33, 42, 66, and 65.

⁶⁷ *Stransham-Ford* (SCA) supra note 8.

⁶⁸ *Stransham-Ford* (SCA) supra note 8 at para 69:

“Does the guarantee of the right to life includes (sic) a right to die, or does it stand in opposition to it and support the criminalisation of PAE? Does the right to dignity extend beyond dignity in the process leading up to our inevitable death, so as to encompass a right to die when and in the manner we choose?”

questions and noted them specifically to show that these questions had not been considered by the High Court, which was one of the reasons which affected the SCA's ability to make a ruling on the development of the common law in relation to VAE.⁶⁹ These questions also serve to show that the common law provision and definition of murder is in fact a law of general application, which does not discriminate in relation to the unlawfulness of the act. In this regard, the court noted, referring to the cases of *Grotjohn*,⁷⁰ *Hibbert*⁷¹ and *Robinson*,⁷² that the state would have a legitimate interest in "imposing constraints on the application of PAE, PAS and other forms of aiding and abetting suicide"⁷³ and that in the light of the factual construct of those cases "some constraint is plainly reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom."⁷⁴ Thus, it would be constitutionally legitimate for the state to enforce a restriction on autonomy in some cases of assisted dying. However, the proper question is what constraint and under what circumstances – whether the current blanket limitation on autonomy to consent to all forms of assisted dying could be narrowed to exclude a VAE factual matrix and medically-assisted dying. Could the circumstances as exhibited in *Grotjohn*,⁷⁵ *Hibbert*⁷⁶ and *Robinson*⁷⁷ be distinguished from VAE

When we are in reality concerned with the implications of the criminal law for the medical profession, do the rights of patients warrant a change in existing criminal law as it affects doctors? Does the right to health care extend to the provision and possible administration of lethal agents or does it by necessary implication exclude this? What are the implications of palliative care for the question whether a person's dignity is infringed by their inability to terminate their own life or have it terminated?"

⁶⁹ *Stransham-Ford* (SCA) supra note 8.

⁷⁰ *Grotjohn* supra note 64.

⁷¹ *S v Hibbert* 1979 (4) SA 717 (D) at 722:

"Now in the present case the accused set in motion a chain of events which ended in the deceased pressing the trigger of a fire-arm which she had been given by the accused and thus causing her death. The successive words and actions of the accused were designed to place her in possession of that fire-arm and were accompanied by the obvious hazard that the deceased might be persuaded to inflict upon herself an injury which could result in her death. The accused's conduct fell short only of the final act of pulling the trigger. It seems to me that the act of pulling the trigger to which all the other conduct conducted, cannot in any sense be described as independent of the course of conduct. That being so, we conclude that there was, in the proper sense of that expression, no *actus novus interveniens* which broke the chain of causation set in motion and continued by the series of acts of the accused which I have mentioned. The accused must, as we have found, have appreciated that injury and possibly death could result from his actions. That being so there is present the necessary intention to bring home a charge of murder. We find therefore that the accused occasioned the death of the deceased by his conduct; that he had the necessary intention and is therefore guilty as charged of murder."

The wife of the accused was depressed and expressed a desire to commit suicide. The accused handed her a firearm and she shot herself. The accused was convicted of murder. The court followed the rule established in *Grotjohn* supra note 63.

⁷² *S v Robinson and Others* 1968 (1) SA 666 (A). In this case the accused, Mr Robinson was hired by the deceased to kill himself, his wife and a friend so as to avoid financial ruin and make an insurance claim.

⁷³ *Robinson* supra note 72 at para 71.

⁷⁴ *Stransham-Ford* (SCA) supra note 8 at para 71.

⁷⁵ *Grotjohn* supra note 64.

⁷⁶ *Hibbert* supra note 71.

⁷⁷ *Robinson* supra note 72.

in an effort to gauge unlawfulness and permissibility of VAE based on the legal conviction of society? We would ask whether the current limitation on consent and autonomy ought to, under a constitutional dispensation, apply to VAE; whether the decisions in the cases of *Grotjohn*,⁷⁸ *Hibbert*⁷⁹ and *Robinson*⁸⁰ should continue to apply to VAE under a constitutional dispensation. To answer this question “requires a court to consider the nature of any right which is infringed by the present state of the law; the importance and purpose of the limitation; its nature and extent; the relation between the limitation and its purpose and less restrictive means to achieve that purpose.”⁸¹ What is evident though from the dictum in *Stransham-Ford*⁸² is that the core constitutional value and right which is challenged as being infringed by the blanket prohibition on an assisted death, is dignity as informed by autonomy.

5.4.2 *The nature of the right*

The argument is that the common law position and criminalisation of VAE violates the right to dignity by placing limits on autonomy. Although autonomy is not a listed ground in the Constitution, the Constitutional Court has through numerous dicta firmly held that autonomy is entwined with dignity.⁸³ If a court is presented with an appropriate case, it would have to consider whether the common law crime of murder and the limits placed on patient autonomy prohibiting VAE, offend against the spirit, purport and objects of the Bill of Rights in the Constitution, notably the value and right to dignity.

In *NM v Smith*,⁸⁴ O’Regan J discussed autonomy and confirmed that autonomy is a distinct element of the right to dignity:

“Underlying all these constitutional rights is the constitutional celebration of the possibility of *morally autonomous* human beings independently able to form opinions and act on them ...

Our Constitution seeks to assert and promote the autonomy of individuals”.⁸⁵

And in *Barkhuizen v Napier*,⁸⁶ the majority of the Constitutional Court confirmed that autonomy was fundamental to the element of dignity. Ngcobo J for the majority noted that:

⁷⁸ *Grotjohn* supra note 64.

⁷⁹ *Hibbert* supra note 71.

⁸⁰ *Robinson* supra note 72.

⁸¹ *Stransham-Ford* (SCA) supra note 8 at para 71.

⁸² *Stransham-Ford* (SCA) supra note 8 at para 71.

⁸³ *S v Makwanyane* 1995 (3) SA 391 (CC); *NM v Smith* 2007 (5) SA 250 (CC); *Barkhuizen v Napier* 2007 (5) SA 323 (CC); *Khumalo v Holomisa* 2002 (5) SA 401 (CC).

⁸⁴ *NM v Smith* 2007 (5) SA 250 (CC).

⁸⁵ *NM v Smith* (SCA) supra note 84 at paras 145-146. O’Regan J penned a dissenting judgement. Langa CJ concurred with both the majority and the minority judgements in relation to the discourse on the rights to privacy and dignity.

⁸⁶ *Barkhuizen* supra note 83.

“Self-autonomy, or the ability to regulate one’s own affairs, even to one’s detriment, is the very essence of freedom and a vital part of dignity”.⁸⁷

5.4.2.1 *Autonomy and dignity in law*

Heated and principled positions founded on the reasons for criminalisation (protecting the vulnerable from abuse and the sanctity of life)⁸⁸ abound when the topic of the permissibility of VAE arises. These arguments are centred on concepts of autonomy, dignity, *boni mores* and the purpose served by maintaining the prohibition. Referring with approval to Haysom’s concept of the open society and the connection between personal development and autonomy, Ackermann J stated that

“An ‘open society’ ... is a society in which persons are free to develop their personalities and skills, to seek out their own ultimate fulfilment, to fulfil their own humanness and to question all received wisdom without limitations placed on them by the State. The ‘open society’ suggests that individuals are free, individually and in association with others, to pursue broadly their own personal development and fulfilment and their own conception of the ‘good life’”.⁸⁹

It is submitted that individuals are also free, individually and in association with others, to pursue their own personal development and fulfilment and their own conception of the good death. What this also means is that people may have to realise dignity with the help of others. As far as VAE is concerned patients seek and require physician assistance to end their lives (through the provision or administration of life-ending medication), and thus require the assistance of another in order to realise individual dignity in the form of a medically assisted death. Proponents argue that a person’s dignity is violated when they are denied the opportunity to direct or control their own life in such a way that their worth and dignity is infringed and diminished when they cannot exercise autonomy and enlist the services of a physician to realise their own end.

Dignity is the underlying value of the Constitution and it is also a listed right in the Bill of Rights:

“Viewed in the context of s 1(a) of the Constitution – which proclaims ‘human dignity’ as one of the values on which the South African state is founded – s 10 makes it clear that human dignity, besides being a value and a right, is also a categorical imperative.”⁹⁰

⁸⁷ *Barkhuizen* supra note 83 at para 57.

⁸⁸ Discussed later herein.

⁸⁹ *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others* 1996 (1) SA 984 (CC) at para 50.

⁹⁰ Ackermann *Human Dignity: Lodestar for Equality in South Africa* op cit note 45 at 95.

Dignity is alleged to be violated when patients are not allowed to autonomously choose and consent to the time and manner of their own death when they are prohibited from seeking assistance in realising that end. This in turn is a violation of the Constitution's categorical imperative – the protection and instilment of dignity through the law. This means that courts, when faced with the issue of development of the law, common or statutory, must determine whether the law fulfils the constitutional imperative. If it does not, then the law can be struck down or developed to bring it within the constitutional imperative. Before a court can embark on this second step of development, it would have to consider the purpose that the limitation serves and whether or not the limitation can be achieved through less restrictive means. If the purpose can be achieved through less restrictive means, the limitation is an unconstitutional violation.

In *Bernstein v Bester*⁹¹ the court held that “rights, like the right to privacy, are not based on notions of the unencumbered self, but on the notion of what is necessary to have one's own autonomous identity”.⁹² In *Khumalo v Holomisa*⁹³ the court confirmed and expanded the principle and linked autonomy to dignity:

“It should also be noted that there is a close link between human dignity and privacy in our constitutional order. The right to privacy, entrenched in s 14 of the Constitution, recognises that human beings have a right to a sphere of intimacy and autonomy that should be protected from invasion. This right serves to foster human dignity.”⁹⁴

Thus, the right to dignity, entrenched in s 10 of the Constitution, recognises that human beings also have a right to autonomy, which collectively should be protected from violation. The right to autonomy serves to foster the realisation of human dignity, and so the two are inextricably linked as they inform self-worth. Persons have the right to have their self-worth respected and protected. Self-worth is individual and subjective, and in the light of the above, the State through its laws should make self-worth realisable even through the instrumentality of others. It may well be necessary that a person requires assistance from another realise their own dignity.⁹⁵

5.4.2.2 *Autonomy and dignity in medical practice*

⁹¹ *Bernstein and Others v Bester and Others NNO* 1996 (2) SA 751 (CC).

⁹² *Bernstein* supra note 91 at para 65.

⁹³ *Khumalo v Holomisa* 2002 (5) SA 401 (CC).

⁹⁴ *Khumalo v Holomisa* supra note 93 at para 27.

⁹⁵ For example, in order to realise the right to education, the State must make available and accessible schools and teachers; in order to realise the right to health and health care, the State must make hospitals, clinics, doctors and nurses available and accessible.

At the core of the practice of medicine lies the doctrine of informed consent and patient autonomy, with the purpose of ensuring that patients receive medical care which instils dignity. The Health Professions Council of South Africa (HPCSA) recognises that respect for persons and autonomy are core ethical values which guide its members:

“2.3.1 Respect for persons: Health care practitioners should respect patients as persons, and acknowledge their intrinsic worth, dignity, and sense of value.

2.3.5 Autonomy: Health care practitioners should honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences.”⁹⁶

Pugh notes that “informed consent requirements are ubiquitous in health care, and they are regarded as a cornerstone of ethical medical practice. It is also often treated as a truism that these requirements are to be justified by the principle of respect for autonomy”.⁹⁷ Nevhutalu notes that

“The ‘denial’ of patients being allowed to make decisions in relation to their treatment and care clearly shows disrespect for their autonomy and dignity. Despite the complexity of problems faced by the healthcare system, there is no excuse to deny patients their right to self-determination”.⁹⁸

Even in a restraint-constrained environment, patient autonomy is key. Factors like the general state and competency of health-care and health-care services available to the individual also play a role in the decision-making process. But whatever facilities, medicines, means and technologies exist and are available to patients, personal autonomy and personal dignity in the light of the above considerations still shape the personal decision-making process of any individual patient. These decisions (and thereby autonomy and dignity) are only realised with the assistance of a physician. However, physicians are barred from giving effect to a patient’s autonomous request for a dignified death through VAE, and will be criminally liable if they do.⁹⁹

⁹⁶ HPCSA *Ethical Guidelines for Good Practice in the Health Care Professions: ‘Booklet 1: General Ethical Guidelines for Health Care Professions’* (2016) available at https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf, accessed on 3 December 2021.

⁹⁷ J Pugh *Autonomy, Rationality, and Contemporary Bioethics* (2020) 149 available at <https://www.ncbi.nlm.nih.gov/books/NBK556864/>, accessed on 6 February 2021.

⁹⁸ H K Nevhutalu *Patients’ Rights in South Africa’s Public Health System: Moral-Critical Perspective* (unpublished LLD thesis, University of Stellenbosch 2016) 182-183 available at <https://core.ac.uk/download/pdf/188225483.pdf>, accessed on 6 February 2021.

⁹⁹ *Stransham-Ford* (SCA) supra note 8 at para 3:

“Legal issues arise because such actions by medical practitioners have long been treated in various different societies as criminal. The intended purpose of this litigation was to determine whether that should be the case in South Africa.”

In the context of the practice of medicine generally, and more specifically in VAE, individual autonomy and personal dignity is a subjective view unique to the patient, which amongst others considers individual pain tolerances (physical, emotional, spiritual and mental) and individual perception of the quality of life (loss of independence, autonomy, the ability to communicate, personal perception of loss of value of self to one's self and to others, the ability to care for one's own personal needs and hygiene). Suffering in this sense may diminish an individual's quality of life where these considerations inform their own conception of personal dignity. A lack of objective suffering will not necessarily mean that one's life is dignified. In this vein, where dignity and a dignified existence rest within the individual's perception of what a dignified life is, suffering cannot be determined by objective standards, and neither can the infringement of dignity. This is the distinction then between human dignity in the broader sense and individual dignity as would be the consideration in VAE and end-of-life decision-making. Dignity as informed by autonomy is accepted as the reason why patients can make the informed decision to cease medical treatment, regardless of how effective the treatment would be or how detrimental refusal would be, even if the choice will objectively be harmful to the individual in that it will hasten death. However, living a dignified life, without suffering in the medical context, necessarily requires assistance from physicians, who by prescribing medications and administering treatments, work in concert with consenting patients to alleviate pain and suffering, knowing that the treatment option elected by the patient can hasten death. Such conduct is, through the legal convictions of society, lawful, ethical and morally acceptable, yet the opposite is true for VAE.¹⁰⁰

Autonomous decision-making forms the core of medical practice which has, since the Second World War, been premised on the value of human dignity, autonomy and informed consent.¹⁰¹ The Constitution holds human dignity as its founding premise,¹⁰² and further specifically enshrines the right to dignity,¹⁰³ making the right to have one's dignity respected

¹⁰⁰ 'World Medical Association Declaration of Venice on Terminal Illness' Adopted by the 35th World Medical Assembly Venice, Italy, October 1983 and revised by the WMA General Assembly, Pilansberg, South Africa, October 2006:

"The patient's right to autonomy in decision-making must be respected with regard to decisions in the terminal phase of life. This includes the right to refuse treatment and to request palliative measures to relieve suffering but which may have the additional effect of accelerating the dying process. However, physicians are ethically prohibited from actively assisting patients in suicide. This includes administering any treatments whose palliative benefits, in the opinion of the physician, do not justify the additional effects."

¹⁰¹ Universal Declaration of Human Rights (1948).

¹⁰² S1 of the Constitution, 1996:

"The Republic of South Africa is one, sovereign, democratic state founded on the following values: (a) Human dignity, the achievement of equality and the advancement of human rights and freedoms."

¹⁰³ S10 of the Constitution, 1996.

and protected, justiciable. While patient autonomy is the central feature in medical treatment, the principle does not easily translate as analogous when it comes to VAE; it is completely disregarded as a result of the criminal law prohibition on consent to death.

5.5 AUTONOMY AND DIGNITY IN VOLUNTARY ACTIVE EUTHANASIA

The common law prohibition on VAE is argued as being an infringement of the right to dignity because it limits autonomy. This was argued by the applicant in *Stransham-Ford v Minister of Justice and Correctional Services and Others*.¹⁰⁴ In this case, the applicant was diagnosed with incurable cancer and at the time of the application, the applicant was in the last stages of the disease.¹⁰⁵ He claimed that he was suffering intractably and that although he was receiving palliative care, his current state of existence did not accord with his right to dignity.¹⁰⁶ The prohibition prevented him from seeking an end to his life in a way that he deemed dignified where the effect of the common law prohibition prevented him from accessing a medically assisted death. The limitation meant that he was prevented from realising his own self-worth at the end of his life.

Of course, there is no legal duty to live, and under South African law, suicide is not an offence. However, it was argued that denying him the choice to freely and voluntarily end his life via medical assistance violated his right to dignity as informed by autonomy. Anything less, in this context, would leave him with one of two lawful choices: end his own life in an undignified¹⁰⁷ fashion by hanging, shooting, starvation, or any other way that the act of *suicide* can be committed; or live what is left of his life with intractable pain and suffering.¹⁰⁸ The choice is a cruel one, and death (or what remains of life) is undignified if a patient would prefer not to have to resort to using those mechanisms to commit suicide and would not want to continue to live in intractable pain and suffering. Accepting this argument, the High Court referred to the dictum of *Carter v Canada* and quoted as follows:

“It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician’s assistance in dying and may be

¹⁰⁴ *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (6) BCLR 737 (GP) at para 3.

¹⁰⁵ *Stransham-Ford* (HC) supra note 104 at paras 7-9.

¹⁰⁶ *Stransham-Ford* (HC) supra note 104 at para 6.

¹⁰⁷ Undignified because patients do not have a legal choice of using a less gruesome means for ending their lives – D Benatar ‘Assisted suicide, voluntary euthanasia and the right to life’ in J Yorke (ed) *The Right to Life and the Value of Life* (2010) chapter 12 at 291.

¹⁰⁸ Section 12(e) of the Constitution.

condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent and dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.”¹⁰⁹

Thus, the argument is that failing to permit VAE to suitable patients who request such, means imposing a duty to live a life devoid of quality and dignity because such life is not life; it is mere existence which is permeated with pain, suffering, anguish, degradation and uncertainty. The effect is that the common law prohibition on VAE and consent to death with assistance forces such patients to commit suicide by resorting to less than humane methods and doing so earlier than they would prefer to for fear of loss of physical capacity,¹¹⁰ or to continue to live with suffering until death naturally occurs.

In drawing a distinction on the permissibility of PE and VAE based on lawfulness as gauged by the legal convictions of society, Burchell notes that

“It is important to remember that the court in *Grotjohn* focused on the issue of causation rather than the unlawfulness of conduct. Although the conduct of the accused in that case was clearly unlawful, other cases raising the contentious issue of dying with dignity might require qualification.”¹¹¹

Burchell draws a distinction between aiding and abetting suicide (in a non-medical context) and VAE, suggesting that the former ought to remain a criminal offence while the latter ought not to. The *Grotjohn* rule is undeniably broad when the definitional elements for criminal liability are engaged, and in cases of VAE, it would be impossible to conclude that the assisting physician neither intended nor caused the death of the patient when he assists a patient to end their own life. Burchell is correct. The answer lies in determining whether VAE is *contra bonos mores* and unlawful conduct which constitutional convictions would seek to

¹⁰⁹ *Stranham-Ford* (HC) supra note 104 at para 17.

¹¹⁰ D Benatar ‘Assisted suicide, voluntary euthanasia, and the right to life’ in J Yorke (ed) *The Right to Life and the Value of Life: Orientations in Law, Politics and Economics* (2010) at 291-292:

“The legal freedom to kill oneself without the assistance of others is often insufficient for the same sort of reason that a freedom to treat oneself medically is often insufficient. Some of us are sometimes capable of medicating ourselves. We have a headache and thus we ingest a tablet that brings relief. We incur a minor cut, which we disinfect and then perhaps plaster. However, we are not expected to diagnose more complicated or serious ailments or to decide, unaided, which therapies to pursue. The reason is obvious. Most people lack the requisite training to diagnose and to treat effectively, and the consequence of prohibiting others from helping them would be that people would be much worse off.

Something similar can be said of those who want to die. While many people who find that their lives have reached an intolerably low quality could kill themselves unaided, they would run the risk, if acting without assistance, of either dying painfully or gruesomely or of botching the attempt. In any of these cases they would be worse off than if they had been able to secure professional assistance. Moreover, there are some people who simply cannot kill themselves unaided. There are others who cannot kill themselves even with assistance, as they are so paralyzed that they are unable to perform any action that will bring about their deaths.”

¹¹¹ JM Burchell *Principles of Criminal law* 5 ed (2016) 110 fn110.

continue to criminalise based on a balancing of competing interests and the rights argued as being infringed by the prohibition. If it is not *contra bonos mores*, then the practices ought to be lawful and justifiable. This requires consideration of when and under what circumstances VAE could be reasonable and justifiable, by determining whether the purpose of the prohibition is distinguishable from the purpose of the prohibition in relation to murder. If the purposes are distinguishable, then the rule established in *Grotjohn* could be qualified and limited to exclude VAE, without which for

“[a]s long as X is punished for assisting Y to commit suicide, the case for allowing Y, in special circumstances, to agree to die with dignity seems weakened... On the face of it, *Grotjohn* would appear to cast a net of criminality over the conduct of the person (usually a doctor) who helps a person (usually a patient) to die with dignity”.¹¹²

Burchell does not say commit suicide or murder, but says “die with dignity” instead.¹¹³ He sets apart death with dignity from murder or assisted suicide, thereby placing “death with dignity” outside of the net of criminal liability by categorising it as a form of conduct that ought to be lawful and not a species of murder. Of course, this depends on whether the constitutional convictions would deem VAE as reasonable and justifiable. By saying “death with dignity” instead of “murder” or “commit suicide” in this context there is room for a constitutional challenge focused on the prohibition of consent to an assisted death as being an unjustifiable and unreasonable violation of the right to dignity in the narrow construct of VAE. By drawing a distinction between murder as articulated in *Grotjohn* and “death with dignity” in VAE, Burchell firmly places the issue of the lawfulness of VAE within the ambit of the right to dignity. As such VAE could be decriminalised when viewed in the specific context of medically assisted dying, but other forms of assisted dying would not be lawful. This is evidenced by the fact that Burchell refers to the factual construct in *Grotjohn* as “clearly unlawful”, suggesting that VAE would not be “clearly unlawful”. He thus supports Milton’s¹¹⁴

¹¹² Burchell, *Principles of Criminal Law* 5ed op cit note 111 at 213.

¹¹³ Burchell *Principles of Criminal Law* 5ed op cit note 111.

¹¹⁴ P M A Hunt & J R L Milton *South African Criminal Law and Procedure, Vol. 2, Common Law Crimes* 2 ed (1996) at 356:

“It is submitted that, as in England and the Continental countries, incitement to commit suicide ought by legislation be made a statutory crime, but to treat them as murder seems to be going too far. A troubling question in this regard is one which has come to the forefront in connection with demand for decriminalisation of euthanasia. This is that of the position of the physician (or family member) who assists a terminally ill person to commit suicide. The principles enunciated in *Grotjohn* clearly would hold the person providing assistance liable for murder. It is argued, however, that this type of euthanasia ought not to be criminalised. The contention is that since suicide is not a crime, every person has the right to commit suicide. This being so, it ought not to be unlawful to provide whatever assistance is needful to exercise the right. What real difference is there on the practical level between watching a terminally ill person swallow poison he has obtained himself and has taken with no assistance, and watching him doing so after having provided him with the poison in question?”

argument that inciting, encouraging and assisting suicide is a crime and ought to be so when performed outside of the medical context of VAE, but “death with dignity” is not and should not be. I agree.

These submissions reflect not only a semantic shift in the terminology from murder to death with dignity, but also reflect a *mores* shift towards properly reflecting the constitutional convictions of society in the light of the spirit, purport and objects of the Bill of Rights, particularly dignity and autonomy and their role in the realisation of self-worth at the time of death. The shift properly separates conduct which ought to be criminalised and punished from that which should not. It is in this light that a court must consider the nature and role of dignity in the Constitution and how an infringement of this right can trigger development of the common law. But to do this, we must first identify the nature of the right or rights that are challenged as being violated by the common law. For the present purpose, I consider the nature of the right to dignity and a dignified life by analysing the components which have been argued inform its nature.

5.5.1 *The sanctity of life*

Intentionally causing the death of another person is criminalised because life is viewed as sacrosanct, and even in a constitutional democracy, its continued criminalisation would be justified because criminalisation serves a legitimate purpose¹¹⁵ – to prevent and punish the unlawful and intentional causing of the death of another human being, as murder is the most reprehensible violation of the right to life. However, not all killings are viewed as heinous and unlawful, nor are they labelled and punished as the crime of murder. So, it becomes clear that what the law is concerned with is unlawfulness and the circumstances under which death was caused, which in turn determines whether the heinous crime of murder has been committed as opposed to a justified killing.

In cases of conviction for murder, the law has traditionally reserved and handed down its most serious forms of punishment. Although found guilty of murder, the accused in

¹¹⁵ A L Bendor & H Dancig-Rosenberg ‘Unconstitutional criminalization’ (2016) 19(2) *New Crim L Rev: An Internat & Interdiscip J* 171 at 182:

“Largely, the rules of criminal liability and specific criminal offenses are derived from basic principles, denoting a relation similar to the one existing between constitutional and regular law. Moreover, in liberal democratic societies, both constitutional law and the basic principles of criminal law are based on a conception of persons as rational beings, capable of distinguishing right from wrong and having autonomous freedom of choice. In constitutional law, this image underlies the justification for the recognition of human rights, including the non-criminalization right. In criminal law, this image underlies the requirement for factual and mental elements in order to impose liability. This requirement reflects the justification to impose liability on those who chose to harm protected social values.”

Hartmann was given a non-custodial sentence. This was also the case in *De Bellocq*¹¹⁶ where the accused was found guilty of murder, but had not been sentenced. Sentencing had been remanded for a period of six months.

Where the gauge of unlawfulness and the legal convictions of society and punishment for murder in the guise of VAE are concerned, Fox and Freiberg note that in relation to sentencing VAE, courts demonstrate that these acts of homicide are on the lowest end of the range of severity and moral reprehensibility by meting out punishments that are not severe.¹¹⁷ In this sense then, the legal convictions of society set the normative standard for behaviour by demarcating VAE as murder, but the reprehensibility of the conduct does not reflect in the sentencing. South African courts¹¹⁸ punish murder in the form of VAE less severely than other forms of homicide offences which evidences that even pre-constitutionally, the legal convictions of society impacted society's sense of fairness reflected through sentencing.¹¹⁹

Van der Merwe notes that resolution of the permissibility of VAE and its distinction from the crime of murder will not be found through the elements of causation and intention, and

¹¹⁶ *S v De Bellocq* 1975 (3) SA 538 (T) at 538:

"I am also informed that the accused is not likely to remain in this country for more than six months or so and I think justice would be done if I pass a sentence in terms of sec. 349 of the Criminal Procedure Act. The sentence will be that the accused is discharged on condition that she enters into recognizances to come up for sentence within the next six months if called upon. I will not order any amount of money to be deposited in connection with these recognizances."

In this case, the accused drowned her baby who was diagnosed with toxoplasmosis, which rendered the child disabled, severely handicapped and unable to receive nourishment except by artificial means. She was convicted of murder, but was discharged on her own recognisance. The issue of sentencing had been remanded for six months, but such had never occurred. She and her husband were only temporarily resident in South Africa and were due to return to their native country within six months.

¹¹⁷ R Fox & A Freiberg *Sentencing: State and Federal Law in Victoria* 2 ed (1999) 886.

¹¹⁸ *Hartmann* 1975 (3) SA 532 (C); *S v De Bellocq* supra note 116.

¹¹⁹ The SALRC in its report referred to the cases of *R v Davidow* 1955 WLD unreported, *S v De Bellocq* 1975 (3) SA 538 (T), *S v Hartmann* 1975 (3) SA 532 (C), *S v McBride* 1979 (4) SA 313 (W), *S v Marengo* 1990 WLD unreported and *S v Smorenburg* 1992 CPD unreported, at paras 4.78-4.83 and noted at para 4.84 as follows:

"All of the above-mentioned cases deal with active euthanasia. In each case the accused actively contributed to the death of the deceased. In each case the motive for the act was to end the suffering or useless existence of the deceased. However, in no case could the act be regarded as lawful. The courts, at best, reflected the sense of justice of the community regarding the blameworthiness of the accused by imposing light sentences."

More recently in *S v Nkwanyana* 2003 (1) SA 303 (W) where the court found the accused guilty of murder for having killed the deceased albeit at her own repeated requests. In this case, the accused was sentenced as follows at 310:

"Count 1, the count relating to the murder of the deceased: Five years' imprisonment, wholly suspended for five years on condition that you are not convicted during the period of the suspension for the commission of an offence involving the intentional infliction of bodily injury."

See also the case of Professor Sean Davison who in 2019 pleaded guilty to three counts of murder. He entered into a plea and sentencing agreement with the state. He was sentenced to eight years of house arrest, five of which were suspended - J Evans, 'Euthanasia advocate Sean Davidson sentenced to 3 years house arrest for murder' News24 19 June 2019, available at <https://www.news24.com/News24/breaking-euthanasia-advocate-sean-davison-sentenced-to-3-years-house-arrest-for-murder-20190619> accessed on 25 May 2023.

identifies the real problem as related to the policy reasons which demarcate behaviour and acts as lawful or unlawful:

“The problem...lies in the word “unlawful” in the definition of murder. It is seldom a contested issue whether the Samaritan had the intention to take the patient’s life, yet they try to justify it by saying their intentions were noble. But it still leads to a conviction of murder. There is also legally speaking no issue with any of the other elements of a crime either. The act which led to death could usually be identified and isolated, such as writing a prescription or giving an injection. Furthermore, applying any number of theories to establish the causal chain will indicate the act was the factual and legal cause of the death. Rather the “unlawfulness” of the act should be focused on. This could be achieved in the simplest way by creating a special defence available only to medical practitioners and their assistants and only in very specific circumstances.”¹²⁰

We must thus consider what the underlying and true purpose is for the unlawfulness of VAE. The object and function of law generally then, is not too different from that of conventional morality and essentially is a formalisation and codification of it. Unlawfulness is linked to the purpose that criminalisation serves – to determine which conduct is a transgression of norms as well as to effectively punish transgressions. Sentencing matters aside, there are two arguments raised to show what the State’s purpose is in maintaining the criminal law prohibition by continuing to criminalise VAE: the sanctity of life, and the need to protect the weak and vulnerable from abuse.

Opponents to the decriminalisation of VAE argue that life is sacrosanct.¹²¹ However, the notion that life is sacrosanct is proven to have been compromised by the courts and legislatures in favour of the *quality* of life. Keown notes that the shift towards permissibility of some forms of harms has transformed serious criminal offences into medical practices based on social convenience and need.¹²² The causing of death is a grave harm, yet in relation to PE which undeniably causes death, our courts have ruled that facilitating a patient’s death may be

¹²⁰ A Van der Merwe *An Analysis of Assisted Dying and the Practical Implementation Thereof in South African Criminal Law* (unpublished LLM, University of Pretoria 2017) at 18.

¹²¹ J Keown ‘The legal revolution: From “sanctity of life” to “quality of life” and “autonomy”’ (1998) 14 *J Contemp Health L & Pol’y* 253: “for centuries, the law in both common law and civil law jurisdictions has stoutly upheld the principle of the ‘sanctity of life’.”

¹²² Keown op cit note 121 at 254:

“The Abortion Act of 1967, widely imitated around the globe, overturned the historic prohibition on abortion. Abortion was transformed from a serious criminal offense to a minor medical procedure, commonly performed for reasons of social convenience rather than medical necessity”.

Similarly, in South Africa, abortions have been decriminalised and legalised through the Choice of Termination of Pregnancy Act. The constitutionality of the legislation was challenged in the case of *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance and Amicus Curiae)* 2005 (1) SA 509 (T). The case was dismissed.

justifiable in certain contexts.¹²³ In *Clarke v Hurst NO*, the court noted that while the hastening of a person's death was not *ordinarily* justified,

“[i]t has come to be accepted that the doctor may give a terminally ill patient drugs with the object of relieving his pain, even if, to the doctor's knowledge, the drugs will certainly shorten the patient's life”.¹²⁴

Thirion J noted that in such cases, in South African law, the legal convictions of society would consider the doctor's conduct reasonable, justifiable and therefore not a criminal offence.¹²⁵ As has been shown in previous Chapters, justifiability depends *inter alia* on the exercise of patient autonomy, which is accepted even though the course of treatment consented to undeniably hastens (and causes) death. It is submitted that proponents of the sanctity of life argument would have to admit that passive euthanasia practices violate the sanctity of life in that by design PE hastens death and inevitably cuts life short. With such an admission, any argument based on the sanctity and inviolability of the right to life is diminished. In such an instance, the argument that VAE ought to remain criminalised because it violates the sanctity of life while PE does not, fails.¹²⁶

As much as arguments are made from the perspective of the sanctity of life as the reason for maintaining the criminal prohibition on VAE, it is clear that the law permits the intentional hastening and causing of death in certain medical contexts. The lawfulness of PE for example is (depending on the circumstances) premised on patient autonomy and dignity, while the unlawfulness of active euthanasia is also premised on patient autonomy and dignity, but has a limitation thereof. The limitation is justified in that it is necessary to protect dignity. The arguments for and against seem to be an illogical and false distinction when premised on the notion of the sanctity of life, when what we realise is that the law and the Constitution no longer protect only the sanctity of life, but the quality of it; and quality, in the context of VAE is determined by the patient themselves, not by others.

The State has an interest in protecting the right to life. But the interest extends only in as far as an unlawful and thereby unconstitutional violation of the right is occasioned. Murder is criminalised for being an unlawful and intentional violation of a victim's right to life, and

¹²³ *Clarke v Hurst NO* supra note 4. See also the English case of *Airedale NHS Trust v Bland* [1993] AC 789.

¹²⁴ *Clarke v Hurst* supra note 4 at 657, referring with approval to the dictum of Devlin J in the English case of *R v Adams* 1957 Crim LR 365.

¹²⁵ Regarding intention and causation see Chapters Four and Five herein.

¹²⁶ A McGee ‘Does withdrawing life-sustaining treatment cause death or allow the patient to die?’ (2014) 22(1) *Medical L Rev* 26 at 29.

the State's shared interests in maintaining society and the public order. Van der Merwe notes that

“Murder is a serious crime and should remain punishable, but a distinction should be made when it is committed within the circumstances of assisted dying – along with other requirements – and the law should evolve to reflect this.”¹²⁷

Expanding on Van der Merwe's submission, it would be more correct to state that a distinction between VAE and murder should be made with the element of unlawfulness, which would separate VAE from murder. It is not merely the sanctity of life which the Constitution protects, but the quality of it.¹²⁸ As such then, the submission is that what is required is a consideration of the constitutional convictions of society in determining whether the same exemption from lawfulness can be extended to VAE, based on the quality of life and not merely the sanctity of it. The Constitutional Court in *Makwanyane* noted that there is a distinction between lawful and unlawful violations of the right to life, which is informed by how life is defined in the circumstances, once competing interests and rights are balanced. Killing in defence of self or when attempting to effect an arrest are justifiable,¹²⁹ as is causing death through PE. Mahomed J posed the following questions particularly in relation to justifiable killing and the right to life in the medical context:

“Does the ‘right to life’, within the meaning of section 9,¹³⁰ preclude the practitioner of scientific medicine from withdrawing the modern mechanisms which mechanically and artificially enable physical breathing in a terminal patient to continue, long beyond the point, when the ‘brain is dead’ and beyond the point when a human ceases to be ‘human’ although some unfocussed claim to qualify as ‘being’ is still retained’? If not, can such a practitioner go beyond the point of passive withdrawal into the area of active intervention? When and under what circumstances?”¹³¹

Mahomed J drew a distinction between the crime of murder and causing death in lawful circumstances, notably medical treatment which hastens and causes death. Mahomed J's first question had already been answered in the affirmative in *Clarke v Hurst NO* where the court ruled that a doctor would not be acting unlawfully in circumstances as described. But how do we answer the learned judge's second question? Mahomed J stated that to answer his second question would require a more focused analysis of the meaning of life particular to the context

¹²⁷ A Van der Merwe *An Analysis of Assisted Dying and the Practical Implementation Thereof in South African Criminal Law* (unpublished LLM, University of Pretoria 2017) at 18-19.

¹²⁸ *S v Makwanyane* 1995 (3) SA 391 (CC).

¹²⁹ *Makwanyane* supra note 128 at para 269.

¹³⁰ Of the Interim Constitution, now section 11.

¹³¹ *Makwanyane* supra note 128 at para 268.

within which the right to life was being evaluated such that it resulted in the instilling of dignity. It was not before the court to give a comprehensive meaning to life in these broader, medical contexts, but it did by an obiter remark indicate that the law and the meaning of the right to life would have to be refined particularly in the context of VAE and the right to dignity.¹³²

In the VAE scenario we must ask whether the state has an interest in preserving life in all circumstances including these specific circumstances. With the direction of Mahomed J, the answer to that question would lie in defining life and giving it a fuller meaning, taking a holistic and constitutional view of what the right to life means. O'Regan J offered further insight, and gave a more refined meaning to the right to life in her dictum, such that it means more than mere existence, but rather a particular quality of life. She stated that

“the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, but the right to human life... The right to life, thus understood, incorporates the right to dignity. So, the rights to human dignity and life are entwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished.”¹³³

O'Regan J says that the right to life is violated if life itself is lived without dignity, and by extension if a law of general application limits one's ability to live a dignified life, then the right to life itself is violated. It is not just the right to life which is enshrined, it is the right to a *dignified* life. Thus, the state is not under a duty to protect life as mere existence at all costs, it is instead constitutionally bound to protect the right to a dignified life, and by extension, a *dignified* death;¹³⁴ and the state must ensure that its laws promote and support life with dignity.

As the right to life properly means the right to more than mere existence and a right to a particular quality of life informed by dignity, a purpose aimed at protecting the *sanctity* of life in a way that means mere *existence*, fails. I turn now to consider the second reason for the retention of the criminal law prohibition: the need to protect the weak and vulnerable from abuse.

5.5.2 *Protecting the weak and vulnerable from abuse*

The second argument for maintaining a criminal prohibition in relation to limiting autonomy in VAE cases is the argument that the prohibition is necessary to protect the weak and

¹³² *Makwanyane* supra note 128 at para 269.

¹³³ *Makwanyane* supra note 128 at paras 326-327.

¹³⁴ The implication for unlawfulness rests on whether the blanket prohibition is itself an unlawful violation of the right to life as informed by the right to dignity. Consent links with dignity as informed by autonomy.

vulnerable from abuse. The High Court in *Stransham-Ford* identified this argument as the “sole true concern”¹³⁵ related to the decriminalisation of VAE, dismissing the sanctity of life argument. Regarding the *Stransham-Ford* case (High Court), in an interview, the Minister of Justice at the time, Mr. Michael Masutha said his department was “opposing assisted suicide simply because no one under the Constitution has a right to kill another person. He was adamant that by assisting any person to kill themselves – one becomes party to murder.”¹³⁶ This statement ignores that in law, people are in fact excused from criminal liability for having caused the death of others in certain circumstances, for example when acting in self-defence, or as has been shown, through acts of passive euthanasia. Intentionally causing the death of another person is clearly justifiable in certain circumstances. Suicide however is not a criminal offence, and so what is criminalised by the prohibition on VAE is death (or suicide) by medical assistance. As the criminal law prohibition makes consent to one’s own death irrelevant, it criminalises the conduct of the physician who assists a patient who seeks an assisted death, and prevents patients from exercising autonomy and lawfully seeking VAE, without effectively and properly considering the purpose of the limitation in the light of the factual construct of VAE. They may request it, but the law prohibits a physician from assisting. The High Court in *Stransham-Ford* noted that the limitation on autonomy was ironic when in fact people can exercise autonomy regarding life and death matters, but are barred from doing so in the specific context of VAE:

“The irony is, they say, that we are told from childhood to take responsibility for our lives but when faced with death we are told we may not be responsible for our own passing. There are many other ironic considerations in this context. One can choose one’s education, one’s career, one can decide to get married, one can live according to a lifestyle of one’s choice, one can consent to medical treatment or one can refuse it, one can have children and one can abort children, one can practice birth control, and one can die on the battlefield for one’s country. But one cannot decide how to die.... The irony again is that the State sanctions death when it is bad for a person, but denies it when it is good.”¹³⁷

¹³⁵ *Stransham-Ford* (HC) supra note 104 at para 17:

“Applicant’s Counsel submitted that it has been recognized that, but for the risk posed to the weak and vulnerable, active voluntary euthanasia should be legalized. That was also the view of the South African Law Reform Commission, and it is clear from the option that it proposed and the discussions surrounding the various options that this is indeed a major consideration. It is not an issue in the present application. I agree that there should be minimum safe guards in any given context, but at the end of the day each case must be decided on its own merits, and I am sure that any envisaged legislation will provide for sufficient safeguards to be applied depending on the circumstance of each individual sufferer.”

¹³⁶ N Manyathi-Jele ‘Judges ruling in assisted suicide case divides South Africa’ (2015) June *De Rebus*, available at <http://www.derebus.org.za/judges-ruling-in-assisted-suicide-case-divides-south-africa/>, accessed on 3 February 2021.

¹³⁷ *Stransham-Ford* (HC) supra note 104 at para 14.

Where the sanctity of life argument fails, opponents to the decriminalisation of VAE and the recognition of patient autonomy in VAE cases raise this second argument and maintain that the prohibition should remain because

“it is difficult to ascertain the patient’s real consent; that there would be danger of abuse; that the doctor may diagnose a disease as incurable when it is in fact curable; that allowing voluntary euthanasia would be the thin wedge leading to a general disrespect for the sanctity of life.”¹³⁸

These concerns are by no means trivial, and the concern about the quality of a patient’s consent was addressed in Chapter Three. For these reasons, the argument that not accepting consent and not permitting VAE fails, because the legal convictions of society already accept consent to death in PE matters, and can identify which patients are decisionally vulnerable and which are not.

The limit on consent and autonomy is aimed at protecting the weak and the vulnerable from abuse, but it also means that patients who do not identify as weak or vulnerable are limited in exercising their autonomy by being prevented from accessing VAE. While the weak and vulnerable do require protection, the prohibition is overly-broad and grossly disproportionate if it unreasonably prevents those who do not identify as such and do not require the protection offered by the prohibition from exercising an autonomous choice made in appreciation of the consequence of that choice. The applicants in a new case *Walter and Others*¹³⁹ have filed and served their plea through the High Court of Gauteng. The date for the hearing has not been set. In this case the applicants, Suzanne Walter and Diethelm Harck, argue that the prohibition on VAE violates their right to dignity, because they do not identify as weak and vulnerable. The application is being opposed by the Health Professions Council of South Africa who are cited as the third respondent. The HPCSA identifies in its pleadings that vulnerable patients are those:

- “45.4.1 who have, or are in the terminal phase of, a serious disease or medical condition;
- 45.4.2 who are mentally or physically disabled;
- 45.4.3 who are of an advanced age.”¹⁴⁰

¹³⁸ G Williams ‘Euthanasia and abortion’ (1965) 38(2) *U Colo L Rev* 178 at 180.

¹³⁹ *Walter and Others v the Minister of Health and Others*, Case no. 31396/2017, Gauteng Division of the High Court (unreported). Available at <https://www.wits.ac.za/media/wits-university/faculties-and-schools/commerce-law-and-management/research-entities/cals/documents/programmes/rule-of-law/in-court/CALS%20Amicus%20Application%20Walter%20v%20Minister%20of%20Health.pdf> . Accessed on 14 February 2022.

¹⁴⁰ *Ibid.*

The submission from the HPCSA is that patients who are terminally ill, physically disabled, or old, do not have the capacity to make autonomous decisions. For reasons already explained in Chapter Four, this argument fails. Both the law and medical practice guidelines have rules for gauging the quality of consent and decision-making, none of which are hindered by illness, physical disability or advanced age. Even in cases of patients who are “mentally disabled” either because they always were so disabled, or those who due to their illness lose decision-making capacity, such disability is no bar to decisions being made on their behalf under the auspices of the patient’s best interests, through proxy decision-making.

So, the argument based on the need to protect the weak and vulnerable fails when it is in fact possible to gauge the quality of consent despite the nature of the illness or advanced age. As far as medical misdiagnosis is concerned, this can be mitigated by requiring second opinions to confirm the diagnosis, as is the requirement in permissive jurisdictions. These arguments go to the weight that should be attached to the purpose of any limitation, which assists in the balancing process.

5.5.4 Limitations and purposes

The limits placed on autonomous decision-making in VAE become central to the argument that the blanket prohibition violates individual dignity.¹⁴¹ In terms of s 36(2) of the Constitution all rights enshrined in the Constitution can be limited where limitation is necessary to prevent conflicts with other rights such that they do not align with the spirit, purport and objects of the Bill of Rights. Essentially, s 36 calls on courts to engage in a balancing exercise which engages the elements of inquiry for limitation as listed in s 36. A balance must be struck between the nature of the right infringed, the purpose of the provision, whether there is a rational and justifiable connection between the limitation and the purpose it serves, and whether the purpose can be achieved in a way that is less restrictive of the right the restriction limits.¹⁴²

¹⁴¹ Autonomy is more fully discussed in Chapter Three related to patient autonomy and decision-making, drawing an analogy and contrast with autonomous decision-making capacity in cases of palliative euthanasia. I argue that the limit placed on autonomous decision-making in PAS and PAE is unconstitutional and unjustified.

¹⁴² De Vos & Freedman op cit note 46 at 367. Much weight *should* be attached to the value of dignity and the right to autonomy. This is because human dignity plays such a central role in our constitutional system. I have also shown that in the context of a competent adult applying for VAE, not much weight can be attached to the two reasons given for criminalising VAE. If criminalising VAE does not promote the spirit, purport and object of the right to dignity, then it is not necessary to show that it is also irrational. In any event, it would satisfy the rationality test. This is because the two goals are legitimate in a constitutional democracy and the absolute prohibition of VAE does uphold life and protect the vulnerable from abuse. Engaging the balancing exercise will determine whether decriminalisation of VAE can still uphold the goals of the blanket prohibition, albeit through less restrictive means.

A limitation on the exercise of individual rights may be justifiable and therefore constitutional if the limitation serves a legitimate purpose which cannot be achieved through less restrictive means. This requires consideration of the harm that the limitation seeks to prevent (its purpose) and whether the limitation is proportionate to the purpose. What this simply means is that there must be a justification for the limitation. In deciding whether the limitation is justified, courts¹⁴³ have referred to the proportionality test, and although De Vos and Freedman note that reliance on the use of the word proportionality can cause confusion as “the term’s flexibility lends itself to morally appealing but legally inexact analysis”¹⁴⁴ the authors accept the reality that the concept of proportionality is, in fact, part of the limitation analysis and constitutional jurisprudence lexicon.¹⁴⁵

Thus, the crux of justifiability and the limitations analysis is to assess whether there is a rational connection between the limitation and the purpose thereof. Having identified the rights which are limited, the purpose it serves and noting that the purpose of the limitation, particularly that of protecting the weak and vulnerable from abuse, we see that there is a rational connection between the limitation and the purpose. So, the first part of the limitation analysis, the question of rationality, has been satisfied. The crux of the analysis is the proportionality test (i.e. the balancing exercise), which tests whether the rational purpose identified can be achieved in any other way which would be less restrictive of the right that the law of general application infringes upon. This is because the limitation (the absolute prohibition of VAE) absolutely achieves the goals of upholding life and the prevention of abuse (or the risk thereof). However, proportionality as a requirement of the limitations analysis further asks whether the purpose can be achieved through less restrictive means. This question is asked as part of a

¹⁴³ *Makwanyane* supra note 128 at 104 per Chaskalson J referring to section 33 of the Interim Constitution:

“The limitation of constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality. This is implicit in the provisions of section 33(1). The fact that different rights have different implications for democracy, and in the case of our Constitution, for ‘an open and democratic society based on freedom and equality’, means that there is no absolute standard which can be laid down for determining reasonableness and necessity. Principles can be established, but the application of those principles to particular circumstances can only be done on a case by case basis. This is inherent in the requirement of proportionality, which calls for the balancing of different interests. In the balancing process, the relevant considerations will include the nature of the right that is limited, and its importance to an open and democratic society based on freedom and equality; the purpose for which the right is limited and the importance of that purpose to such a society; the extent of the limitation, its efficacy, and particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question. In the process regard must be had to the provisions of section 33(1), and the underlying values of the Constitution, bearing in mind that, as a Canadian Judge has said, ‘the role of the Court is not to second-guess the wisdom of policy choices made by legislators.’”

¹⁴⁴ De Vos & Freedman op cit note 46 at 363.

¹⁴⁵ De Vos & Freedman op cit note 46 at 367.

broader balancing process. Not only must the court ask if there are less restrictive means, it must also attach weight to all the different factors (the nature of the right, the purpose of the limitation, and the extent of the limitation), and then weigh them up against one another. Thus, despite rationality of the limit when viewed with the purpose of the limitation, the limitation will be unconstitutional if the purpose can be achieved by less restrictive means.

5.5.4.1 *Less restrictive means*

Section 36(1)(e) of the Constitution relates to proportionality and asks whether the purpose can be achieved through “less restrictive means”. What this means is that if there is more than one way of achieving the purpose which the limitation serves, then “the one that interferes less intensively with the right that is to be limited, must be chosen.”¹⁴⁶

The argument raised by proponents of the decriminalisation of VAE is that the means for achieving the State’s purpose unjustifiably infringes the right to dignity by discounting patient autonomy. The prohibition thus denies patients the right to choose the time and manner of their own deaths. The purpose of the prohibition – to protect the weak and vulnerable – can be achieved through less restrictive means by reliance on informed consent requirements to identify which patients require the level of protection offered by the prohibition and which do not.

The High Court in *Stransham-Ford* ruled in favour of the applicant, but the decision, taken on appeal to the SCA was overturned on appeal. The Minister of Justice, in welcoming the SCA’s decision, stated that the High Court’s decision “had far-reaching implications on its interpretation and possible abuse by others in the absence of a legislative framework that regulates assisted suicide.”¹⁴⁷ It is important to note that this statement admits that the blanket prohibition may be overly-broad, and that it may be possible to permit VAE if the practice was regulated in a manner that accommodates for safeguards aimed at mitigating against concerns about abuse. The statement concedes that there are in fact less restrictive ways of achieving the purpose which criminalisation is meant to achieve.

Turning to jurisdictions that permit VAE, notably Canada, the SCA in *Stransham-Ford* noted that VAE is lawful in that jurisdiction only if and when it is performed and accessed in

¹⁴⁶ I M Rautenbach ‘Proportionality and the limitation clauses of the South African Bill of Rights’ (2014) 17(6) *PER / PELJ* at 2257.

¹⁴⁷ O Kumwenda-Mtambo ‘South Africa's appeals court overturns ruling allowing 'assisted dying'’ *Reuters*, 6 December 2016, available at <https://www.reuters.com/article/us-safrica-health-euthanasia-idUSKBN13V1BH>, accessed on 4 February 2021.

line with legislated-for requirements, notably informed consent, the assessment of the mental capacity of the patient throughout the decision-making process, and the nature and prognosis of the terminal illness.¹⁴⁸ This strikes the right balance between the limitation of rights and the purpose served by the limitation because the informed consent guidelines, together with the assessment of mental capacity, would be sufficient for determining whether the patient was making a decision which is informed, free and voluntary. The Supreme Court of Canada in *Carter v Canada*¹⁴⁹ considered autonomy and dignity in the same breath, as necessary components of each other, and applied the proportionality analysis noting that competing interests may bear upon the limitation of autonomy:

“On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable”.¹⁵⁰

The court considered the arguments regarding limitation and purpose and held that for patients who are competent

“a regime which permits control over the manner of one’s death respects, rather than threatens, their autonomy and dignity, and that the legalization of physician-assisted suicide will protect them by establishing stronger safeguards and oversight for end-of life medical care.”¹⁵¹

Regarding the purpose of the prohibition, the court concluded that adopting a broader, qualitative approach to the right to life meant that quality of life was the right enshrined and protected, not mere existence, and concluded that the right to life so understood also meant a right to death at the time and manner of one’s own choosing, including death by medical assistance:

“that the right to life is not restricted to the preservation of life, but protects the quality of life and therefore a right to die with dignity ... the right to life protects personal autonomy and fundamental notions of self-determination and dignity, and therefore includes the right to determine whether to take one’s own life.”¹⁵²

Patients who seek VAE argue that they suffer from a violation of their right to dignity as a result of the criminalisation of all forms of assisted deaths, and that the common law crime of murder is overly-broad in that it includes VAE. The restriction on autonomy as a result of the prohibition, unjustifiably and unconstitutionally violates their right to dignity. Sachs J promotes and supports a

¹⁴⁸ *Stranham-Ford (SCA)* supra note 8 at para 106.

¹⁴⁹ *Carter v Canada (AG)* 2015 SCC 5.

¹⁵⁰ *Carter v Canada (AG)* supra note 148 at para 2.

¹⁵¹ *Carter v Canada (AG)* supra note 148 at para 10.

¹⁵² *Carter v Canada (AG)* supra note 148 at para 59.

“...situation-sensitive human rights approach...that...focuses not on abstract categories, but on the lives as lived and the injuries experienced by different groups in our societies...The focus on dignity results in emphasis being placed simultaneously on context, impact and the point of view of affected persons.”¹⁵³

Similarly, for patients seeking VAE, the argument is that they are harmed and their rights are violated by the continued criminalisation and categorisation of VAE as murder, which fails to take a situation-sensitive view of their personal positions and the circumstances under which an assisted death is sought. While the limitation on autonomous decision-making is aimed at protecting the weak and vulnerable from abuse, it is submitted that where patients do not identify as vulnerable, the limitation on autonomy is not constitutional. However, criminalisation may still be necessary if decriminalisation would result in harm to the broader society. From the broader policy objective of criminalisation, if there is no evidence to suggest that patients who seek to end their lives with assistance are “especially contagious or prone to corrupting others”¹⁵⁴ or where “power nor specific resource allocation are at issue”¹⁵⁵ as both being traditional and justifiable grounds for the limitation of rights, individual dignity and autonomy must prevail and trump all other competing interests.¹⁵⁶ Although legalising conduct specifically identified as VAE may result in more people seeking an assisted death, safeguards would be able to assess whether the request is genuine, or is made in a state of vulnerability such that the patient’s mental capacity is questioned. In such an instance the patient would not qualify for VAE, and so the purpose of protecting the weak and vulnerable would in fact be achieved, despite the regime being permissive.

It is submitted that in these terms, the limitation is not justifiable and reasonable when it prevents patients who are not vulnerable from accessing VAE which they argue is a violation of the right to dignity as the prohibition prevents them from seeking death in the manner and at the time of their choosing. In those cases where patients are not vulnerable, the right to dignity and autonomy clearly outweighs the purpose underlying the criminalisation of VAE, namely the sanctity of life and the protection of the vulnerable. If the quality of the consent of a patient who seeks VAE can be established, then the blanket prohibition is unconstitutional because it denies those patients the right to choose a dignified death, at the time and manner of their choosing. The current requirements for consent to be valid are relied upon to permit consent in cases of passive euthanasia, even in cases of patients who are terminally ill, of

¹⁵³ *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) at para 126.

¹⁵⁴ *National Coalition for Gay and Lesbian Equality* supra note 153 at 128.

¹⁵⁵ *National Coalition for Gay and Lesbian Equality* supra note 153.

¹⁵⁶ *National Coalition for Gay and Lesbian Equality* supra note 153.

advanced age, or physically disabled. As such, there is no legitimate reason for maintaining the blanket prohibition of consent in VAE matters, when the HPCSA relies on the same measures of vulnerability that do not qualify as such in PE. The HPCSA's argument fails in this respect too. It is submitted that the purpose of protecting the vulnerable can be achieved through a legislated and regulated system which demarcates the bounds and requirements for VAE, particularly the circumstances under which such conduct would be justifiable and reasonable.¹⁵⁷ The purpose of the prohibition is rational and is linked to the prohibition, however, as the purpose can be achieved through less restrictive means, the prohibition is unconstitutional. Even though the criminalisation of VAE is rational, it does not promote the spirit, purport and object of the value of dignity and the right to autonomy. This is because in the context of adult, competent applicants, the value of dignity and the right to autonomy outweigh the goals of criminalising VAE, namely the sanctity of life and protecting the vulnerable, and there are alternative less restrictive means.

5.6 DEATH WITH DIGNITY IN CANADA – PURPOSE, LIMITATION AND PROPORTIONALITY IN CONTEXT

The Constitution of the Republic of South Africa and its Bill of Rights was “developed using the Canadian Charter of Human Rights and Freedoms as a template.”¹⁵⁸ Similar to the South African Constitution, the Canadian Charter of Rights and Freedoms¹⁵⁹ also contains a limitations clause in s 1 of the Charter. It provides that “the rights and freedoms set out in ...[the Charter] are subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.” It is not surprising then that the Canadian rights jurisprudence has had a marked influence on developments of the same in South Africa.¹⁶⁰ As this is the position and influence of the Charter, I turn to consider the case

¹⁵⁷ *Stransham-Ford* (HC) supra note 104 at para 13 where the court considered the recommendations of the SALRC (Project 186) in its report on euthanasia: *Euthanasia and the Artificial Preservation of Life* (1998):

“the present writers finally submit, that the underlying values, spirit and purport of the applicable sections in the Constitution, seem to be supportive of the introduction of voluntary active euthanasia in South Africa. Such a dispensation, along the lines of the recommendation of the South African Law Commission, should be strictly regulated and monitored to ensure the autonomy of competent terminally ill patients while guarding against any possible abuse of the system. Ultimately, they say, euthanasia is a matter of patient autonomy and individual choice. They also quote from a European writer who was already in the 14th century enlightened enough to have said the following: ‘Life is dependent on the will of others, death on ours.’ I agree, and the Constitution supports this view.”

¹⁵⁸ M R Phooko ‘Evaluating Canadian and South African collaborative human rights initiatives: A preliminary analysis and research agenda’ (2017) 4 *The Transnat H R Rev* 224.

¹⁵⁹ Here after referred to as the Charter.

¹⁶⁰ *S v Zuma and Two Others* 1995 (4) BCLR 401 (SA); *S v Makwanyane* 1995 (3) SA 391 (CC).

of *Carter v Canada*¹⁶¹ where the court embarked on a rights and limitations analysis related to the lawfulness of VAE. This case was repeatedly referred to by both the High Court and SCA in *Stransham-Ford*.

One of the applicants in this case was Ms Gloria Taylor. She had been diagnosed with amyotrophic lateral sclerosis (ALS) in 2009 and a month later was told that within a period of six months she would very likely be paralysed. She was given a life expectancy of one year. In the progression of her disease, she became acutely aware of the criminal law restriction placed upon her and others in her situation from seeking assistance in dying. She was also concerned that given the probability of being affected by paralysis, she would not be able to take her own life – suicide is not a criminal offence under Canadian law. However, due to her impending physical incapacity she would be prejudiced by the criminal prohibition on assisted dying if she were to seek assistance to commit suicide, due to the provision in the Canadian Penal Code.¹⁶² She realised that once she became paralysed she would be destined to live in a state of pain and discomfort till the natural end of her life.

In 2012, the British Columbia Civil Liberties Association (BCCLA) together with Ms Taylor, made the decision to challenge the criminal prohibition on assisted suicide. Three further individual claimants joined Ms Taylor and the BCCLA – Dr William Shoichet, a physician who was willing to perform assisted suicide in appropriate cases provided that the law became permissive of the practice; and Lee Carter and Hollis Johnson. Carter and Johnson were the daughter and son-in-law (respectively) of Kay Carter, a woman who had travelled to Switzerland with their assistance, to seek assistance in dying at the assisted suicide clinic (Dignitas). Carter and Johnson agreed to assist her, despite knowing that on their return to Canada, they could face prosecution for the crime of aiding and abetting suicide.

I turn now to analyse how the Court applied section 1 of the Canadian Charter of Rights and Freedoms to the challenge raised by Carter and others.

5.6.1 *Law of general application*

¹⁶¹ *Carter v Canada (AG)* 2015 SCC 5.

¹⁶² Section 241(b) of the Criminal Code of Canada.

The claimants challenged¹⁶³ s 241(b)¹⁶⁴ and related sections¹⁶⁵ of the Criminal Code of Canada on the grounds that the prohibition on assisted suicide violated their rights under various sections of the Canadian Charter of Rights and Freedoms.¹⁶⁶ Section 241(b) of the Criminal Code was a law of general application, broad enough to include VAE. The Attorney-General of Canada countered this argument by stating that the absolute prohibition was necessary to prevent the abuse of weak and vulnerable persons from effectively being murdered. Patients who were weak and vulnerable required protection which could only be provided if the blanket prohibition was maintained. The prohibition was necessary to avoid this.¹⁶⁷

5.6.2 *The nature of the right infringed*

In the analysis of whether there had been a violation of the rights afforded in s 7 (the rights to life, liberty and security of the person) of the Charter, the courts were required to embark on a two-stage analysis: First, to determine if there had been a violation of the right to life, liberty or security of the person. And then, if a violation existed, to consider whether the violation was contrary to the principles of fundamental justice. The argument raised was that the criminal prohibitions in s 241(b) (the prohibition against assisted suicide) and section 14 (the prohibition against consenting to one's own death) of the Canadian Criminal Code violated s 7 (the rights to life, liberty and security of the person) of the Canadian Charter of Rights and Freedoms. In addition, the argument was also raised that the violation of these rights did not satisfy the requirements of the limitation clause in section 1 of the Charter and was unconstitutional and invalid. The question was whether the limitation, and thus the prohibitions, were overly-broad and irrational in light of the principles of fundamental justice. The court accepted the argument that the Charter rights of patients were violated by s 241(b).¹⁶⁸ However, in terms of s 1 of the

¹⁶³ At the trial court as court of first instance.

¹⁶⁴ “241 (1) Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not, (a) counsels a person to die by suicide or abets a person in dying by suicide; or. (b) aids a person to die by suicide.”

¹⁶⁵ Ss 14, 21, 22 and 222 of the Canadian Criminal Code.

¹⁶⁶ *Carter v Canada (AG)*, 2012 BCSC 886; Canadian Charter of Rights and Freedoms hereinafter referred to as ‘the Charter’.

¹⁶⁷ The Charter at paras 749-754:

“risking the deaths of incompetent persons, deaths that are involuntary (i.e. coerced), the deaths of individuals with treatable conditions, the deaths of ‘ambivalent’ individuals, the deaths of ‘misinformed’ individuals, and the deaths of vulnerable populations, including the elderly and people with disabilities”.

¹⁶⁸ *Carter v Canada (AG)* 2012 supra note 166 at para 1306:

“The three rights in s. 7 – to life, liberty and security of the person – should be read together. They influence the meaning of one another, and all must be taken into account in determining the content of the principles of fundamental justice (Rodriguez at 584). Further, the rights of the Charter as a whole must be read in the light of one another and with an understanding of the underlying values that they represent. One such value is the inherent value of human life, as recognized in Rodriguez, where the

Charter, the infringement could still be saved from a declaration of constitutional invalidity if the violation could be demonstrably justified in a free and democratic society.

The State argued that the right to life as enshrined in s 7 of the Charter “does not encompass *quality of life issues*, which it says may implicate security of the person, but not the right to life itself”¹⁶⁹ and that “the right to life does not include the right to choose death”.¹⁷⁰ The court rejected this argument because the rights as phrased in s 7 of the Charter were intertwined, and had to be considered in the context of each other. As such, the court accepted that “the right to life included a right to die with dignity, on the ground that ‘dignity is an integral part of living’”.¹⁷¹ The court pointed out that the right to life was engaged by Ms Taylor when she alleged that

“the legislation has the effect of shortening the lives of persons who fear that they will become unable to commit suicide later, and therefore take their own lives at an earlier date than would otherwise be necessary. That point is supported by evidence from Ms. Taylor as well as other witnesses. In that respect, I agree with the plaintiffs that the right to life is engaged by the effect of the legislation in forcing an earlier decision and possibly an earlier death on persons in Ms. Taylor’s situation.”¹⁷²

Having found that there would be a violation of the right to life, liberty or security of the person, the court had to assess whether the violation was a legitimate one and justifiable in terms of the principles of fundamental justice.¹⁷³ The principles of fundamental justice called for the law in question to be assessed for arbitrariness: whether it was overly-broad and grossly disproportionate.¹⁷⁴

5.6.3 *The purpose of the limitation and rationality*

majority stated that Canadian society is “based upon the intrinsic value of human life and on the inherent dignity of every human being”.

¹⁶⁹ *Carter v Canada* 2012 supra note 166 at para 1313.

¹⁷⁰ *Carter v Canada* 2012 supra note 166 at para 1314.

¹⁷¹ *Carter v Canada* 2015 supra note 161 at para 60.

¹⁷² *Carter v Canada* 2012 supra note 166 at para 1322.

¹⁷³ *Carter v Canada* 2015 supra note 161 at para 81:

“...the principles of fundamental justice are derived from the essential elements of our system of justice, which is itself founded on a belief in the dignity and worth of every human person. To deprive a person of constitutional rights arbitrarily or in a way that is overbroad or grossly disproportionate diminishes that worth and dignity. If a law operates in this way, it asks the right claimant to “serve as a scapegoat” (Rodriguez, at p. 621, per McLachlin J.). It imposes a deprivation via a process that is “fundamentally unfair” to the rights claimant (Charkaoui, at para. 22).”

¹⁷⁴ Unlike the South African limitations analysis, the Canadian model distinguishes clearly between the threshold test (i.e. rationality) and the balancing exercise (i.e. proportionality). A law must first pass the rationality test. If it does not, that is the end of the enquiry and there is no need to balance anything. The law is invalid. If the law does pass the rationality test, then the court moves to the balancing exercise.

A law would be arbitrary, overly-broad and disproportional if it infringed a Charter right without furthering the legislative objective, and if the purpose of the prohibition could be achieved through less restrictive means. In terms of the rights analysis “liberty protects the right to make fundamental personal choices free from state interference”¹⁷⁵ and requires a consideration of the purpose of the criminal law prohibition – what harm is it intended to protect and safeguard against? The court identified the purpose and object of the prohibition as being to prevent abuse of vulnerable people noting the dictum in *Rodriguez*¹⁷⁶ and its primary reason for not allowing PAS or PAE at that time.¹⁷⁷ The court overturned the decision in *Rodriguez* based on a consideration of whether the purpose could in fact be achieved through less restrictive means.

5.6.4 *Can the purpose be achieved through less restrictive means?*

In the light of the above, the court then turned to consider whether the criminal prohibition was overly-broad. For the prohibition to pass this leg of the inquiry and be justifiable, it had to be proved that “restrictions on life, liberty and security of the person must not be more broadly framed than necessary to achieve the legislative purpose”.¹⁷⁸ In other words, could the legislative purpose be achieved through less restrictive means? The claimant’s submission was that ultimately, it was the task of the court “to balance Parliament’s objective of preventing vulnerable persons from being induced to commit suicide, against the constitutional rights of the plaintiffs.”¹⁷⁹ They argued that the purpose of the prohibition was to prevent people from being unlawfully induced to commit suicide in a state of vulnerability, and that they did not fall into this category as their decisions were informed and based on consent and autonomy. As such, the court concluded that

“The legislation’s infringement of s. 15 equality rights is not demonstrably justified under s. 1 of the Charter. The purpose of the absolute prohibition against physician-assisted suicide, as determined by *Rodriguez*, is to prevent vulnerable persons from being induced to commit suicide at times of weakness. That purpose is pressing and substantial and the absolute

¹⁷⁵ *Carter v Canada* 2015 supra note 161 at para 64.

¹⁷⁶ *Rodriguez v British Columbia (AG)* [1993] 3 SCR 519.

¹⁷⁷ *Carter v Canada* 2012 supra note 166 at para 934 quoting from *Rodriguez*:

“Given the concerns about abuse that have been expressed and the great difficulty in creating appropriate safeguards to prevent these, it cannot be said that the blanket prohibition on assisted suicide is arbitrary or unfair, or that it is not reflective of fundamental values at play in our society. I am thus unable to find that any principle of fundamental justice is violated by s. 241(b)”.

¹⁷⁸ *Carter v Canada* 2012 supra note 166 at para 1339.

¹⁷⁹ *Carter v Canada* 2012 supra note 166 at para 1354.

prohibition against assisted suicide is rationally connected to it. However, a less drastic means of achieving the legislative purpose would be to keep an almost-absolute prohibition in place with a stringently limited, carefully monitored system of exceptions allowing persons in Ms. Taylor's situation – grievously and irremediably ill adult persons who are competent, fully-informed, non-ambivalent and free from coercion or duress – to access physician-assisted death. Thus, the legislation does not impair Ms. Taylor's equality rights as little as possible. Further, the legislation has very severe adverse effects on Ms. Taylor and others in her situation, that are not outweighed by its benefits. For those reasons, and despite affording due deference to Parliament, I conclude that the legislation's absolute prohibition falls outside the bounds of constitutionality".¹⁸⁰

As far as the consideration of whether abuses of vulnerable people would occur if the prohibition was lifted, the court stated that "a prohibition with carefully designed and well enforced exceptions would less restrict the plaintiffs' interests in life, liberty and security of the person, but the question is whether a prohibition without exceptions is necessary in order to meet the government's objectives."¹⁸¹ The court concluded that a blanket prohibition would only be necessary and thus constitutionally justifiable if

"evidence showed that physicians are unable reliably to assess competence, voluntariness and non-ambivalence in patients, or that physicians fail to understand or apply the informed consent requirement for medical treatment."¹⁸² In assessing the evidence, the court analysed evidence from permissive jurisdictions and held that it showed support for the conclusion that 'a system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable persons from being induced to commit suicide while permitting exceptions for competent, fully-informed person acting voluntarily to receive physician-assisted death'.¹⁸³

The question of gross disproportionality relates to the limitation and the purpose that limitation serves – whether the purpose can be achieved through less restrictive means. It causes a court to consider balancing of the purpose that criminalisation serves and whether it unjustifiably limits the rights of those who do not fall within the ambit of the purpose of the prohibition. In South Africa, this would require an analysis of the limitations clause enshrined in s 36 of the Constitution which would facilitate resolution of the issue of whether the purpose of protecting the weak and vulnerable can be achieved if the prohibition is lifted.

¹⁸⁰ *Carter v Canada* 2012 supra note 166 at para 16.

¹⁸¹ *Carter v Canada* 2012 supra note 166 at para 1364.

¹⁸² *Carter v Canada* 2012 supra note 166 at para 1365.

¹⁸³ *Carter v Canada* 2012 supra note 166 at para 1367.

Having fully discussed the government's purpose under the overly-broad requirement, the court in *Carter v Canada* held that

“the effect of the absolute prohibition of the life, liberty and security of the person interests of the plaintiffs is very severe, and is grossly disproportionate to its effect on preventing inducement of vulnerable people to commit suicide, promoting palliative care, protecting physician-patient relationships, protecting vulnerable people, and upholding the state interesting the preservation of life”.¹⁸⁴

5.6.5 *Remedy and Reform*

In the final analysis, the court held that the prohibition on assisted suicide as enunciated in s 241(b) of the Criminal Code was overly-broad as far as it extended to prohibit physician-assisted suicide within the narrow confines of the physician-patient relationship.¹⁸⁵ Justice Smith not only declared the prohibition constitutionally invalid, she also posited requirements for a patient to qualify for physician-assisted suicide, which effectively discounted the Attorney General's arguments for justification of the blanket prohibition regarding the protection of vulnerable individuals. Accepting and acknowledging the doctrine of separation of powers and the law-making role of Parliament, Justice Smith suspended the declaration of constitutional invalidity for a period of 12 months in order to allow Parliament sufficient time to draft and consider appropriate legislation. This was based on the submission by the Attorney General regarding timeframes for implementation.¹⁸⁶

This 12-month suspension would not have seen realisation of Ms Taylor's rights claim for at least a 12-month period,¹⁸⁷ and given her life expectancy and the fact that the court realised and accepted her claim, not to effect some kind of remedy particular to her would have been, in the court's contemplation, unjust. As a result, Justice Smith granted a constitutional

¹⁸⁴ *Carter v Canada* 2012 supra note 166 at para 1378.

¹⁸⁵ *Carter v Canada* 2012 supra note 166 para 1393:

“of no force and effect to the extent that (it prohibited) physician-assisted suicide by a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully-informed, non-ambivalent competent adult who:

- (a) Is free from coercion and undue influence, is not clinically depressed and who personally (not through a substituted decision maker) requests physician-assisted death; and
- (b) Is materially physically disabled or is soon to become so, has been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury), is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy as determined by reference to treatment options acceptable to the person, and has an illness causing enduring physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person”.

¹⁸⁶ *Carter v Canada* 2012 supra note 166 at para 1395.

¹⁸⁷ This would have been longer if the matter was taken through the various stages of the appeal process.

exemption, a personal remedy, which would make Ms Taylor and Ms Taylor alone (and a physician who assisted her), exempt from the criminal prohibition of s 241(b) pending either parliamentary resolution through the enactment of legislation declaring physician-assisted suicide legal, or the expiration of the 12-month period. Justice Smith placed conditions on the reliance by Ms Taylor on the constitutional exemption, *inter alia* that a physician had to attest to her terminal status and further that she was in fact near death.

The decision was taken on appeal to the British Columbia Court of Appeal, which overturned the judgment of the court *a quo* on the grounds that it found that it was bound by the decision in *Rodriguez*. The matter then went on appeal to the Supreme Court of Canada (SCC) in consideration of *stare decisis* where it was held that “*stare decisis* is not a straitjacket that condemns the law to stasis”.¹⁸⁸ The SCC applied the “new legal issue” test and considered whether there was a change in circumstances or evidence which “fundamentally shifts the parameters of the debate”¹⁸⁹ which would allow the matter to be reconsidered under a new issue. Accepting that there had been a number of developments internationally, as well as support from within Canada itself evidenced by the various reports from the Royal Society of Canada as well as the Select Committee of the National Assembly of Quebec, showing a shift in societal views on the issue, the court pronounced that it was not bound by *stare decisis* and the *Rodriguez* decision.

The SCC then moved on to consider the merits of the constitutional arguments in relation to the right to life, liberty and security of the person in light of the prohibitions in s 241(b) and s 14 of the Criminal Code,¹⁹⁰ and subsequently upheld the decision of the court *a quo*, thus confirming the declaration of constitutional invalidity. The SCC confirmed that the prohibition on assisted dying was arbitrary, over-broad and grossly disproportionate. The court ruled that:

“Section 241(b) and s. 14 of the Criminal Code unjustifiably infringe s. 7 of the Charter and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.”¹⁹¹

¹⁸⁸ *Carter v Canada (AG)* 2015 supra note 161 at para 44.

¹⁸⁹ *Carter v Canada (AG)* 2015 supra note 161 at para 44.

¹⁹⁰ *Carter v Canada (AG)* 2015 supra note 161 at para 20:

“It is these two provisions that prohibit the provision of assistance in dying. Sections 21, 22 and 222 are only engaged so long as the provision of assistance in dying is itself an “unlawful act” or offence.”

¹⁹¹ *Carter v Canada (AG)* 2015 supra note 161 at para 147.

The SCC gave the government until 6 June 2016 to enact suitable legislation to properly legalise and regulate the practice of assisted dying. Bill C-14¹⁹² was passed into law on 17 June 2016, and decriminalised both PAS and PAE, while maintaining the criminal prohibition as far as it relates to assisted dying in the forms of murder and aiding and abetting suicide in the non-medical context. The Bill amended s 241 of the Criminal Code by creating an exemption from criminal liability for physicians and nurses who provided “medical assistance in dying” (MAID) to qualifying patients. MAID is defined in s 241.1 as amended as:

- “(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
- (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.”

5.7 DEVELOPMENT AND THE CONSTITUTIONAL IMPERATIVE IN SOUTH AFRICA – *STRANSHAM-FORD* AND BEYOND

The *Stransham-Ford*¹⁹³ case placed the issue of permissibility of VAE before the South African judiciary. The applicant argued that the common law was overly-broad in that the prohibition on assisted deaths unjustifiably limited his right to dignity. He prayed that the court develop the common law crime of murder such that VAE would no longer fall within its ambit. The High Court ruled that the applicant was entitled to a medically assisted death in the form of either PAS or PAE because

“The common law crimes of murder or culpable homicide in the context of assisted suicide by medical practitioners, insofar as they provide for an absolute prohibition, unjustifiably limit the Applicant’s constitutional rights to human dignity, (s 10) and freedom to bodily and psychological integrity (s 12(2)(b), read with s 1 and 7), and to that extent are declared to be overbroad and in conflict with the said provisions of the Bill of Rights...”¹⁹⁴

Thus, the applicant was

¹⁹² An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), available at <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 1 December 2021.

¹⁹³ *Stransham-Ford* (HC) supra note 104.

¹⁹⁴ *Stransham-Ford* (HC) supra note 104 at para 26.

“...entitled to be assisted by a qualified medical doctor, who is willing to do so, to end his life, either by administration of a lethal agent or by providing the Applicant with the necessary lethal agent to administer himself...”¹⁹⁵

As such

“The medical doctor who accedes to the request of the Applicant shall not be acting unlawfully, and hence, shall not be subject to prosecution...”¹⁹⁶

The High Court ruled that the common law ought to develop because constitutional rights were being violated. The High Court decision was taken on appeal to the Supreme Court of Appeal (SCA) by the Minister of Justice and Constitutional Development and others. The decision of the High Court was overturned by the Supreme Court of Appeal (SCA) which unanimously upheld the appeal on the following three interrelated grounds: first, that the matter was moot as the applicant passed away before the court could render its decision, second that there had not been a proper discourse and examination of the extant law, and third that the High Court made its decision without having complied with the Uniform Rules of Court.¹⁹⁷

This first ground is what effectively rendered the matter moot, with the SCA holding that once the High Court became aware of the passing away of the applicant, Fabricius J ought to have rescinded the order originally made,¹⁹⁸ stating that “no further purpose could be served by granting”¹⁹⁹ the relief sought by the applicant. The court pronounced judgment while it was unaware of the passing away of the applicant. On the following Tuesday, the High Court reconvened for Fabricius J to hand down the reasons for his judgment and was requested by the HPCSA to recall the order originally made. This he refused to do stating that his judgement “had broader societal implications”.²⁰⁰ The SCA noted that given the nature of the application, particularly that the application was brought solely and wholly in the name of the applicant

¹⁹⁵ *Stransham-Ford* (HC) supra note 104 at para 26.

¹⁹⁶ *Stransham-Ford* (HC) supra note 104 at para 26.

¹⁹⁷ *Stransham-Ford* (SCA) supra note 8 at para 5:

“Firstly, Mr Stransham-Ford had died on the morning of 30 April 2015 two hours before an order was made. As a result his cause of action ceased to exist and no order should have been made thereon. His death did not result in a claim passing to his estate and the estate had no interest in further pursuing this litigation or any *locus standi* to do so.

Secondly, there was no full and proper examination of the present state of our law in this difficult area, in the light of authority, both local and international, and the constitutional injunctions in relation to the interpretation of the Bill of Rights and the development of the common law.

Thirdly, the order was made on an incorrect and restricted factual basis, without complying with the Uniform Rules of Court and without affording all interested parties a proper opportunity to be heard. Viewed overall, the circumstances of the case were such that it was inappropriate for the court below to engage in a reconsideration of the common law in relation to the crimes of murder and culpable homicide.”

¹⁹⁸ *Stransham-Ford* (SCA) supra note 8 at para 5.

¹⁹⁹ *Stransham-Ford* (SCA) supra note 8 at para 15.

²⁰⁰ *Stransham-Ford* (SCA) supra note 8 at para 17.

alone; that throughout the documentation and arguments raised by the applicant he referred only to himself and to his rights, his dignity, his pain, etc, that the order ultimately granted was tailored for the applicant alone, and did not create precedent, the cause of action died when the applicant died.

That being said, the SCA agreed that mootness due to the death of one of the parties was not necessarily a bar in or of itself to the court continuing to pronounce on a matter. Fabricius J's view that his judgement "had broader societal implications"²⁰¹ was the reason for other courts to pronounce on matters despite mootness.²⁰² However, that alone was not the deciding factor. There are a multitude of interrelated considerations that must act in concert for a court to exercise the s 39(2) constitutional imperative when faced with mootness.

The SCA explained that the discretion related to mootness is reserved for higher courts, and only "if it is in the interests of justice to do so, (it) may consider and determine matters even though they have become moot".²⁰³ The SCA itself remarked rather strongly in this regard that it does "not accept that it is open to courts of first instance to make orders on causes of action that have been extinguished, merely because they think that their decision will have broader societal implications"²⁰⁴ and "unless the occasion arises in litigation that is properly before the court, it is not open to a judge to undertake that task. The courts have no plenary power to raise legal issues and make and shape the common law".

The next consideration is the phrase "in the interests of justice" as a deciding factor for consideration of a matter despite mootness, and whether a higher court could pronounce on the constitutional issues raised. The Constitutional Court was faced with this question in *Legal Aid South Africa v Magidiwana and Others*²⁰⁵ and the dissenting judgment handed down by Nkabinde J elucidates what criteria make up this elusive, seemingly all-encompassing phrase. She states, referring to *Van Wyk v Unitas Hospital and Another*,²⁰⁶ that the

"...relevant considerations are whether the order that the Court may make will have any practical effect either on the parties, or on others, whether it is in the public interest for the Court to exercise its discretion to resolve the issues and whether the decision will benefit the larger public or achieve legal certainty."²⁰⁷

²⁰¹ *Stransham-Ford* (SCA) supra note 8 at para 24.

²⁰² *Stransham-Ford* (SCA) supra note 8 at para 26.

²⁰³ *Stransham-Ford* (SCA) supra note 8 at para 22.

²⁰⁴ *Stransham-Ford* (SCA) supra note 8 at para 23.

²⁰⁵ *Legal Aid South Africa v Magidiwana and Others* 2015 (11) BCLR 1346 (CC).

²⁰⁶ *Van Wyk v Unitas Hospital and Another* 2008 (2) SA 472 (CC).

²⁰⁷ *Stransham-Ford* (SCA) supra note 8 at para 58.

While there was no doubt that the issue of permissibility of VAE is of public interest, the fact that the issue was particularly complex and that there had been no full discourse on the position of the law is what made it impossible for the SCA to make a ruling on the development of the common law crime of murder in relation to VAE. As such, the SCA noted specifically that the High Court's decision was based on an incorrect discourse of the extant law. The SCA said that any consideration of constitutionality could not (and should not) be made without fully dissecting the *corpus juris* applicable in South Africa, and considering it in the light of the spirit, purport and objects of the Bill of Rights. The dearth of evidence before the High Court, the haste with which the matter was determined and the fact that evidentiary issues only came to light when the issue was canvassed before the SCA, made for a fatal cocktail which could not rescue the plea as brought by the respondents in the *Stransham-Ford* appeal. In any event, it is clear from the High Court judgment that the decision of that court was not intended to create precedent or be applicable to future cases, or serve in fact to develop the common law. Fabricius J noted specifically in this regard that:

“The prayers sought by Applicant were addressed by me in Court and Counsel for Applicant and Third Respondent also provided me with a suggested amendment, were I to grant an order. I reflected upon this, and amended it to ensure that the relief was case dependant and certainly not a precedent for a general uncontrolled ‘free for all’ as it was suggested.”²⁰⁸

As such, the final order of the court applied only to the applicant and did not apply to any other patients, with the court ordering that “[e]xcept as stipulated above (specific to the applicant alone and no other persons), the common law crimes of murder and culpable homicide in the context of assisted suicide are not affected.”²⁰⁹ Accordingly, the High Court decision was not intended to develop the common law crime of murder. The SCA in *Stransham-Ford* concluded that given the above-mentioned reasons, the High Court was in the circumstances wrong to rule that the crimes of murder and culpable homicide ought to be developed to permit VAE.²¹⁰

²⁰⁸ *Stransham-Ford* (HC) supra note 104 at para 25.

²⁰⁹ *Stransham-Ford* (HC) supra note 104, order number 4 at para 26.

²¹⁰ *Stransham-Ford* (SCA) supra note 8 at para 101:

“It was wrong to hold that the common law crimes of murder and culpable homicide needed to be or should be developed to accommodate for PAE and PAS...When an appropriate case comes before our courts the common law will no doubt evolve in the light of the considerations outlined there and the developments in other countries. It is of course possible that Parliament will, as has occurred in other countries, intervene and pass legislation on the topic. That would be welcome if only because it would give effect to the proper role of Parliament in a society where the doctrine of the separation of powers has application.”

Thus, an appropriate case would require full arguments on the right or rights that the common law prohibition infringed, the purpose of the limitation and whether the purpose could be achieved through less restrictive means. The submission is that it is in fact possible for the courts to develop the common law under the auspices of s 39 of the Constitution by applying the limitations analysis of s 36, to bring the common law in line with constitutional convictions if a court is satisfied that the common law provision offends the spirit, purport and objects of the Bill of Rights in the Constitution.

It is submitted, that following the principles and reasoning adopted in *Carter v Canada* in relation to the limitation analysis, it would be possible for our courts to conclude that where physicians are in fact able to determine whether patients are making an informed and autonomous request (as they do in relation to any and all other decisions of a medical nature) the limit placed on autonomy infringes the right to dignity and such limitation is constitutionally unjustifiable. As such, the common law blanket prohibition against VAE in South Africa,²¹¹ would be overly-broad, and a violation of the right to dignity in a way that is disproportionate to the purpose that limitation serves as the purpose can be achieved through less restrictive means.

5.8 BONI MORES – THE REAL REASON FOR THE PROHIBITION EXPOSED

It is submitted that the reasoning of the court in *Carter v Canada*²¹² would be compelling and instructive for a court in South Africa adjudicating on the permissibility and decriminalisation of VAE in the light of there being marked parity between application and implementation of the South African constitutional principles for development of the law, and that of the Canadian Charter of Rights and Freedoms, as well as the way in which the rights identified have been interpreted by both jurisdictions. The decision confirms that the criminal law prohibition on consent to death results in an infringement of dignity. As such, a patient ought to be allowed to request and consent to VAE, and consent ought to avail as a defence for a physician who renders the necessary assistance, as to do otherwise would be unconstitutional. Such a decision and exercise of autonomy in the realisation of the right to dignity, is for some people “very important to their sense of dignity and personal integrity, that is consistent with their lifelong

²¹¹ *Grotjohn* and confirmed in *Hartmann* by way of obiter remark.

²¹² *Carter v Canada (AG)* 2015 at para 66: “We agree with the trial judge. An individual’s response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy.”

values and that reflects their life's experience"²¹³ even though it may be so different from the norm. It is a

“decision that is rooted in their control over their bodily integrity; it represents their deeply personal response to serious pain and suffering. By denying them the opportunity to make that choice, the prohibition impinges on their liberty and security of the person. As noted above, s. 7 recognizes the value of life, but it also honours the role that autonomy and dignity play at the end of that life.”²¹⁴

It is clear that the only reason for the impermissibility of VAE rests in consideration of the additional element of criminal liability, unlawfulness. Unlawfulness is considered in two contexts. First, in relation to defences which can be raised to exclude unlawfulness and thereby justify conduct which *prima facie* is unlawful, and second, the measure of unlawfulness of conduct based on an assessment of whether the conduct itself ought to be criminalised. The first aspect regarding unlawfulness focused on consent as a defence excluding unlawfulness and lead into a discussion of the circumstances under which consent could avail as a possible defence. The focus here turned to informed consent requirements, particularly capacity and competency, and how these were assessed generally and then specifically to patients who elect and consent to PE. It relates to patient autonomy, and it was shown that an autonomous decision made by a patient, albeit a lawful one, could be vetoed if the patient lacked capacity and competency. It was also shown that patients are competent to consent to medical treatment which ultimately causes death, provided that the treatment consented to is in law permissible and not *contra bonos mores*.

The second requirement focused on the rule that despite capacity and competency, patient autonomy could only be respected and exercised where the decision taken was itself lawful. Here, the discussion turned to an analysis of the legal convictions of society and the fact that this is used as a benchmark for what forms of conduct could be consented to. If the conduct itself is *contra bonos mores*, then despite capacity and competency, a patient cannot consent to that form of treatment. Categorised as murder, VAE is *contra bonos mores*, with South African law being clear and definitive that consent is never a defence to murder, regardless of the circumstances and factual construct under which death is caused.

The question then became whether it is legitimate for the state, through its laws to place limits on consent when it means a limitation on the exercise of autonomy. This was answered

²¹³ *Carter v Canada (AG)* 2015 supra note 161 at para 68.

²¹⁴ *Carter v Canada (AG)* 2015 supra note 161 at para 68.

by considering the purpose of criminalising conduct, particularly murder, and the protections it seeks to offer society through criminalisation, prosecution and punishment. Specifically in relation to VAE, the main purpose of the prohibition and categorisation as the crime of murder is to protect the weak and vulnerable from abuse. Vulnerable patients were identified as those of advanced age and who were suffering from terminal illness. This became the main consideration because a patient purports to consent to being killed. I examined the consent requirements as they apply to PE, and concluded that even though PE causes death, patients are permitted to consent to this, and their capacity and competency to consent was not without more affected by the nature of their illness, their age, nor the fatal effect that PE has.

Even though permissible, a limitation on autonomy in relation to PE would come into effect if patients are shown to lack decision-making capacity, and it was shown that such a limitation and restriction may be reasonable and justifiable based on the purpose that the limitation serves. However, it is also possible for a proxy decision-maker to consent on behalf of such a patient, even when what is consented to is a form of treatment that can cause death.²¹⁵ In contrast to PE, regardless of capacity and competency, patients are simply not permitted to personally (or through a proxy) make an informed decision and choice to elect VAE, not because they lack capacity or competency, but purely because VAE itself is *contra bonos mores*, is unlawful and is murder. The requirement regarding the acceptability of consent based on capacity and competency was evidenced as being a practical one which depended on the ability to gauge the quality of consent – whether it was real and freely given. Again, the purpose is to ensure that patients who are truly vulnerable are not victims of *mala fides* and abuse. It was shown that there is in fact a reliable way to gauge patient capacity, competency and voluntariness despite the nature of their illness and the effect that the treatment option would have. As such, patient autonomy was respected and consent permitted. In all medical decision-making, such exercise of autonomy through gaugeable and demonstrable capacity, competency and voluntariness, legitimises all forms of treatment, even those which cause death, to the express exclusion of VAE.

Proponents of the legalisation of VAE argue that the limitation placed on autonomy in such cases, unconstitutionally violates a patient's right to dignity, autonomy and life. This led to consideration of the role of human dignity in the Constitution, and whether the permissibility distinction between PE and VAE was justified. Importantly however, it must be borne in mind that proponents are not arguing for the decriminalisation of murder, nor that consent be

²¹⁵ *Clarke v Hurst NO 1992 (4) SA 630 (D)*.

accepted as a defence to murder, but rather that VAE be set apart from murder, to be categorised as lawful conduct which forms part of holistic end-of-life care. In this sense, consent and patient autonomy should render the practice justifiable, thereby exempting an assisting physician from criminal liability. At its core, the argument is that categorising VAE as murder is unconstitutional because doing so amounts to over-criminalisation and is overly broad.

Those who argue for and against the decriminalisation of VAE rely on the Constitution as a basis for both sets of arguments. “The new South African Constitution is a moral document”²¹⁶ and competing morals must yield to constitutional morality. Proponents and opponents both raise constitutional morality as the basis for their polarised positions. These hard cases require judges to balance competing interests rationally through proportionality.²¹⁷ The proportionality exercise enjoins s 36 of the Constitution, and requires that account be taken in each limitation evaluation of first what the purpose of the limitation is and then whether a less restrictive means to achieve the purpose exists and is practically achievable.²¹⁸ The importance of the right sought to be limited must of necessity be taken into account in any proportionality evaluation. In end-of life cases, the right under scrutiny is the right to dignity,²¹⁹ which our courts have concluded, bears more weight than any other right because it adds value and context to all other rights.²²⁰ The right to life²²¹ in the Constitution does not enshrine the right to mere existence; informed by dignity, it enshrines the right to a dignified life.²²² So stated, the state is under a duty to ensure that all possible and reasonable measures are put in place to allow its subjects to experience life and realise self-worth, even in the manner and time of death. Thus “the right to life is not restricted to the preservation of life, but protects quality of life and therefore a right to die with dignity”²²³ at the time and manner of one’s own choosing, even if such is with medical assistance.

It was evidenced that the state does not seek to protect life at all costs, but rather a quality of life informed by dignity; it is not just the sanctity of life which the Constitution protects, but the dignity and quality of it. The discordance between communal sentiment and constitutional *mores* can be expressed in the following way:

²¹⁶ A Chaskalson ‘From wickedness to equality: The moral transformation of South African law’ (2003) 1(4) *Internat J Constit L* 590 at 599.

²¹⁷ *S v Makwanyane* 1995 (3) SA 391 (CC) at para 104: “...weighing up of competing values, and ultimately an assessment based on proportionality...which calls for the balancing of different interests.”

²¹⁸ *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) at para 34.

²¹⁹ Section 10.

²²⁰ The argument is that continued criminalisation unjustifiably limits the right to dignity.

²²¹ Section 11.

²²² Chapter Two.

²²³ *Carter v Canada (AG)* 2015 SCC 5 at para 59.

“On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable.”²²⁴

In competition are a patient’s rights to dignity and society’s concept of permissibility and lawfulness through the workings of *boni mores* and its legal convictions. Here I concluded that with the advent of constitutionalism, the legal convictions of society are not based on sentiment or other bias, but on constitutionalism and constitutional *mores*. I considered the interests of personal autonomy and the desire to protect the weak and vulnerable from abuse and concluded that the blanket prohibition on medically assisted deaths is an unjustifiable limitation on the right to dignity.²²⁵ I considered developments in permissive jurisdictions and contrasted it with the South African requirements for consent to be valid, concluding that a regulatory regime already exists which ensures that vulnerable patients do not suffer abuse, and similarly, the same regime can be used in cases of VAE.²²⁶

Considering the rights arguments and the purpose served by the continued criminalisation of VAE, I concluded that the prohibition was overly-broad and an unjustifiable limitation of a patient’s rights where such patient shows capacity, competency and voluntariness. I further considered whether the purpose could be achieved through less restrictive means, and showed, by examining our own requirements for informed consent, that the purpose of the prohibition could in fact be achieved by identifying and separating patients who require protection (due to an actual lack of competency, capacity or voluntariness) from those who do not. Having concluded that law reform is necessary, I turned to consider how law reform could occur given the direction of the SCA in *Stransham-Ford*.²²⁷ The court noted strongly that if an appropriate case was brought before a court, the common law would “no doubt develop” to bring it in line with constitutionalism. Provided that the issues and competing interests and arguments were properly and fully canvassed, it would be unconstitutional not to decriminalise VAE in the light of the constitutional imperative.

Having concluded through the thesis that law reform and development must occur, the next question is how that should take place. Should it emanate from the courts only and be handled through the judiciary on a case-by-case basis, or should Parliament enact legislation

²²⁴ *Carter v Canada* 2015 supra note 161 at para 2.

²²⁵ Section 11.

²²⁶ Discussed in Chapter Three.

²²⁷ *Stransham-Ford* (SCA) supra note 8 at para 101:

“the common law will no doubt evolve in the light of the considerations outlined there and the development in other countries. It is of course possible that Parliament will, as has occurred in other countries, intervene and pass legislation on the topic.”

which would not only decriminalise VAE, but legalise it and regulate it as well. While legislation would be the ideal, it is unlikely that this will emanate from Parliament of its own accord. The SALRC made recommendations for law reform as early as 1998, and since then nothing has emerged from Parliament. There appears to be no political will to take the process further than the proposed draft bill that was a part of that report. If we are to assume that the decriminalisation of VAE is not on the legislative agenda, another way to bring it on the agenda and force reform would be through a direct order from the Constitutional Court. This has been the route adopted regarding other areas of law reform.²²⁸ How it has worked is that a rights claimant brings a case to court. If the court finds in his favour regarding constitutional repugnancy, then the court can issue a direct order to Parliament such that it must promulgate suitable legislation within a prescribed period of time. This approach is not unique to South Africa, and is in fact the route adopted in Canada specifically in relation to the decriminalisation, legalisation and regulation of VAE as conduct that is justifiable in the light of the rights analysis.²²⁹

The Constitution's premise is that existing law and the existing legal order ought to remain preserved, although this does not mean that it must remain so as in a state of stasis. Section 39 of the Constitution keeps the common-law alive and growing²³⁰ in the sense that existing laws are to be interpreted in a manner that is in keeping with the spirit, purport and objects of the Bill of Rights. Harms posits that the claim that principles of fairness and justice that exist in terms of the common law are in conflict with the Constitution are based on a false premise. And in fact, the Constitution serves rather to enshrine these already established common-law principles,²³¹ with the added criteria of the constitutional imperative.

Landman considers the merits of developing the common law in this area and notes that while the law relating to acts of passive euthanasia²³² merely requires clarification, for active euthanasia, much more substantial reform in the manner of decriminalisation is needed, and that clarification can occur through the constitutional lens:

²²⁸ *Minister of Justice and Constitutional Development and Others v Prince (Clarke, Stobbs and Thorpe Intervening) (Doctors of Life International Inc as Amicus Curiae); National Director of Public Prosecutions and Others v Rubin; National Director of Public Prosecutions and Others v Acton and Others* 2018 (10) BCLR 1220 (CC).

²²⁹ *Carter v Canada (AG)* 2015 SCC 5.

²³⁰ *Pearl Assurance Co Ltd v Union Government* 1934 AD 560 at 563, the common law "is a virile living system of law, ever seeking, as every system must, to adapt itself consistently with its inherent basic principles to deal effectively with the increasing complexities of modern organized society".

²³¹ L T C Harms 'Ontwikkeling van die gemenereg in die lig van artikels 39(3) en 173 van die Grondwet' (2004) 7(2) *PER* 4/22, available at <https://www.ajol.info/index.php/pelj/article/view/43466>, accessed on 5/02/2021.

²³² Terminal pain management; withholding and withdrawal of potentially life-sustaining treatment; and advance directives.

“assisted dying would require *substantial legal reform – decriminalisation* – since it is unlawful in both its forms. The key question is whether legalising assisted dying would be consistent with – or perhaps even required by – the bill of rights in the Constitution, particularly the right to life.”²³³

According to Landman, clarification in relation to acts of passive euthanasia would require legislation which would confirm the legitimacy and acceptability of such practices and define the bounds and requirements for such.²³⁴ It is submitted that clarity also requires an admission that passive euthanasia practices intend to and do cause death, and the reason why they do not attract criminal liability is a question of justifiability, not intention and causation. In this regard and as far as acts of active euthanasia are concerned, Landman notes that the

“common law definitions of criminal offences guiding our case law appear to be inadequate to do justice to the underlying ethical values that inform assistance with dying. They lack the necessary sensitivity for specific circumstances in which persons may wish to claim their right to exercise autonomous choices regarding their suffering and continued life. They leave inadequate legal space for assisting someone to die for their own good, and when that is based on free and rational preference, without risking criminal or civil liability.”²³⁵

5.9 CONCLUSION

Being permitted to make decisions about one’s life and ultimately one’s death cut at the core of the principle of autonomy and is inextricably linked to the right to dignity.²³⁶ Theoretically, autonomy and individual dignity should prevail over the State’s interests in maintaining the blanket prohibition on VAE, but only if the nature of the right outweighs the purpose and extent of the limitation and there are less restrictive means to achieve such purpose.²³⁷

²³³ WA Landman *End-of-Life Decisions, Ethics and the Law: A Case for Statutory Legal Clarity and Reform in South Africa* (2012) at chapter 5.

²³⁴ For example, Landman, op cit note 233 at page 38 states: “In so far as the under-treatment of suffering is the result of uncertainty about the limits and consequences of terminal pain management, and therefore fear of civil and criminal liability, the law guiding such care should be clarified.”

²³⁵ Landman op cit note 233 at 95.

²³⁶ *Carter v Canada (AG)* 2015 supra note 160 at para 66:

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

²³⁷ D J Ncayiyana ‘Euthanasia – no dignity in death in the absence of an ethos of respect for human life’ (2012) 102(6) *SAMJ* 334 at 334.

Death cannot and does not present itself for discussion where there is no life. Death is an unavoidable consequence of life, and is inevitable. As much as it is argued that life begins at the moment of being born alive, so does the process of dying; death is a moment at the end of that process. Life then, is a lived experience of moments that bring us closer to the inevitable. In this contemplation, life, as much as it is a process of dying (however long or short that life actually is) is imbued with intrinsic dignity. When does dignity begin and when does it end?²³⁸ Perhaps we ought to be concerned with affording holders of the right to life and the right to dignity the choice of the least-bad death, a humane end, absent of intractable and prolonged suffering? If dignity is a contemplation of individual self-worth, we should equally afford persons a death worthy of a dignified life.

Human dignity must be preserved and enhanced through other rights. Autonomy informs dignity, and together human beings can realise self-worth through autonomy. The law proscribes certain autonomous conduct which is inherently harmful or potentially harmful to the individual and society, and thus places limits on the exercise and realisation of autonomy so as to foster, protect and instil dignity and preserve social order.²³⁹ However, it is important to draw a distinction between the contexts under which autonomy and dignity are sought to be enforced, and whether the limitation is constitutionally justified and proportional to the purpose that limitation serves.

Fundamental human rights must be considered and balanced against the constitutional imperative and constitutional convictions. The constitutional rights which are of particular importance in the discussion on VAE, as evidenced in the cases discussed above, are the right

²³⁸ M Mahlmann 'Human dignity and autonomy in modern constitutional orders' in M Rosenfeld & A Sajó (eds) *The Oxford Handbook of Comparative Constitutional Law* (2012) at 386:

"An important question to determine the beginning and end of human dignity is whether the existence of individual human life is a sufficient condition for the ascription of dignity or whether it is condition on qualified – for example self-conscious – forms of human life. These questions are connected with the problem, whether personhood is the reason for dignity and when personhood begins – with conception, nidation, sometimes in the pre-natal maturation process (eg. sensitivity to pain, viability), at birth, or even later. Another issue concerns diachronically continuous personal identity and its impact for the protection of self-determination, for example as to a person's pre-dementia decisions for post-dementia issues".

²³⁹ J Keown 'The legal revolution: From "sanctity of life" to "quality of life" and "autonomy"' (1998) 14 *J Contemp Health L & Pol'y* 253 at 266:

"Consequently, it has proscribed, and continues to proscribe, many exercises of autonomy on the ground that they are wrongful. Their wrongfulness often inheres in their infliction of harm upon others or in the exposure of others to the risk of harm, whether or not, as in duelling, the other consents to the risk of harm. But an exercise of autonomy may also be prohibited because it exposes oneself to harm, or to the risk of harm, such as buying and snorting cocaine or, less seriously, driving a vehicle without wearing a seatbelt."

of the person to preservation of his dignity and autonomy²⁴⁰ and the right to life.²⁴¹ It is evident from the *Makwanyane* judgment that the State has an interest in protecting and preserving the right to a dignified life from violation in ways that are unlawful and unconstitutional,²⁴² and thus if the law prevents or limits one's ability to live a dignified life and experience a dignified death, the limit and the law may be contrary to the spirit, purport and objects of the Bill of Rights in the Constitution. It is both lawful and constitutional to kill in self-defence or, in certain circumstances to effect an arrest.²⁴³ However, this also indicates, that while the State has an interest in preserving life, its duty properly means that the State must do what it can to ensure that people are neither killed nor forced to live in a way that is an unconstitutional violation of the right to life as informed by the right to dignity, by placing unconstitutional limits on autonomous decision-making of patients. In the context of VAE, this means that patients ought to be allowed to autonomously choose to end their lives with medical assistance if they perceived this as dignified where if continued existence in a state of intractable pain and suffering is intrinsically and personally viewed as mere existence and not life. The freedom to choose when, and how life ends is a question of dignity through the exercise of autonomy.

According to Mahlmann, autonomy is "habitually ranked as a central, perhaps even necessary, content of human dignity"²⁴⁴ and thus, the role of autonomy in dignity becomes more relevant when the claim is that individual dignity is being violated by norms which limit autonomy. The role of dignity informed by autonomy must be understood if we are to realise the right to protect and respect individual dignity in the assisted-dying paradigm.

Dignity is both a value and a right, and it informs and is inextricably joined with all of the other rights enumerated as enforceable and is itself justiciable. Dignity is in turn informed by autonomy, and thus collectively, dignity and autonomy together inform all other rights. The South African Constitutional Court has applied the value of inherent human dignity in the construct of human beings faced with the arbitrary and unconstitutional deprivation of such through state laws and policies.²⁴⁵ Thus, the dictum of the court in *Makwanyane*²⁴⁶ declared that the death penalty was unconstitutional as it infringed the right to life in that it violated a

²⁴⁰ Section 10 of the Constitution, 1996.

²⁴¹ Section 11 of the Constitution, 1996.

²⁴² *Makwanyane* supra at para 26.

²⁴³ Section 49 of the Criminal Procedure Act. *Govender v Minister of Safety and Security* [2001] ZASCA 80; *Ex Parte Minister of Safety and Security: In re S v Walters* [2002] 4 SA 613 (CC). Self-defence is included in private defence and in South African law, one may lawfully kill in the process of warding off an unlawful attack against a third party or oneself.

²⁴⁴ Mahlmann op cit note 236 at 372.

²⁴⁵ *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1998 (12) BCLR 1517.

²⁴⁶ *Makwanyane* supra.

person's inherent dignity.²⁴⁷ The right to life (and any of the other rights so enshrined) cannot be considered absent of consideration of the impact to human dignity, and in relation to VAE, it also means the role of autonomy when inherent dignity means self-worth. This is a question of constitutional mores and convictions, and cannot be measured against biases of religious or public sentiment.²⁴⁸

As has been discussed, the legal permissibility of VAE must be engaged from the perspective of dignity and autonomy in the context of constitutionalism, and not religious, moral or sentimental bias. Although overturned by the SCA, the High Court decision of *Stransham-Ford*²⁴⁹ quoted with approval the dictum of O'Regan J in *Makwanyane*²⁵⁰ that "the right to life...incorporates the right to dignity". That decision focused on the concept of dignity in the guise of state-imposed undignified suffering, where patients are denied assistance in dying.²⁵¹ However, for reasons already explained, the decision of the High Court was overturned, and so the door is left open, and when an appropriate case is made, a court could properly consider development of the common law in relation to VAE.

The courts and the State are constitutionally bound to preserve the right to a dignified life and protect vulnerable groups from potential abuses, but in a way that affords dignity to the rights bearer, and is not disproportionate or unjustifiably paternalistic. In *Carter v Canada*²⁵² the court considered the principles of fundamental justice in concluding that the right to life meant the right to a dignified life and a dignified death. Dignity has "central significance in the limitations enquiry,"²⁵³ and as autonomy informs dignity, autonomy also becomes central to the enquiry. These fundamental rights, particularly the value of human

²⁴⁷ *Makwanyane* supra at paras 166 (Ackermann J), 174 (Didcott J); (208), (214) (Kriegler J), (217) (Langa J), 268 (Mahomed J), 313 (Mokgoro J), 318, 344 (O'Regan J), 350 and [357] (Sachs J).

²⁴⁸ M L J Koenane 'Euthanasia in South Africa: Philosophical and theological considerations' (2017) 38(1) *Verbum et Ecclesia* 1-9 at 2:

"The polarisation of thinking about euthanasia is influenced by varying religious, cultural, political, sociological and personal convictions of the general public and of the people seeking assisted suicide. Furthermore, the euthanasia debate raises numerous moral dilemmas. The nature of these dilemmas makes it difficult to establish common ground when making decisions about euthanasia. For some it is about compassion, for others it is assisted suicide, while for yet others it represents murder. Therefore, finding consensus regarding moral issues will always remain a difficult task and must also involve an attempt to understand the real issues surrounding euthanasia, such as respect for autonomy, dying with dignity or being condemned to live an undignified life."

²⁴⁹ *Stransham-Ford* (HC) supra note 104.

²⁵⁰ *Makwanyane* supra.

²⁵¹ *Stransham-Ford* (HC) supra note 104 at para 18:

"[t]he author of the Opposing Affidavit of the Third Respondent obviously did not keep in mind that a decision of a person on how to cease life was in many instances a decision very important to their own sense of dignity and personal integrity, and that was consistent with their lifelong values that reflected their life's experience."

²⁵² *Carter v Canada* (AG) 2015 supra note 161.

²⁵³ I Currie & J De Waal *Bill of Rights Handbook* (2013) at 253.

dignity as informed by autonomy, legitimises the decisions an individual would take regarding life and death choices. The status quo however is that *volenti non fit injuria* does not apply in cases of VAE. Consent is not a defence to a criminal charge of murder – a charge and conviction faced by physicians who assist their patients in achieving a dignified death in appreciation of the patient's own intrinsic self-worth.

While not all patients who are suffering from terminal and intractable disease would seek VAE, for those that do, the limitation on autonomy unjustifiably limits their right to dignity where the purpose of the limitation and the means of achieving the purpose are disproportionate and can be achieved through less restrictive means. What law reform will do is allow patients to choose whether, how and when to end their lives with physician assistance.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

This thesis was aimed at analysing the reasons for the current prohibition on voluntary active euthanasia (VAE) in the context of a request for a physician-assisted death being made freely and voluntarily by a competent adult patient who is suffering from a terminal and intractable illness.

The analysis considered the elements of criminal liability for murder, and these elements were the key focus of the relevant chapters based on the approach adopted by the Supreme Court of Appeal in *Stransham-Ford*.¹ This approach facilitated the analysis of the elements in an attempt to test whether there was a distinction between VAE and PE through, *inter alia* intention, causation and unlawfulness. The investigation proved that there is no distinction between the two practices under the first two elements, and confirmed the hypothesis that the distinction rests on the third element for liability, that of unlawfulness. In considering unlawfulness, I looked at consent as a defence to unlawfulness, and the parameters under which this ground of justification is operable. This brought into keener focus the role of the legal convictions of society (gauged through the Constitution) as a benchmark for determining what forms of conduct, and thereby harms, can be consented to, rendering such harms justifiable through *inter alia* consent.

Although the SCA² overturned the decision of the High Court,³ it held that a court in the future could consider the issue afresh when presented with a “proper case”.⁴ A proper case would require that argument be made regarding the scope and content of the common law on murder and how and why VAE falls within its ambit, and further argument on why this should no longer be the case. This would, as has been done in this thesis, lead into constitutional

¹ *Minister of Justice and Correctional Services v Estate Late James Stransham-Ford* 2017 (3) SA 152 (SCA) at para 56.

² *Stransham-Ford* (SCA) supra note 1.

³ *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (6) BCLR 737 (GP).

⁴ *Stransham-Ford* (SCA) supra note 1 at para 101:

“the common law will no doubt evolve in the light of the considerations outlined there and the development in other countries. It is of course possible that Parliament will, as has occurred in other countries, intervene and pass legislation on the topic.”

arguments and an analysis and balancing of competing purposes and interests in the light of the rights to dignity and autonomy.

In all medical matters, including end-of-life cases, like those involving passive euthanasia, a patient's right to autonomy in decision-making is given the highest regard, even if the decision is one that may have the "additional effect of accelerating the dying process."⁵ The core question that this thesis sought to answer was whether the same right to autonomous decision-making could apply to conduct that directly causes death? If so, then VAE should fall outside of the ambit of the common law crime of murder by making VAE conduct which can be justified through consent.

6.2 GROUNDS FOR LEGALISATION AND LAW REFORM

Distinction and permissibility of VAE from murder has rested (in a pre-constitutional era) on the legal convictions of society and the common-law principles of fairness and justice; that is to say, the distinction has been based on perceptions of existing measures of normative convictions as definers of what conduct is permissible.

The key point is that criminalisation must be justifiable and not over-broad;⁶ the criminal law is a powerful tool for maintaining social order, but it must operate and function within the bounds of the Constitution by balancing the purpose served by criminalisation against the means used to achieve that purpose. As was decided in the *National Coalition for Gay and Lesbian Equality*⁷ case, the criminal law must not be used as a tool of oppression which seeks only to enforce a form of *mores* which is not aligned to constitutional *mores*.⁸ Lotter argues that laws created merely to protect public sentiment in the guise of a pre-constitutional understanding of *boni mores* and legal convictions of society should be looked at anew if those *mores* do not align with constitutional *mores*.⁹ Justification for continued criminalisation must be underpinned by cogent and logical reasoning, based on the purpose of criminalisation and whether that purpose can be achieved through less restrictive means. Thus, if criminalisation of VAE as the common law crime of murder is to continue, then "justification

⁵ 'World Medical Association Declaration of Venice on Terminal Illness', Adopted by the 35th World Medical Assembly Venice, Italy, October 1983 and revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006, at para 6.

⁶ *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) at para 119: "The law may continue to proscribe what is acceptable and what is unacceptable...and may, within justifiable limits, penalise what is harmful and regulate what is offensive. What is crucial for present purposes is that whatever limits are established they do not offend the Constitution".

⁷ *National Coalition for Gay and Lesbian Equality* supra note 6.

⁸ See Chapter Two.

⁹ *National Coalition for Gay and Lesbian Equality* supra note 6 at 131.

should be found in and restricted to the objectives of the criminal law”¹⁰ in conjunction with consideration of the purpose of ss 36 and 39 of the Constitution.

Acts of passive euthanasia have been declared to be acts or conduct which have social utility through an assessment of *boni mores*, and that recognises patient autonomy.¹¹ For example, the dictum of *Clarke v Hurst NO* has widely been accepted in South Africa as setting acts of passive euthanasia apart from criminal conduct, unless the acts are alleged to have been performed outside of the strictures of accepted medical practice.¹² The effect of such categorisation is that acts which both intend to and cause death, are justifiable in very specific medical contexts.

Regarding the distinction between the permissibility of active euthanasia and passive euthanasia, the SALRC asked whether the distinction was “real” in as far as there was in law any tangible and justifiable reason to maintain the prohibition on VAE, based on a scrutiny of the definitional elements of the crime of murder:

“It is however important to establish whether any real distinction, whether moral or legal, can be drawn between the two sets of cases. Is it not true that in both cases the person to whom the request was directed, performed the act, and was the intention in both cases not to cause death? Although commentators agreed that there is no general intrinsic moral difference between the two (given informed consent by the patient, assistance by another, and the same outcome), they felt that one could however still argue that there is an important evidentiary difference between the two and that the distinction could therefore have some value in practice. Assisted suicide is a better test of the voluntariness of the choice to die or of the patient's resolve to end his or her life”.¹³

It would appear then that the permissibility distinction could rest on the element of causation if one were to draw a finer distinction between PAS and PAE, where in the case of PAS,

¹⁰ S Lotter ‘Decriminalisation: A principled approach’ (1994) 7(2) *Consultus* at 130.

¹¹ *Clarke v Hurst NO* 1992 (4) SA 630 (C), at 653

“In my view, therefore, the decision whether the discontinuance of the artificial nutritioning of the patient and his resultant death would be wrongful, depends on whether, judged by the legal convictions of our society, its *boni mores*, it would be reasonable to discontinue the artificial nutritioning of the patient.”

And at 660-661:

“It is declared that the applicant, in her capacity as curatrix to the person of the patient, would not act wrongfully or unlawfully

- (i) if she authorises or directs the discontinuance of the nasogastric or any other non-natural feeding regime for the patient;
- (ii) if she withholds agreement to medical or surgical treatment of the patient save such treatment as may seem to her appropriate for the comfort of the patient,

notwithstanding that the implementation of her decisions may hasten the death of the patient.”

¹² J Brown ‘When the exception is the rule: Rationalising the medical exception in Scots law’ (2020) 26(1) *Fundamina: A Journal of Legal History* 1-41.

¹³ SALRC (Project 86) *Euthanasia and the Artificial Preservation of Life* (1998) at para 4.108.

because the final fatal act is carried out by the patient personally, there is further evidence of voluntariness on the part of the patient. However, to permit only PAS and not PAE would discriminate against patients who are not physically able to carry out the final act personally, merely because of physical restrictions. Thus, even if such a patient with physical restrictions is competent to make a request for a medically assisted death, they would not be able to do so simply because the law permits only PAS and not PAE. As discussed in previous chapters, the requirements for assessing the genuineness of consent and patient capacity and competency have never been premised on physical ability, and it is submitted that it should not now feature as a prohibiting factor when deciding whether to permit PAE.

6.3 RESEARCH QUESTIONS ANSWERED

In the light of the questions asked by Mahomed J in *S v Makwanyane*¹⁴ and given the observations made by the SCA in *Stransham-Ford*¹⁵ the research questions identified in Chapter One¹⁶ were canvassed and addressed as follows:

6.3.1 Research Question (a)

Providing an historico-legal background and overview of the crime of murder, and how assisted suicide was placed within the ambit of that crime allowed me to analyse the common law position on PE and VAE through the identified elements. I showed that when these elements are applied and analysed against PE and VAE, both intention and causation are equally provable for both acts. This approach has been consistently followed by South African courts, which have held that PE is conduct which can be identified as being *prima facie* unlawful, but may in certain circumstances be justifiable.¹⁷

¹⁴ *S v Makwanyane* 1995 (3) SA 391 (CC) at para 268.

¹⁵ *Stransham-Ford* (SCA) supra note 1.

¹⁶ (a) What is the common law position on PE and VAE based on the definitional elements of the crime of murder?
 (b) What is the real reason for the lawfulness distinction between PE and VAE?
 (c) If the lawfulness distinction between PE and VAE is based on the interpretation of constitutionally guaranteed rights, can these right also be extended to include VAE in the way they currently apply to PE?
 (d) Even if they can be extended, do the common law principles governing VAE as murder justifiably limit the rights identified?
 (e) If the limitation is unjustifiable, should the law reform to accommodate for VAE as lawful? And
 (f) If so, what are the most appropriate remedies for law reform given competing interests and arguments for and against decriminalisation?

¹⁷ *Clarke v Hurst NO* supra note 11 where the court ruled the PE was lawful, because the *boni mores* permit such conduct as reasonable and justifiable, not because they do not intend to nor cause death.

This was an important preliminary conclusion as it served to debunk the claim of medical professional bodies that the permissibility distinction between PE and VAE is based on intention and causation. I have shown that in terms of legal principles, unless justifiable, physicians who (factually and legally) cause or even merely hasten their patient's deaths, would be found to harbour the necessary intention for criminal liability. This then led to a discussion which sought to identify and unpack the real reason for the permissibility distinction between PE and VAE.

6.3.2 *Research questions (b) and (c)*¹⁸

These questions were answered through a consideration of why the law categorises certain forms of conduct as justifiable and others as not, and proceeded with an analysis of consent as a defence against unlawfulness. The discussion evidenced that deaths resulting from PE, were rendered justifiable through consent when the patient (or their proxy) consents to PE, and further where such death is caused within the confines of accepted medical treatment and practice guidelines, such intentional causing of death would not be *contra bonos mores*. This second requirement serves to set PE apart from murder. PE itself is *prima facie* unlawful, but can be justified because in certain circumstances it is not *contra bonos mores*. The result is that although PE is conduct which causes death, patients are permitted to consent to it.

In such cases the validity of such consent is assessed largely in relation to capacity, voluntariness and competency in an effort to ensure that the decision made by the patient is voluntary and informed. This is in line with the notion of patient autonomy trumping medical paternalism and is the basis on which patients can make decisions about their health and treatment even if the decision hastens death, or is otherwise objectively not in the patient's best interests. However, the same autonomy, competency, capacity and voluntariness is inefficacious for VAE, on the premise that first, VAE itself is *contra bonos mores*, and further that it cannot be permitted because patients who make decisions about VAE are vulnerable to the degree that their ability to make informed decisions is compromised. This argument was proven to be fallacious and I showed that patients who make decisions about PE are no more or less vulnerable than those who make decisions about VAE. As such the permissibility argument based on consent failed as the reason for retention of the prohibition. The only question left regarding permissibility was the one centred on *boni mores* and whether, under a

¹⁸ Discussed fully in Chapters Two, Three and Four.

constitutional dispensation, constitutional *mores* would see VAE as reasonable and justifiable in an open and democratic country, and therefore able to be consented to.

I contrasted PE and VAE in an effort to determine whether patients who sought to access PE were less weak or vulnerable than those who sought VAE. Only if they were less weak and vulnerable could the permissibility distinction between PE and VAE based on the purpose of the prohibition be legitimate. The discussion evidenced that patients who sought VAE were not more vulnerable than those who sought PE, although in both instances some patients could be. Neither the nature of the physical illness nor the advanced age of the patient were on their own factors which meant that patients consenting to PE were weak and vulnerable. In fact, patients who seek VAE may suffer from the same illnesses as those who seek and are permitted to access PE. The real reason for the prohibition is not the quality of the consent, nor the nature of the terminal illness, but rather the type of conduct that the law will consider as lawful and justifiable. This conclusion then led to the third research question – whether the purpose of the prohibition could be achieved through less restrictive means particularly when patients do not identify as weak and vulnerable and show capacity and competency. In such a case, is the blanket prohibition overly-broad and an unconstitutional limitation on a patient’s constitutionally guaranteed rights? The answer to this question was found in *boni mores* and what forms of conduct these *mores* and thereby the law, permit patients to experience dignity through exercising autonomy.

6.3.3 Research questions (d) and (e)¹⁹

Section 36 of the Constitution engages a proportionality assessment, which seeks to identify whether the purpose of a legal provision can be achieved through less restrictive means. One of the preliminary inquiries is whether any constitutionally guaranteed rights are limited through the provision and what those rights are. The preservation and protection of human dignity is the foundation upon which the Constitution stands. It is also the mortar to which every constitutionally guaranteed right clings. Constitutionally guaranteed rights are listed and identifiable, but human dignity give these rights their purpose. Constitutionally guaranteed rights must be interpreted and enforced in a way that instils and protects human dignity.

At first gloss one may be inclined to conclude that the relevant right for discussion in the VAE paradigm is the right to life, but, as has been shown, the right to life is more than mere existence. It is a right to a dignified life. A dignified life means a life wherein autonomy is

¹⁹ Discussed fully in Chapters Four and Five.

respected, and includes decisions made regarding the end of that life. The right to life, therefore, is informed by the right to dignity through the exercising of autonomy. Thus, the argument raised is that the limitation placed on patient autonomy in VAE decisions violates the right to human dignity.

The purpose of the prohibition has been shown correctly to be that of protecting the weak and vulnerable from abuse, but the blanket prohibition is over-broad in that it catches within its net people outside of the class of persons who require the type of protection that it offers. As such, the blanket prohibition is not in accordance with the principle of legality and the constitutional imperative. The purpose can be achieved through less restrictive means, particularly by permitting patients who have the requisite capacity to consent to PAS and PAE.

I showed that arguments both for and against the retention of the prohibition are based on the principles and values which underlie the Constitution (and other policy considerations), not the elements of intention or causation alone. I argued that it is constitutional morality which prevails above all others. Constitutional morality is founded on the value of human dignity, which respects the rights of persons to live autonomously. As such, the criminal law is not the appropriate vehicle for achieving health care policy goals.²⁰ The doctrine of the separation of powers necessarily also means a separation of purposes, and the courts are not the custodians of morality. While the legal convictions of society point to which forms of conduct are criminal and which are not, it is the Constitution that properly determines this. Under a constitutional dispensation, the legal convictions of society means its constitutional convictions, absent of any religious or political biases that may persist within the community that the Constitution protects.

I have shown that the most efficacious way of doing this is through legislation, although, the courts will have a role to play. The approach in comparative jurisdictions proves insightful for mapping the way forward for South Africa, and ultimately I advocate for law reform through legislation and regulation rather than merely development of the common law through the courts on a case-by-case basis.

6.3.4 *Research question (f)*

²⁰ This argument has been discussed regarding the decriminalisation of abortion. It is also the reason why HIV specific offences were not legislated in the final version of the Sexual Offences and Related Matters Amendment Act. (See R Elliott *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper* (2002) for a discussion on the merits of criminalisation of cases of HIV transmission, available at https://data.unaids.org/publications/irc-pub02/jc733-criminallaw_en.pdf accessed on 20 April 2021).

Through the previous chapters, the discussion was whether the law should be reformed to accommodate for a lawful form of VAE. In Chapter Five, I discussed whether reform could occur through the courts, the legislature, or both. When traversing whether the law in this area should be reformed, it appears that the SCA has, by way of *obiter dictum*, remarked that it is a *fait accompli* that the law will reform, when presented with an appropriate case that is properly argued with particular emphasis on the three reasons why development of the law could not occur in the matter as presented and argued before the SCA. The court went further in its concluding remarks, to note that as has occurred in the past in relation to the issue of law and reform of a particularly sensitive nature, it would, be well within Parliament's prerogative to pre-empt such litigation and enact legislation which will to reform of the law in a way that would not only see reform, but also regulation.²¹ In the same breath, the court took judicial notice of and confirmed that the Constitution places the power of law reform and development firmly within the authority and grasp of the courts. The court stressed later, that given that the issue of law reform to accommodate VAE had been canvassed and investigated by the SALRC as early at 1998, it seems unlikely that Parliament will pick up the gauntlet and legislate such reform unless directed to do so by the courts.²²

With that in mind, I submit that law reform will occur in a two-tiered fashion. First, a court will be called to adjudicate on the issue of lawfulness and decriminalisation. If it finds in favour of the applicants who bring such a case, it would then make an appropriate declaration directing Parliament to enact suitable legislation within a prescribed period of time. It is submitted that placing the question of the decriminalisation of VAE within the bounds of constitutionality and the permissibility thereof, is the way to determine whether VAE falls outside of the common-law position as stated in *Grotjohn*. Given the questions raised by the Minister in that case, a constitutional focus would require the court to now consider whether the prohibition on VAE created through *Grotjohn*, applies in *all* cases, particularly cases of VAE. These questions would now be: (i) *Whether a patient has a constitutional right to live and end their lives with dignity by choosing a medically assisted death* and (ii) *Whether a doctor who assists a patient to end their life (either through PAS or PAE) incurs criminal liability?* Thus, at their core, these questions hinge on an interpretation of *boni mores* as interpreted through the Constitution, circumstances under which consent can operate as a

²¹ *Stransham-Ford* supra note 1.

²² *Stransham-Ford* supra note 1 at para 116 wherein the court noted that although Parliament would be ideally placed to legalise, decriminalise and regulate a permissible form of VAE, "nearly twenty years have passed and this exhortation has not been heeded."

defence, and the mechanisms for ensuring the genuineness of the consent. It was shown that *mores* and society's sense of justice and fairness as gauged through the Constitution, view the limitation on patient autonomy to access VAE as inconsistent with the spirit, purport and objects of the Bill of Rights and especially the right to dignity and autonomy.

In the paragraphs which follow, I will discuss how and in what shape law reform could occur, based on the route and model adopted by Canada.²³

6.4 RECOMMENDATIONS FOR LAW REFORM

In Canada, assisted suicide was a criminal offence codified in s 241 of the Canadian Criminal Code. The first attempt at legalisation arose in the case of *Rodriguez v British Columbia (AG)*²⁴ where the court held that the blanket prohibition was justifiable and necessary to protect the vulnerable from abuse. Later, in *Carter v Canada*,²⁵ the *Rodriguez* decision was overturned, in that reliance on current informed consent requirements were adequate for ensuring that vulnerable members of the population could be protected from the abuse envisaged in *Rodriguez*. Because it was possible to achieve the purpose identified as the reason for the blanket prohibition through less restrictive means, the blanket prohibition was held to be over-broad and a form of over-criminalisation for patients who did not identify as vulnerable. Thus the blanket prohibition violated two rights guaranteed by the Canadian Charter of Rights and Freedoms:²⁶ the right to life, liberty and security of the person (s 7) and the right to equality (s15).

The decision in *Carter* resulted in the enactment of the legislative amendments to s 241 of the Canadian Criminal Code, which has extensive amendments regulating lawful VAE while maintaining other non-medical forms of assisted suicide and euthanasia as crimes. Similar to the position in the Netherlands, the Canadian law retains the specific offence of aiding and abetting suicide for cases that fall outside of the amendments made in terms of s 241.

While it is well within the power and competency of South African courts to develop the common law and accept the permissibility of VAE by acknowledging the value of autonomy, consent and dignity of patients, the SCA in *Stransham-Ford* noted that the issue of

²³ See Annexure A below.

²⁴ [1993] 3 SCR 519.

²⁵ [2015] SCC 5.

²⁶ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11.

decriminalisation should ideally be left to the legislature. Unfortunately, considering that Parliament has not made any strides towards this endeavour since the 1998 SALRC Report, it is unlikely that any such legislation is forthcoming. It is more likely, as was the case in *Carter v Canada* that a court will pronounce on constitutional invalidity and then direct that legislation and regulations be enacted by Parliament within a prescribed time frame. This approach to law reform is one that has been adopted in South Africa in relation to a number of other cases where the constitutionality of the extant law has been challenged.²⁷

“With great power comes great responsibility.”²⁸ It is submitted that this great power rests with both the courts and Parliament, who have the power to develop the common law. Both of these bodies bear the great responsibility of ensuring that the spirit, purport and objects of the Bill of Rights are upheld by developing, creating and shaping the law so that the constitutional rights of the people are not unjustifiably and unreasonably violated. And if there is such a violation, the courts and Parliament have a responsibility to right wrongs.

If it were left entirely up to the courts, such that every request for VAE had to be adjudicated upon prior to administration, a real concern is that this will add to the burdens of patients, financially, emotionally and otherwise. This would mean, that even if VAE is legalised, it will only be accessible to those who can afford to apply to court for it. While a court order may be thought of as being necessary to confirm that a patient is making the request competently and voluntarily so as to rule out *mala fides* and abuse, the same objective can be achieved through legislation and regulation of such requests. In the main, it would simply mean a contextualisation and codification of currently accepted tests for valid consent within the VAE factual matrix.

Drawing on the experience and the reforms enacted in Canada, South African courts should legalise VAE by pronouncing that patients who are adults, and are competent, can voluntarily and autonomously make an informed decision to end their lives with physician assistance. Such an informed decision will render the conduct of the physician as non-criminal. Furthermore, Parliament should bear the responsibility of enacting suitable legislation which will provide measures and mechanisms for the implementation of VAE in a way that can be monitored and regulated.

²⁷ *Minister of Justice and Constitutional Development and Others v Prince (Clarke and Others Intervening); National Director of Public Prosecutions and Others v Rubin; National Director of Public Prosecutions and Others v Acton* 2018 (6) SA 393 (CC).

²⁸ S Lee and S Ditko *Amazing Fantasy No. 15: Spider-Man* (1962).

Any legislation drafted to this effect would require a definition for VAE that sets out the criteria which separates it and make it distinguishable from the common law crime of murder. It should also identify qualifying criteria which would further determine whether an act of VAE is medical treatment as defined, or a criminal act. Suitably drafted legislation would seek to achieve the appropriate balance between the competing interests of the state and patients, premised on voluntariness and autonomy, and would in the main cater for the following as qualifying criteria:

- (a) The patient must be a competent (capable) adult;²⁹
- (b) The patient must be one who ordinarily qualifies for health care in South Africa and is ordinarily resident here;³⁰
- (c) The patient must be suffering from a terminal illness³¹ and suffering intolerably and intractably;³²

²⁹ Legislation would be able to provide criteria for assessing competency and voluntariness, albeit codification of currently accepted and practiced methods. A limitation to this thesis was that the research and work considered only adult patients who are competent. It does not consider VAE in respect of patients who are minor children. Annexure A below at s 1:

“‘capable patient’ means that in the opinion of a court or in the opinion of the patient’s attending physician, psychiatrist, or psychologist, a patient has the ability to make and communicate health-care decisions to health care-providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available;

‘competent patient’ is given the same meaning as capable;”

³⁰ This has been included to avoid the hazards of the ‘euthanasia tourism’ phenomenon, and is a requirement in most jurisdictions which have legislated for legalised VAE. It would also assist in ensuring continuity in management of the patient such that practitioners who have been treating the patient, both past and present, can be engaged where and if necessary, to report on prognosis and voluntariness. Annexure A below at:

s1 “‘ordinarily resident’ means a person who resides in South Africa;” and at s 13:

“Only requests for physician-assisted suicide and physician-administered euthanasia made by persons who are ordinarily resident in South Africa shall be considered. Evidence of residence in South Africa shall include but are not limited to:

- (1) possession of a valid South African identity document, or its equivalent; or
- (2) registration as a voter; or
- (3) proof of address.”

³¹ Annexure A below at s 1:

“‘terminal illness’ or ‘terminal disease’ means an illness, injury or other physical condition that-

- (a) is incurable and irreversible and that has been medically confirmed and will, within reasonable medical judgement, produce death withing six months; or
- (b) In reasonable medical judgement, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering; or
- (c) Causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.”

³² Annexure A below at s 1:

“‘intractable and unbearable illness’ means an illness, injury or other physical or mental condition, but excluding a terminal illness, that –

- (a) offers no reasonable prospect of being cured; and
- (b) causes severe physical suffering of a nature and degree not reasonable to be endured.”

To qualify for Physician-assisted suicide or physician-administered euthanasia, the patient must meet certain criteria and the physician must adhere to certain protocols. In this regard, see s 3 of Annexure A.

- (d) Any request for PAS or PAE made by a patient must be independently assessed by mental health care experts as well as experts in the particular illness with which the patient is afflicted;³³
- (e) A physician should be permitted to provide both PAS and PAE as this will meet the needs of patients who have exhibited competency and willingness but are unable to personally and physically administer the lethal medication;³⁴
- (f) Assistance may be rendered only by a medical health care professional who is registered with the HPCSA (including doctors, nurses, pharmacists, and in primarily palliative care scenarios, HOSPICE practitioners);³⁵
- (g) Assistance would include either the prescription and provision of lethal medication, or the direct administration thereof;³⁶
- (h) Patients can elect to have the VAE procedure administered at home or at hospital;
- (i) All patients are to be informed of their right to access VAE, and if a patient makes inquiries or requests the procedure, further counselling and competency assessments ought to be carried out to ensure that the patient is making a free, voluntary, un-coerced, informed and autonomous decision.³⁷
- (j) Patients must be informed that they can change their mind at any time;³⁸
- (k) No health care practitioner is obligated to assist a patient in PAS or PAE for any reason whatsoever, including conscientious objection, but must instead refer the patient to a practitioner who is willing to render such assistance;³⁹
- (l) Health care practitioners who assist and provide PAS or PAE are obligated to keep full and comprehensive records and to consult with relevant experts before acceding to a patient's request;⁴⁰
- (m) After PAS or PAE is administered, reports etc. must be made to the relevant health care body and to the Department of Health.⁴¹

³³ Links to (a) above as it assesses competency and considers the effect of the nature of the illness on competence and cognitive function. see s 3 of Annexure A.

³⁴ See Annexure A s 2.

³⁵ See Annexure A s 2.

³⁶ See Annexure A s 1 where physician-assisted suicide and physician-administered euthanasia are defined. See also s 2 of Annexure A which lists persons who may in appropriate circumstances be excluded from criminal liability.

³⁷ See Annexure A 'purpose' and 'preamble'.

³⁸ See Annexure A s 7(7)(a) and (b).

³⁹ See Annexure A s 3(9).

⁴⁰ See Annexure A s 3(3).

⁴¹ See Annexure A s 7(8).

This thesis advocates neither a policy which is pro-life nor pro-death, but rather one that is pro-choice, enabling patients to experience a life of quality through their choices, even when the choice is about how to end their lives in a manner that enforces their own sense of dignity as guaranteed by the Constitution of the Republic of South Africa.⁴²

⁴² Constitution of the Republic of South Africa, 1996.

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United Kingdom

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Washington Death with Dignity Act

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<p style="text-align: center;">ANNEXURE A PROPOSAL FOR LEGISLATION</p>
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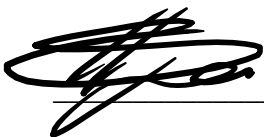
Dear Reader,

This piece of draft legislation has been influenced by the findings in this thesis. The wording used has been drawn largely from similar legislative instruments which have been enacted in other jurisdictions, particularly Bill C-14 as legislated in Canada,¹ the Washington Death with Dignity Act,² and the draft bill (End of Life Decisions Act 1999) that was proposed in the SALRC Report (Project 86, *Euthanasia and the Artificial Preservation of Life*, 1998).³

Due to the strictures and requirements of legislative drafting, wording and phraseology is very similar and is unavoidable by design. Quotation marks have been omitted simply so that the appearance is as close in appearance to what a formal piece of legislation would be. However, citations are included via footnoting, and the relevant portions appear in italicised font.

It is my hope that when the courts and the legislature are ready to implement the developmental changes advocated for in this thesis, this proposal for legislation makes that task less onerous.

Memento Vivere : Memento Mori, but you get to choose how.



Suhayfa Bhamjee

16 July 2022

¹ <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

² <https://app.leg.wa.gov/rcw/default.aspx?cite=70.245.010>, accessed on 25 June 2022.

³ https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

MEDICALLY ASSISTED DEATH WITH DIGNITY ACT

Purpose:

*To regulate end-of-life decisions and to provide for matters incidental thereto.*⁴

It is necessary to create exemptions from the offences of murder, attempted murder and culpable homicide, *in order to permit medical practitioners and nurse practitioners to provide medical assistance in dying and to permit pharmacists and other persons to assist in the process;*⁵

It is necessary to *specify the eligibility criteria and the safeguards that must be respected before medical assistance in dying may be provided to a person;*⁶

It is necessary to *require that medical practitioners and nurse practitioners who receive requests for, and pharmacists who dispense substances in connection with the provision of, medical assistance in dying provide information for the purpose of permitting the monitoring of medical assistance in dying, and authorise the Minister of Health to make regulations respecting that information;*⁷ and

⁴ This wording is taken verbatim from the SALRC Report on Euthanasia, 1998, particularly Annexure C which has the draft bill as proposed in the report. This section ties in with the fair labelling arguments by creating a specific category of lawful homicides within the confines of medically assisted deaths. Further, although outside of the scope of this dissertation, the draft legislation includes, where appropriate, accommodation for the formal legal recognition of 'living wills' and 'advance directives' as to exclude such would be an incomplete piece of legislation. As per the discussion in this thesis related to the case of *Clarke v Hurst NO*, there is certainly need for clarity and reform in this area as well, and the issue of lawful VAE is linked with the legal recognition of living wills.

⁵ The italicised portion is taken verbatim from <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. This section caters for the status of individuals who are licensed to participate in PAD (physician assisted death). Such categorisation offers a defence excluding unlawfulness to only the listed persons, to the exclusion of all others, in keeping with the discussion of *Grotjohn*.

⁶ The italicised portion is taken verbatim from <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. This section ties in with qualifying criteria that must be exhibited by the patient, notably the nature and prognosis of the physical illness. It serves to qualify the lawfulness of PAD to only physical illnesses which are terminal and thus excludes illness of a psychological nature.

⁷ The italicised portion is taken verbatim from <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. This ties in with the arguments for regulation and reporting criteria in an effort to prevent patient abuse and PAD being administered in an unfettered and unchecked manner. The practice is to be regulated and monitored by the Department of Health and the Health Professions Council of South Africa, which would further properly recognise the practice as a medical one. This section also properly acknowledges the causal role that these medical professionals have in PAD, but if done according to the legislation and regulations, their causal role will not attract criminal liability.

*It is necessary to create new offences for failing to comply with the safeguards, for forging or destroying documents related to medical assistance in dying, for failing to provide the required information and for contravening the regulations.*⁸

To be introduced by the Minister of Justice

Preamble:-

*Whereas the Parliament and the People of the Republic of South Africa recognises the autonomy of persons who have a grievous and irremediable medical condition that causes them enduring and intolerable suffering and who wish to seek medical assistance in dying;*⁹

*Whereas robust safeguards, reflecting the irrevocable nature of ending a life, are essential to prevent errors and abuse in the provision of medical assistance in dying;*¹⁰

*Whereas it is important to affirm the inherent and equal value of every person's life and to avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill, or disabled;*¹¹

Whereas vulnerable persons must be protected from being induced, in moments of weakness, to end their lives;

Whereas suicide is a significant public health issue that can have lasting and harmful effects on individuals, families and communities;

Whereas, in light of the above considerations, permitting access to medical assistance in dying for competent adults whose deaths are reasonably foreseeable strikes the most appropriate balance between the autonomy of persons who seek medical assistance in dying

⁸ The italicised portion is taken verbatim from <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. In addition to creating a statutory offence of aiding and abetting suicide for non-medical cases, this section and relevant sections herein serve to create specific offences where medical professionals do not adhere to the lawfulness requirements as stated hereunder.

⁹ The italicised portion is taken verbatim from <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

¹⁰ The italicised portion is taken verbatim from <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

¹¹ The italicised portion is taken verbatim from <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other;

Whereas it is desirable to have a consistent and considered approach to various matters related to medical assistance in dying, including the delivery of health care services in the public as well as private sphere, and the regulation of health care professionals, as well as insurance contracts, state prosecutors, coroners, medical examiners and pharmacists;

Whereas it is acknowledged that the HOSPICE offers an invaluable service to patients and families when their services are called upon, often carrying out their work under grave emotional and financial constraints;

*Whereas persons who avail themselves of medical assistance in dying should be able to do so without adverse legal consequences for their families – including loss of eligibility for benefits – that would result from their death;*¹²

Whereas everyone has freedom of conscience and religion under section 15 of the Constitution of the Republic of South Africa;

*Whereas nothing in this Act affects the guarantee of freedom of conscience and religion;*¹³

Whereas the Government of the Republic of South Africa recognises that in the living conditions of South Africans, there are diverse circumstances and that different groups have unique needs, and it commits to working with civil society and various stake holders to facilitate access to palliative and end-of-life care, care and services for individuals living with Alzheimer's and dementia, appropriate mental health supports and services and culturally and spiritually appropriate end-of-life care for all patients;

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:

1. Definitions

(1) *In this Act, unless the context otherwise indicates-*

¹² The italicised portion is taken verbatim from <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

¹³ The italicised portion is taken verbatim from <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

*‘advance directive’ is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions;*¹⁴

*‘adult’ means a person who is 18 years or older;*¹⁵

*‘attending physician’ means the physician who has primary responsibility for the care of the patient and treatment of the patient’s terminal illness;*¹⁶

*‘capable patient’ means that in the opinion of a court or in the opinion of the patient’s attending physician, psychiatrist, or psychologist, a patient has the ability to make and communicate health-care decisions to health care-providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available;*¹⁷

‘competent patient’ is given the same meaning as capable;

*‘competent witness’ means a person of the age of 18 years or over who at the time he witnesses the directive or power of attorney is not incompetent to give evidence in a court of law and for whom the death of the maker of the directive or power of attorney holds no benefit;*¹⁸

¹⁴ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. Although the focus of this thesis was not on advance directives and living wills, the inclusion in this draft bill is necessary as it has a bearing for patients who qualify for PAS/PAE but are later rendered incapable of self-administering the lethal dose. As such, the advanced directive can be relied on in appropriate cases. Save for this definition, nothing further in this submission will refer to living wills or advance directives.

¹⁵ The focus of this thesis was on PAS and PAE for adults only. As children are specifically identified as a group that requires special protection, the rights of minors and the applicability of PAS/PAE to them has not been discussed and for that reason has not been included in the draft legislation.

¹⁶ Taken verbatim from the Washington Death with Dignity Act, <https://app.leg.wa.gov/rcw/default.aspx?cite=70.245.010>, accessed on 25 Jun2 2022. This serves to ensure that an established doctor-patient relationship exists between the doctor and the patient such that the physician is properly aware of the wishes of the patient and the patient’s prognosis. It is only with an established relationship that the genuineness of the consent and decision-making capacity can be properly gauged as the physician would be more alert to the patient’s demeanor etc.

¹⁷ Taken verbatim from the Washington Death with Dignity Act, <https://app.leg.wa.gov/rcw/default.aspx?cite=70.245.010>, accessed on 25 June 2022. To avoid ‘euthanasia tourism’. This is also included to mitigate an allegation that the patient’s decision-making capacity may be impaired which can result in the consent not being real. Used to establish whether the patient is making a free and voluntary decision absent of mala fides and undue influence. Reliance on expert evaluation will also serve to protect against abuse of those individuals who are vulnerable to coercion.

¹⁸ Serves to mitigate against mala fides and abuse of power by ensuring that witnesses do not stand to benefit financially from the death of the patient.

***‘consulting physician’** means a physician who is qualified by speciality or experience to make a professional diagnosis and prognosis regarding the patient’s disease;¹⁹*

***‘counselling’** means one or more consultations as necessary between a psychiatrist and/or psychologist registered with the HPCSA and other relevant professional bodies, and the patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgement;²⁰*

‘court’ means a provincial or local division of the High Court of South Africa within whose jurisdiction the patient is ordinarily resident;

***‘family member’** in relation to any person, means that person’s spouse, parent, child, grandchild, brother or sister;²¹*

‘health care provider’ means a person registered with the HPCSA, *licensed, certified or otherwise authorised or permitted by the law of the Republic of South Africa to administer health-care or dispense medication in the ordinary course of business or practice of a profession, and includes a health-care facility;*²²

***‘informed decision’** means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, or to seek direct assistance in having that medication administered by a registered health-care professional, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:*

(a) His or her medical diagnosis;

(b) His or her prognosis;

¹⁹ Taken verbatim from the Washington Death with Dignity Act, <https://app.leg.wa.gov/rcw/default.aspx?cite=70.245.010>, accessed on 25 Jun2 2022, A physician other than the attending physician, who may have particular expertise in the nature of the specific illness with which the patient is afflicted. This expert will be able to more accurately and reliably assess longevity etc. This also serves to ensure that PAS and PAE are only performed by qualified medical professionals who have properly and adequately assessed the patient.

²⁰ Taken verbatim from the Washington Death with Dignity Act, <https://app.leg.wa.gov/rcw/default.aspx?cite=70.245.010>, accessed on 25 June 2022. This is to consider and evaluate the state of mind of the patient. It is not meant in the sense of the offence of aiding and abetting suicide. This is counselling for therapeutic and evaluative purposes.

²¹ Taken verbatim from the SALRC Report on Euthanasia, 1998 https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

²² Taken verbatim from the Washington Death with Dignity Act, <https://app.leg.wa.gov/rcw/default.aspx?cite=70.245.010>, accessed on 25 June 2022.

- (c) *The potential risks associated with taking the medication prescribed;*
- (d) *The probable result of taking the medication to be prescribed; and*
- (e) *The feasible alternatives, including but not limited to comfort care, palliative care, hospice care and pain control.*²³

'intractable and unbearable illness' means an illness, injury or other physical or mental condition, but excluding a terminal illness, that-

- (a) *offers no reasonable prospect of being cured; and*
- (b) *causes severe physical suffering of a nature and degree not reasonable to be endured.*²⁴

'lawyer' means an attorney as defined in s 1 of the Attorney's Act, 1979 (Act 53 of 1979) and s 1 of the Legal Practice Act, 2014 (Act 28 of 2014) and an advocate as defined in s 1 of the Admission of Advocates Act, 1964 (Act 74 of 1964) and s 1 of the Legal Practice Act, 2014 (Act 28 of 2014);

'life-sustaining medical treatment' includes the maintenance of artificial feeding;²⁵

'living will' is a signed and witnessed document called a “declaration” or “directive.” instructing an attending physician to withhold or withdraw medical interventions from its signer if he/she is in a terminal condition and is unable to make decisions about medical treatment;²⁶

'medical practitioner' means a medical practitioner registered as such in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);²⁷

²³ Taken verbatim from the Washington Death with Dignity Act, <https://app.leg.wa.gov/rcw/default.aspx?cite=70.245.010>, accessed on 25 June 2022. This takes into consideration the requirements for informed consent as discussed in Chapter Three.

²⁴ Taken verbatim from the SALRC Report on Euthanasia, 1998 https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

²⁵ Taken verbatim from the SALRC Report on Euthanasia, 1998 https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

²⁶ Taken verbatim from <https://www.patientsrightscouncil.org/site/advance-directives-definitions/>, accessed on 25 June 2022.

²⁷ Taken verbatim from the SALRC Report on Euthanasia, 1998 https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

‘medically confirmed’ means that the medical opinion of the *attending physician has been confirmed by a consulting physician who has examined the patient and the patient’s relevant medical records*;²⁸

‘nurse’ means a nurse registered as such in terms of the Nursing Act 50 of 1978 and authorised as a prescriber in terms of section 31(14)(b) of the proposed [South African Medicines and Medical Devices Regulatory Authority Bill];²⁹

‘palliative care’ means *treatment and care of a terminally ill patient with the object of relieving physical, emotional and psycho-social suffering and of maintaining personal hygiene*;³⁰

‘patient’ means a person who is under the care of a physician, regardless of whether such care is obtained through private medical practice or dispensed via a government health care facility in South Africa;³¹

‘physician’ means a medical doctor licensed to practice medicine in the Republic of South Africa by the HPCSA;

‘physician-assisted suicide’ occurs when a medical practitioner, nurse, pharmacist or physician assists a qualified patient to end their own lives by providing the means and or/knowledge required to commit suicide. This includes the provision of actual medication or a prescription for medication. However, the patient self-administers the lethal medication.

‘physician-administered euthanasia’ occurs when a medical practitioner, nurse, or physician assists a qualified patient to end their own lives by directly administering to the patient the lethal medication.

²⁸ Taken verbatim from <https://www.patientsrightscouncil.org/site/advance-directives-definitions/>, accessed on 25 June 2022.

²⁹ This inclusion serves to acknowledge that causal role that nurses may play in the PAS/PAE of a qualifying patient. Nurses are included herein so as to properly ensure that they are not held criminally liable under the crime of aiding and abetting suicide, provided of course that they meet the relevant criteria for such exemption.

³⁰ Taken verbatim from the SALRC Report on Euthanasia, 1998 https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

This includes the practice and care protocols of HOSPICE.

³¹ To discourage ‘euthanasia tourism.’

‘qualified patient’ means a capable adult who is ordinarily resident in the Republic of South Africa and has satisfied the requirements listed in this Act in order to³² access either physician-assisted suicide or physician-administered euthanasia;

‘ordinarily resident’ means a person who resides in South Africa;

‘spouse’ includes a person with whom one lives as if they were married or with whom one habitually cohabits;³³

‘terminal illness’ or **‘terminal disease’** means an illness, injury or other physical condition that -

- (a) is incurable and irreversible and that has been medically confirmed and will, within reasonable medical judgement, produce death within six months; or
- (b) in reasonable medical judgement, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering; or
- (c) causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.

2. Counselling, aiding, or incitement to commit suicide or directly assists in causing death³⁴

- (1) *Everyone [other than those persons identified in s2(2)] is guilty of an offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,*

(a) counsels a person to die by suicide or abets a person in dying by suicide; or

(b) aids a person to die by suicide; or

³² Taken verbatim from the Washington Death with Dignity Act, <https://app.leg.wa.gov/rcw/default.aspx?cite=70.245.010>, accessed on 25 June 2022. Included to discourage euthanasia tourism and further to provide the safe-guard of an established doctor-patient relationship such that the physician has more than a cursory knowledge of the patient’s medical condition.

³³ Taken verbatim from the SALRC Report on Euthanasia, 1998 https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

³⁴ This section creates the specific statutory offence of aiding and abetting suicide for which prosecution will follow. Such conduct is unlawful.

*(c) directly administers a lethal substance which causes death.*³⁵

- (2) *No medical practitioner, physician, pharmacist or nurse practitioner commits an offence under s 2(1) if they provide a qualifying patient with medical assistance in dying in accordance with the provisions of this Act.*³⁶
- (3) *No person is a party to an offence under s 2(1) if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with the provisions of this Act.*
- (4) *No pharmacist who dispenses a substance to a person other than a medical practitioner or nurse practitioner commits an offence under section 2(1) if the pharmacist dispenses the substance further to a prescription that is written by such a practitioner in providing medical assistance in dying in accordance with this Act. It is incumbent upon the pharmacist to take reasonable steps to ensure that the prescription is real and not a forgery.*³⁷
- (5) *No person commits an offence under paragraph s 2(1) if they do anything, at another person's explicit request, for the purpose of aiding that other person to self-administer a substance that has been prescribed for that other person as part of the provision of medical assistance in dying in accordance with this Act.*³⁸

*(a) For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying.*³⁹

3. A person may receive medical assistance in dying only if they meet all of the following criteria:

- (1) (a) they are ordinarily resident within the Republic of South Africa;

³⁵ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent> accessed on 25 June 2022. It creates the statutory offence of counselling, aiding, or incitement to commit suicide or directly assists in causing death.

³⁶ This section creates the medical exemption.

³⁷ The relevant department can make regulations for the recording and reporting of such information, as well as criteria for establishing genuineness of the prescription.

³⁸ This would include all forms of assistance before the point of self-administration. It properly acknowledges the causal role played by assistors but makes such assistance lawful.

³⁹ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. This section lists exemptions for criminal liability.

- (b) *they are at least 18 years of age and capable of making decisions with respect to their health;*
- (c) *they have a grievous and irremediable medical condition;*
- (d) *they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and*
- (e) *they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.*⁴⁰

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) *they have a serious and incurable illness, disease or disability;*
- (b) *they are in an advanced state of irreversible decline in capability;*
- (c) *that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and*
- (d) *their natural death has become foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.*⁴¹

(3) *Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must*

- (a) *be of the opinion that the person meets all of the criteria set out in section 2(1);*

⁴⁰ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. Serves to create a basis for qualifying criteria.

⁴¹ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. The time frame of months or weeks has been left out of this draft bill for the reason that it may impact on decision making capacity and imply decision making vulnerability.

- (b) *ensure that the person's request for medical assistance in dying was*
 - (i) *made in writing and signed and dated by the person or by another person under subsection (4), and*
 - (ii) *signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;*⁴²
- (c) *be satisfied that the request was signed and dated by the person - or by another person under subsection (4) — before two independent witnesses who then also signed and dated the request;*
- (d) *ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;*
- (e) *ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);*
- (f) *be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent;*⁴³
- (g) *immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and*
- (h) *if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.*⁴⁴

⁴² Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

⁴³ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

⁴⁴ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

- (4) *If the person requesting medical assistance in dying is unable to sign and date the request, another person — who is at least 18 years of age, who understands the nature of the request for medical assistance in dying and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death — may do so in the person's presence, on the person's behalf and under the person's express direction, after the decision of the patient has been confirmed as being genuine and uncoerced by a relevant health care professional (psychologist or psychiatrist).*⁴⁵
- (5) *Any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may act as an independent witness, except if they*
- (a) *know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death;*
 - (b) *are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides;*
 - (c) *are directly involved in providing health care services to the person making the request; or*
 - (d) *directly provide personal care to the person making the request.*⁴⁶

⁴⁵ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. The constitution and construction of the committee must be determined in accordance with section 7 below.

⁴⁶ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

- (6) *The medical practitioner or nurse practitioner providing medical assistance in dying and the medical practitioner or nurse practitioner who provides the opinion referred to in paragraph (3)(e) are independent if they*
- (a) *are not a mentor to the other practitioner or responsible for supervising their work;*
 - (b) *do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or*
 - (c) *do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.*⁴⁷
- (7) *Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable laws, rules or standards.*⁴⁸
- (8) *The medical practitioner or nurse practitioner who, in providing medical assistance in dying, prescribes or obtains a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose.*⁴⁹
- (9) *For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying.*⁵⁰

⁴⁷ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

⁴⁸ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. The HPCSA is to create ethical guidelines and protocols as has been done for other matters including abortion, palliative care and withdrawing and withholding treatment.

⁴⁹ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. This will assist the pharmacist in assessing whether the prescription is genuine.

⁵⁰ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. Conscientious objection as is the case with abortions.

- (10) A medical practitioner, pharmacist or *nurse practitioner* who, in providing medical assistance in dying, knowingly fails to comply with all of the requirements set out is guilty of an offence and is liable:
- (a) on conviction on indictment, to a term of imprisonment of not more than five years; or
 - (b) on summary conviction, to a term of imprisonment of not more than 18 months.⁵¹
- (11) Everyone commits an offence who commits forgery in relation to a request for medical assistance in dying, and is guilty of an offence and liable:
- (a) on conviction on indictment, to a term of imprisonment of not more than five years; or
 - (b) on summary conviction, to a term of imprisonment of not more than 18 months.⁵²
- (12) Everyone commits an offence who destroys a document that relates to a request for medical assistance in dying with intent to interfere with
- (a) another person's access to medical assistance in dying; or
 - (b) the lawful assessment of a request for medical assistance in dying;
- and is liable on conviction, to a term of imprisonment of not more than 14 years.⁵³

⁵¹ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. Creates a statutory offence.

⁵² Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. Creates a statutory offence and prescribed punishments.

⁵³ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022. Creates a statutory offence and prescribed punishments.

4. Conduct of a medical practitioner in the event of clinical death⁵⁴

- (1) *For the purposes of this Act, a person is considered to be dead when two medical practitioners agree and confirm in writing that a person is clinically dead according to the following criteria for determining death, namely -*
- (a) the irreversible absence of spontaneous respiratory and circulatory functions;*
or
 - (b) the persistent clinical absence of brain-stem function.*
- (2) *Should a person be considered to be dead according to the provisions of section 4(1), the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of life-sustaining treatment.⁵⁵*

5. Mentally competent person may refuse treatment⁵⁶

- (1) *Every person -*
- (a) above the age of 18 years and of sound mind; or*
 - (b) above the age of 14 years, of sound mind and assisted by his or her parents or guardian;*
- is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.*
- (2) *Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in section 5(1) is, that such a person's refusal is based on the free and considered exercise of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.*
- (3) *Care should be taken when taking a decision as to the competency of a person, that an individual who is not able to express him or herself verbally or adequately, should*

⁵⁴ Codifies the decision in *Clarke v Hurst NO* and the HPCSA practice guidelines.

⁵⁵ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

⁵⁶ Codifies the HPCSA guidelines.

not be classified as incompetent unless expert attempts have been made to communicate with that person whose responses may be by means other than verbal.

- (4) *Where a medical practitioner as contemplated in subsection (2) does not share or understand the first language of the patient, an interpreter fluent in the language used by the patient must be present in order to facilitate discussion when decisions regarding the treatment of the patient are made.*⁵⁷

6. Conduct of medical practitioner in relieving distress⁵⁸

- (1) *Should it be clear to a medical practitioner responsible for the treatment of a patient who has been diagnosed by a medical practitioner as suffering from a terminal illness that the dosage of medication that the patient is currently receiving is not adequately alleviating the patient's pain or distress, he or she shall -*

- (a) *with the object to provide relief of severe pain or distress; and*
- (b) *with no direct intention to kill;*

*increase the dosage of medication (whether analgesics or sedatives)⁵⁹ to be given to the patient until relief is obtained, even if the secondary effect of this action may be to shorten the life of the patient, or direct that a nurse or other relevant health care worker administer said medication to the patient.*⁶⁰

- (2) A medical practitioner or nurse having been duly instructed by a medical practitioner, who treats a patient as contemplated in section 6(1) shall record in writing his or her findings regarding the condition of the patient and his or her conduct in treating the patient, which record will be documented and filed in and become part of the medical record of the patient concerned.

⁵⁷ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

⁵⁸ Codifies the HPCSA guidelines on palliative care, and is included specifically for cases where a patient has not made any declaration or request of PAS/PAE. This section is included to codify the medical exemption for palliative care cases. It does not however imply that the doctrine of double effect applies to any cases other than as specifically catered for here in section 5.

⁵⁹ Caters for the concerns related to the nature and scope of medications prescribed and the arguments related to intention and causation.

⁶⁰ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

7. Physician-assisted suicide and physician-administered euthanasia⁶¹

- (1) *Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall give effect to the request if he or she is satisfied that-*
- (a) *the patient is suffering from a terminal or intractable and unbearable illness or disease;*⁶²
 - (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 section 7(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;*

⁶¹ Sets out qualification criteria, without which a medical professional will be acting unlawfully and in contravention of the statute.

⁶² Taken verbatim from the SALRC report on Euthanasia, (1998)

https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

- (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.*
- (2) *No medical practitioner to whom the request to make an end to a patient's suffering is addressed as contemplated in subsection (1), shall give effect to such a request, even though he or she may be convinced of the facts as stated in that subsection, unless he or she has conferred with an independent medical practitioner (consulting physician) who is knowledgeable with regard to the terminal illness from which the patient is suffering and who has personally checked the patient's medical history and examined the patient and who has confirmed the facts as contemplated in subsection (1)(a), (b) and (i).*
- (3) *A medical practitioner who gives effect to a request as contemplated in sub-section (1), shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner (consulting physician) with whom he or she has conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).*
- (4) *The termination of a patient's life on his or her request in order to release him or her from suffering may not be effected by any person other than a medical practitioner;*
- (5) *A medical practitioner who gives effect to a patient's request to be released from suffering as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act provided that all due procedural measures have been complied with.*
- (6) *If a patient who has orally requested his or her medical practitioner to assist the patient to end the patient's life is physically unable to sign the certificate of request, any person who has attained the age of 18 years, other than the medical practitioner referred to in subsection (2) above, or the consulting physician, may, at the patient's request and in the presence of the patient and both medical practitioners, sign the certificate on behalf of the patient.*

- (7) (a) *Notwithstanding anything in this Act, a patient may rescind a request for assistance under this Act at any time and in any manner without regard to his or her mental state.*
- (b) *Where a patient rescinds a request, the patient's medical practitioner shall, as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record.*
- (8) *The following shall be documented and filed in and become part of the medical record of the patient who has been assisted under this Act:*
 - (a) *a note of the oral request of the patient for such assistance;*
 - (b) *the certificate of request;*
 - (c) *a record of the opinion of the patient's medical practitioner that the patient's decision to end his or her life was made freely, voluntarily and after due consideration;*
 - (d) *the report of the consulting physician referred to in subsection (2) above;*
 - (e) *a note by the patient's medical practitioner indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the substance prescribed.⁶³*

8. Decision by Panel or Committee⁶⁴

- (1) *Physician-administered euthanasia may be performed by a medical practitioner only, and then only where the request for the physician-administered euthanasia of the patient has been approved by an ethics committee constituted for that purpose and consisting of five persons as follows:*
 - (a) *two medical practitioners other than the practitioner attending to the patient;*
 - (b) *one lawyer;*

⁶³ Taken verbatim from Bill C-14 <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent>, accessed on 25 June 2022.

⁶⁴ Where patient has an advance directive, but is not able to speak or otherwise indicate their wishes personally; or where the patient is not physically able to self-administer the prescribed medication.

- (c) *one member sharing the home language of the patient;*
 - (d) *one member from the multi-disciplinary team.*
- (2) *In considering and in order to approve a request as contemplated in section 8(1) the Ethics Committee has to certify in writing that:*
- (a) *in its opinion the request for physician-administered euthanasia by the patient is a free, considered and sustained request;*
 - (b) *the patient is suffering from a terminal or intractable and unbearable illness;*
 - (c) *physician-administered euthanasia is the only way for the patient to be released from his or her suffering.*
- (3) *A request for physician-administered euthanasia must be heard within three weeks of it being received by the Committee.*
- (4) (a) *The Committee which, under subsection (2), grants authority for physician-administered euthanasia must, in the prescribed manner and within the prescribed period after euthanasia has been performed, report confidentially to the Director-General of Health, by registered post, the granting of such authority and set forth-*
- (i) *the personal particulars of the patient concerned;*
 - (ii) *the place and date where the euthanasia was performed and the reasons therefore;*
 - (iii) *the names and qualifications of the members of the committee who issued the certificates in terms of the above sections; and*
 - (iv) *the name of the medical practitioner who performed the euthanasia.*⁶⁵
- (b) The Director-General may call upon the members of the Committee required to make a report in terms of subsection (4) or a medical practitioner referred to in subsection (1) to furnish such additional information as he may require.

⁶⁵ Taken verbatim from the SALRC report on Euthanasia, 1998, https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

- (5) *The following shall be documented and filed and become part of the medical record of the patient who has been assisted under this Act:*
- (a) *full particulars regarding the request made by the patient;*
 - (b) *a copy of the certificate issued in terms of subsection (2);*
 - (c) *a copy of the report made in terms of subsection (4).⁶⁶*

9. Directives as to the treatment of a terminally ill person⁶⁷

- (1) *Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive in the form of a living will declaring that if he or she should ever suffer from a terminal illness and would as a result be unable to make or communicate decisions concerning his or her medical treatment or its cessation, medical treatment should not be instituted or any medical treatment which he or she may receive should be discontinued and that only palliative care should be administered.*
- (2) *A person as contemplated in subsection (1) shall be competent to entrust any decision-making regarding the treatment as contemplated in that subsection or the cessation of such treatment to a competent agent by way of a written power of attorney, and such power of attorney shall take effect and remain in force if the principal becomes terminally ill and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof.⁶⁸*
- (3) *A directive contemplated in subsection (1) and a power of attorney contemplated in subsection (2) and any amendment thereof, shall be signed by the person giving the directive or power of attorney in the presence of two competent witnesses who shall sign the document in the presence of the said person and in each other's presence.*

⁶⁶ Taken verbatim from the SALRC report on Euthanasia, 1998, https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

⁶⁷ This section gives legal recognition to advance directive with particular focus on patients who qualify for PAS/PAE but later, due to the progress of their illness, are unable to access PAS/PAE.

⁶⁸ Taken verbatim from the SALRC report on Euthanasia, 1998, https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

- (4) *When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) or (2) regarding his medical treatment or the cessation thereof have been issued, the decision-making regarding such treatment or the cessation thereof shall, in the absence of any court order or the provisions of any other Act, vest in such guardian or curator.*
- (5) *Such directive can include a request for Physician-Assisted suicide and physician-administered euthanasia, provided that the patient has, pursuant to the making of such directive, qualified.*⁶⁹

10. Conduct in compliance with directives by on or behalf of terminally ill patients

- (1) *No medical practitioner shall give effect to a directive regarding the refusal or cessation of medical treatment or the administering of palliative care which may contribute to the hastening of a patient's death, unless-*
 - (a) *the medical practitioner is satisfied that the patient concerned is suffering from a terminal illness and is therefore unable to make or communicate considered decisions concerning his or her medical treatment or the cessation thereof; and*
 - (b) *the condition of the patient concerned, as contemplated in paragraph (a), has been confirmed by at least one other medical practitioner (consulting physician) who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition because of his expert knowledge of the patient's illness and his or her examination of the patient concerned.*
- (2) *Before a medical practitioner gives effect to a directive as contemplated in subsection (1) he shall satisfy himself, in so far as this is reasonably possible, of the authenticity of the directive and of the competency of the person at the time of issuing the directive.*
- (3) *Before giving effect to a directive as contemplated in subsection (1), a medical practitioner shall inform the interested family members of the patient of his or her*

⁶⁹ Taken verbatim from the SALRC Report on Euthanasia, 1998
https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

*findings, that of the consulting physician contemplated in paragraph (b) of subsection (1), and of the existence and content of the directive of the patient concerned.*⁷⁰

- (4) *If a medical practitioner is uncertain as to the authenticity as regard to the directive or its legality, he shall treat the patient concerned in accordance with the provisions set out in section 8 below.*
- (5) (a) *A medical practitioner who gives effect to a directive as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and the manner in which he or she implemented the directive.*
- (b) *A medical practitioner as contemplated in paragraph (b) of subsection (1) shall record in writing his or her findings regarding the condition of the patient concerned.*⁷¹
- (6) A directive concerning the refusal or cessation of medical treatment as contemplated in sub-section (1) and (2) shall not be invalid and the withholding or cessation of medical treatment in accordance with such a directive, shall, in so far as it is performed in accordance with this Act, not be unlawful even though performance of the directive might hasten the moment of death of the patient concerned.
- (7) Where the terms of the directive include the prescription and or administering of a lethal substance to end the patient's life, the medical practitioner concerned must refer the matter to the ethics committee and follow those procedures as contemplated in paragraph 5 above.

11. Conduct of a medical practitioner in the absence of a directive⁷²

- (1) *If a medical practitioner responsible for the treatment of a patient in a hospital, clinic or similar institution where a patient is being cared for, is of the opinion that the*

⁷⁰ Taken verbatim from the National Health Amendment Bill, 2019.

⁷¹ Taken verbatim from the SALRC report on Euthanasia, 1998, https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

⁷² Subsection 5 herein is most important. Unless a patient has an advance directive, it remains unlawful for a physician to administer PAS/PAE.

patient is in a state of terminal illness as contemplated in this Act and unable to make or communicate decisions concerning his or her medical treatment or its cessation, and his or her opinion is confirmed in writing by at least one other consulting physician who has not treated the person concerned as a patient, but who has examined him or her and who is competent to submit a professional opinion regarding the patient's condition on account of his or her expertise regarding the illness of the patient concerned, the first-mentioned medical practitioner may, in the absence of any directive as contemplated in section 6(1) and (2) or a court order as contemplated in section 9, grant written authorisation for the cessation of all further life-sustaining medical treatment and the continued administering of palliative care only.

- (2) *A medical practitioner as contemplated in subsection (1) shall not act as contemplated in subsection (1) if such conduct would be contrary to the wishes of the interested family members of the patient, unless authorised thereto by a court order.*
- (3) *A medical practitioner as contemplated in subsection (1) shall record in writing his or her findings regarding the patient's condition and any steps taken by him or her in respect thereof.*
- (4) *The cessation of medical treatment as contemplated in subsection (1) shall not be unlawful merely because it contributes to causing the patient's death.⁷³*

12. Family notification

- (1) The attending physician shall recommend that the patient notify the next of kin of his or her request for physician-assisted suicide or physician-administered euthanasia.
- (2) A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

13. Residency requirement

⁷³ Taken verbatim from the SALRC report on Euthanasia, 1998, https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

Only requests for physician-assisted suicide and physician-administered euthanasia made by persons who are ordinarily resident in South Africa shall be considered. Evidence of residence in South Africa shall include but are not limited to:

- (1) possession of a valid South African identity document, or its equivalent; or
- (2) registration as a voter; or
- (3) proof of address.⁷⁴

14. Powers of the court⁷⁵

- (1) *In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 9, a court may, if satisfied that a patient is in a state of terminal illness and unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, order the cessation of medical treatment.*
- (2) *A court shall not make an order as contemplated in subsection (1) without the interested family members having been given the opportunity to be heard by the court.*
- (3) *A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who have expert knowledge of the patient's condition and who have treated the patient personally or have informed themselves of the patient's medical history and have personally examined the patient.*
- (4) *A medical practitioner who gives effect to an order of court as contemplated in this section shall not thereby incur any civil, criminal or other liability whatsoever.*
- (5) *This is in respect only of the cessation of medical treatment, and does not apply to the administration of physician-assisted suicide or physician-administered euthanasia.⁷⁶*

⁷⁴ These requirements are similar to those in *The Regulation of Interception of Communications and Provision of Communication-related Information Act* 70 of 2002.

⁷⁵ Codifies the decision in *Clarke v Hurst NO* and the HPCSA guidelines on consent by proxy decision makers, but adds in a further protection by placing the decision with the Court as final arbiter.

⁷⁶ Taken verbatim from the SALRC Report on Euthanasia, 1998, https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

15. Interpretation

*The provisions of this Act shall not be interpreted so as to oblige a medical practitioner to do anything that would be in conflict with his or her conscience or any ethical code to which he or she feels himself or herself bound.*⁷⁷

16. Short title

This Act shall be called the Medically Assisted Death with Dignity Act 20xx.

⁷⁷ Taken verbatim from the SALRC Report on Euthanasia, 1998, https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf, accessed on 25 June 2022.

APPENDIX 1 ETHICAL CLEARANCE



29 November 2018

Ms Suhayfa Bhamjee (982169980)
School of Law
Pietermaritzburg Campus

Dear Ms Bhamjee,

Protocol reference number: HSS/2151/018D

Project title: Death and dying in Constitutional Democracy - The persistent vegetative state and palliative paralysis of end-of-life decision making in South Africa. A call for law reform

Full Approval – No Risk / Exempt Application

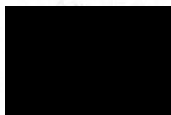
In response to your application received on 02 October 2018, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully



Professor Shenuka Singh (Chair)

/ms

Cc Supervisor: Professor SV Hoor
Cc Academic Leader Research: Dr Freddy Mnyongani
cc School Administrator: Ms Robynne Louw

Humanities & Social Sciences Research Ethics Committee

Professor Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

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Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za

Website: www.ukzn.ac.za



Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

27 July 2022

Suhayfa Bhamjee (982169980)
School of Law
Pietermaritzburg Campus

Dear S Bhamjee,

Protocol reference number: HSS/2151/018D

Project title: Death and dying in Constitutional Democracy - The persistent vegetative state and palliative paralysis of end-of-life decision making in South Africa. A call for law reform

Amended title: Death and dying in constitutional democracy - An analysis of the criminal law and a call for law reform

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 14 June 2022 has now been approved as follows:

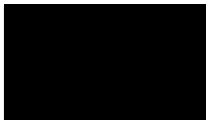
- Change in title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

Best wishes for the successful completion of your research protocol.

Yours faithfully



.....
Professor Dipane Hlalele (Chair)

/dd

Humanities & Social Sciences Research Ethics Committee
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Tel: +27 31 260 8350 / 4557 / 3587
Website: <http://research.ukzn.ac.za/Research-Ethics/>

Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

INSPIRING GREATNESS

26 January 2023

Suhayfa Bhamjee (982169980)
School of Law
Pietermaritzburg Campus

Dear S Bhamjee,

Protocol reference number: HSS/2151/018D

Project title: Death and dying in Constitutional Democracy - The persistent vegetative state and palliative paralysis of end-of-life decision making in South Africa. A call for law reform

Revised title: Death and dying in constitutional democracy - An analysis of the criminal law and a call for law reform

Amended revised title: Death and dying in a constitutional democracy – An analysis of the South African criminal law and a call for law reform

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 24 January 2023 has now been approved as follows:

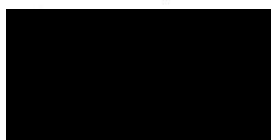
- Change in title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

Best wishes for the successful completion of your research protocol.



Yours faithfully



Professor Dipane Hlalele (Chair)

/ms

Humanities & Social Sciences Research Ethics Committee
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Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

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