

Implementing a permissive regime for assisted dying
in South Africa: a rights-based analysis.

by
Kirsty Lee Frances
211517741

This research project is submitted in fulfilment of the regulations
for the LLM degree at the University of KwaZulu-Natal.

2015

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This thesis is written in memory of all those who were denied the right to a dignified death and in support of those who continue to show immense strength through compassion and advocate for the rights of those whose voices cannot be heard.

In the past two centuries we have improved the length of our lives and the quality of said lives to the point where we feel somewhat uneasy if anyone dies as early as the biblical age of seventy. But there comes a time when technology outpaces sense, when a blip on an oscilloscope is confused with life, and humanity unravels into a state of mere existence.

It’s that much heralded thing, the quality of life, that is important. How you live your life, what you get out of it, what you put into it and what you leave behind after it. We should aim for a good and rich life well lived and, at the end of it, in the comfort of our own home, in the company of those who love us, have a death worth dying for.[°]

[°] Sir Terry Pratchett “Shaking Hands with Death” (2010) delivered as the Richard Dimbleby Lecture, published by Corgi Books 2015.

TABLE OF CONTENTS

Statement of Originality	1
Acknowledgements	2
Table of Contents	3
Table of Cases	7
Table of Statutes	9
CHAPTER 1: INTRODUCTION	10
1.1 Introduction	10
1.2 Overview of thesis	13
1.3 Terminology and Definitions	14
1.3.1 Euthanasia	14
1.3.2 Active Euthanasia	15
1.3.3 Passive Euthanasia	15
1.3.4 Voluntary Euthanasia	16
1.3.5 Involuntary Euthanasia	16
1.3.6 Non-voluntary Euthanasia	16
1.3.7 Doctor-Assisted Suicide	17
1.3.8 Assisted Dying	18
1.3.9 Patient Autonomy	19
CHAPTER 2: RECENT LEGAL DEVELOPMENTS IN ASSISTED DYING	21
2.1 <i>Carter v Canada</i>	21
2.1.1 Background	22
2.1.2 Statutory Provisions: Canadian Criminal Code	24
2.1.3 Constitutional Rights: Canadian Charter of Rights and Freedoms	25
2.1.4 Judicial History: British Columbia Supreme Court	26
2.1.4.1 Trial Judge's Charter Analysis: s15	27
2.1.4.2 Trial Judge's Charter Analysis: s7	28
2.1.5 Judicial History: British Columbia Court of Appeal	29
2.1.6 Analysis of s7: Does the law infringe the right to life, liberty and security of the person?	32

2.1.6.1 Life	32
2.1.6.2 Liberty and Security of the Person	34
2.1.7 Principles of Fundamental Justice	35
2.1.7.1 Arbitrariness	37
2.1.7.2 Overbreadth	37
2.1.7.3 Gross Disproportionality	38
2.1.8 Analysis of s15	38
2.1.9 Analysis of s1: Justification of the Infringement	39
2.1.9.1 Rational Connection	39
2.1.9.2 Minimal Impairment	40
2.1.9.3 Deleterious Effects and Salutary Benefits	41
2.1.10 Conclusion and Remedy	42
2.2 <i>Stransham-Ford v Minister of Justice and Correctional Services and Others</i>	44
2.2.1 Background	44
2.2.2 Order sought by Applicant	46
2.2.3 Analysis of Applicant's health, quality of life and imminent future	46
2.2.4 Current legal position in South Africa	49
2.2.5 Basis of the Applicant's Relief	50
2.2.6 Freedom, security and control to die with dignity	50
2.2.7 Humanity of euthanasia to cease unbearable suffering	55
2.2.8 The core concern regarding the legalisation of euthanasia	56
2.2.9 International developments of the law pertaining to euthanasia	56
2.2.10 The South African Law Commission's Report on Euthanasia and the Artificial Preservation of Life	58
2.2.11 Respondent's Argument	59
2.2.12 Relief sought by the Applicant	60
2.2.13 Findings of the Court	60
2.3 <i>Seales v Attorney-General</i>	62
2.3.1 Background	62
2.3.2 Analysis of Application and Ruling	64
2.3.3 Key principles	66
2.3.3.1 Sanctity of life	66

2.3.3.2	Respect for human dignity	66
2.3.3.3	Respect for individual autonomy	67
2.3.3.4	Protection of the vulnerable	69
2.3.4	Analysis of the Criminal Law provisions	70
2.3.5	Analysis of the rights-based arguments: the right to life (s8)	72
2.3.5.1	The right to life	72
2.3.5.2	Exemptions established by law	74
2.3.5.3	Consistency with the principles of fundamental justice	74
2.3.6	Analysis of the rights-based arguments: the right not to be subjected to torture or cruel treatment (s9)	77
2.3.7	Concluding remarks	79
 CHAPTER 3: RIGHTS-BASED ANALYSIS OF ASSISTED DYING		 80
3.1	Background Information	80
3.2	Limitation of rights under the Constitution	80
3.2.1	Introduction	80
3.2.2	Background	81
3.2.3	The structure of the limitation of rights	84
3.3	Assisted dying: a constitutional, rights-based analysis	86
3.3.1	Introduction	86
3.3.2	Does the prohibition on assisted dying limit a constitutionally protected right?	87
3.3.2.1	The right to life	88
3.3.2.2	The right to dignity	92
3.3.2.3	Autonomy	96
3.3.3	The meaning and effect of the prohibition on assisted dying	97
3.3.3.1	Development of the prohibition on assisted dying in criminal law	98
3.3.3.2	Effect of the prohibition on assisted dying	101
3.3.4	Can the limitation of these rights be justified under section 36?	104
3.3.4.1	Introduction	104
3.3.4.2	Law of general application	105
3.3.4.3	Is the limiting measure reasonable and justifiable?	106
a.	What is the purpose of the limiting measure?	107

b. Is the purpose of the limiting measure legitimate in an open and democratic society?	112
c. Is there a rational connection between the limiting measure and the purpose thereof?	116
d. Alternative, less-restrictive means	116
3.3.4.4 Balancing and Proportionality	119
3.4 Conclusion of the limitation enquiry	121
CHAPTER 4: PROPOSED LEGISLATIVE FRAMEWORK	123
4.1 Introduction	123
4.2 The Draft Bill: Background	123
4.3 Definitions	126
4.4 Procedures	132
4.5 Decision making by panel or committee	137
4.6 Safeguards	141
4.6.1 Attending and consulting physicians	141
4.6.2 Timeframes/Waiting periods	141
4.6.3 Written Request: Declaration of Intent/Certificate of Request	143
4.6.4 Counselling	150
4.6.5 Rescission of Request	153
4.6.6 Conscientious Objection	154
4.6.7 Role of a doctor/medical practitioner	156
4.6.8 Reporting	158
CHAPTER 5: CONCLUSION	163
Bibliography	167
Annexure A: Lecretia Seales' first affidavit in the proceedings	170

TABLE OF CASES

Canada

Blencoe v British Columbia (Human Rights Commission) 2000 SCC 44.
Canada (Attorney-General) v Bedford 2013 SCC 72.
Carter v Canada (Attorney-General) 2012 BCSC 886.
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CHAPTER 1: INTRODUCTION

1.1 Introduction

If one death is accompanied by torture, and the other is simple and easy, why not snatch the latter? Just as I shall select my ship, when I am about to go on a voyage, or my house when I propose to take a residence, so shall I choose my death when I am about to depart from life. Moreover, just as a long-drawn-out life does not necessarily mean a better one, so a long-drawn-out death necessarily means a worse one.

For mere living is not a good, but living well. Accordingly, the wise man will live as long as he ought, not as long as he can. He will mark in what place, with whom, and how he is to conduct his existence, and what he is about to do. He always reflects concerning the quality, and not the quantity, of his life. As soon as there are many events in his life that give him trouble and disturb his peace of mind, he sets himself free.

It is not a question of dying earlier or later, but of dying well or ill. And dying well means escape from the danger of living ill.¹

Death, suicide and euthanasia are issues that have engaged the minds of philosophers, theologians, lawyers and laymen alike for many centuries.² In the modern-day debate surrounding euthanasia, many academics use the recent technological advancements in healthcare and the preservation of life as a point of departure.³ Although modern advancements in medicine may have brought the issue of euthanasia to the fore and reignited the debate surrounding end of life care, there exists a long history of moral, religious, philosophical, ethical

¹ Seneca *Moral Letters to Lucilius: Letter 70 (LXX On the Proper Time to Slip the Cable) Epistolae Morales*.

² JD Papadimitriou et al 'Euthanasia and suicide in antiquity: viewpoint of the dramatists and philosophers' (2007) 100 *Journal of the Royal Society of Medicine* 25-28.

AJ Van Hooff 'Ancient euthanasia: 'good death' and the doctor in the Graeco-Roman world' (2004) 58 *Social Science & Medicine* 975-985.

³ AM Diaconescu 'Euthanasia' (2012) 4 *Contemporary Readings in Law and Social Justice* 474-483.

JF McDougall & M Gorman *Contemporary World Issues, Euthanasia: A Reference Handbook* 2 ed (2008) 6.

I Dowbiggin *A Concise History of Euthanasia: Life, Death, God and Medicine* 1 ed (2007) 7.

and legal debates preceding the 21st Century discourse on euthanasia.⁴ As a result of the technological and legal developments internationally in the field of end of life care, several jurisdictions have moved toward a permissive regime in which assisted dying is sanctioned through legislation. However, not all countries have been receptive to these ideas, and even the countries that have allowed for legalisation of assisted dying have done so only in limited circumstances and under strict conditions.

Traditionally, South Africa has been reluctant to deal with issues surrounding end of life care and assisted dying.⁵ However, since the advent of the constitutional dispensation in South Africa, the debate surrounding assisted dying gained momentum, as the rights enshrined in the Constitution of the Republic of South Africa, Act 108 of 1996 (1996 Constitution) provided a platform upon which these issues could be debated. In 1998, the South African Law Commission's Report on Euthanasia and the Artificial Preservation of Life (Project 86),⁶ which included a Draft Bill on the proposed End of Life Decisions Act, was presented to the Minister of Health. However, progress stalled when the Minister of Health turned her attention to the more pressing health concerns at the time, such as the HIV/AIDS epidemic.⁷ Nonetheless, many academics and independent organisations continued to work toward understanding the complex legal issues surrounding assisted dying, despite government's reluctance to engage further in the matter.

The issues surrounding assisted dying once again became the focus of public debate in South Africa in 2010 when Professor Sean Davison returned home from New Zealand where he was facing murder charges for helping his terminally ill mother to die.⁸ Then, once again, in 2015 when terminally ill Advocate Robin Stransham-Ford applied to the North Gauteng High Court,

⁴ Most of the moral, religious, philosophical, ethical and legal arguments that have been propounded over the centuries have been modified and absorbed into the modern debate. Accordingly, an examination of the most recent and relevant issues pertaining to euthanasia, end of life decisions and assisted dying provide a full understanding of the complex issues that have developed over centuries.

⁵ LB Grove (2008) *Framework for the Implementation of Euthanasia in South Africa* (LLM Thesis) Retrieved from University of Pretoria UPspace Institutional Repository 3-4.

⁶ SA Law Commission (SALC) Discussion Paper 71 *Euthanasia and the Artificial Preservation of Life* (1998) ("Project 86").

⁷ K Magardie 'Euthanasia not for SA' 2001 <http://mg.co.za/article/2001-04-12-euthanasia-not-for-sa>.

⁸ T Holmes 'Granting a Death Wish: South Africa's Euthanasia Debate' <http://mg.co.za/article/2013-03-28-00-granting-a-death-wish>.

seeking permission for a doctor to assist him in ending his life, without the risk of facing prosecution.⁹

This most recent development in the South African discourse pertaining to assisted dying, namely the *Stransham-Ford* case, was decided at a time of increased legal interest in assisted dying globally, with high profile cases being decided in Canada and New Zealand within the same year. In February 2015, the Supreme Court of Canada passed judgment in the landmark case of *Carter v Canada (Attorney-General)*¹⁰ and found in favour of the Applicant, granting her the right to an assisted death.¹¹ The Supreme Court of Canada established an influential judicial precedent and shifted the onus onto the government to promulgate legislation that will permit the practice of assisted dying in Canada. Shortly after judgement was handed down in the *Carter* case, the *Stransham-Ford* case appeared before the North Gauteng High Court and the judgment relied heavily on the precedent set by *Carter*. The Applicant was thus granted the right to a doctor-assisted death. The third case that received international attention following the decisions of *Carter* and *Stransham-Ford* was the New Zealand case of *Seales v Attorney-General*¹² in which the Wellington High Court denied terminally ill lawyer Lecretia Seales the right to end her life with the assistance of her doctor.¹³

These three cases have contributed greatly toward the global debate on euthanasia and assisted dying, however, once it has been determined whether there is a constitutional duty to provide for assisted dying, the responsibility will ultimately lie in the hands of the South African legislature to ensure that a secure legislative framework is enacted in order to regulate the practice of assisted dying and to ensure protection for all parties involved in the process of end of life care and assisted dying.

⁹ *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (4) SA 50 (GP).

¹⁰ *Carter v Canada (Attorney-General)* 2015 SCC 5.

¹¹ *Ibid* 147.

¹² *Seales v Attorney General* [2015] NZHC 1239.

¹³ *Ibid* 12-13.

1.2 Overview of thesis

This study considers the current South African position on assisted dying and related end of life matters, and argues that there is an unjustifiable infringement of the constitutionally protected rights to life, dignity and autonomy as a result of the prohibition on assisted dying. In order to remedy this limitation of rights, a proposed legislative framework shall be proposed for the purposes of establishing a permissive regime in which those who require and seek the assistance of a medical practitioner in order to end their lives are permitted to do so, while protecting the rights and interests of patients and medical practitioners alike.

Throughout the legal and philosophical debate, however, it is important to remember that the issues pertaining to euthanasia and assisted dying are presented for more than just theoretical consideration. There are real people suffering from incurable illnesses who have to endure intolerable pain and suffering and are victims in the current prohibitory regime. In a democratic South Africa, built on the ideals of freedom, dignity and equality for all, where the rights of all citizens should be respected and protected, it is submitted that no person should be made to suffer the indignity of a progressively degenerative illness when they have unequivocally expressed a clear and rational intention to end their own life, but require the assistance of a medical practitioner in order to do so.

Despite having to balance competing, and often conflicting, cultural beliefs and values, democratic South Africa has already made progressive and often controversial decisions that allow for the realisation of rights guaranteed by the Bill of Rights. Controversial issues such as same-sex marriages and abortions challenge the traditional and conservative values upheld by many cultural and religious groups in South Africa, however, carefully drafted legislative changes were made to allow for a permissive regime that ensures the protection and guarantee of rights enshrined in the Bill of Rights.¹⁴

¹⁴ The Choice on Termination of Pregnancy Act 92 of 1996 allows for the legal termination of pregnancy under controlled circumstances and conditions and the Civil Union Act 17 of 2006 was enacted following the case of *Minister of Home Affairs and Another v Fourie and Another* 2006 (1) SA 524 (CC) in which the Constitutional Court unanimously held that same-sex couples have the right to marry.

Similarly, assisted dying lies at the centre of a debate which requires sensitivity and respect for conflicting cultural practices and religious beliefs. The effect of the prohibition on assisted dying, however, has such severe implications for those who are denied a dignified existence that urgent reform is required in South Africa. Legislation must be enacted in order to ensure that those affected by the prohibition on assisted dying are afforded the right to retain control over their lives when stripped of dignity and autonomy as a result of an incurable terminal illness.

1.3 Terminology and definitions

In the discourse on assisted dying, there are numerous terms with subtle differences in their definitions that, when used interchangeably, cause confusion and blur the lines of debate. For the sake of clarity, the most important key terms relevant to the issues surrounding assisted dying have been defined below.

1.3.1 Euthanasia

‘Euthanasia’ is defined herein as the intentional ending of a life of suffering, usually by a doctor.¹⁵ It can be further defined as conduct that brings about an easy and painless death for persons suffering from an incurable or painful disease or condition.¹⁶ Euthanasia is usually performed by a doctor or healthcare professional, but when the act is performed by a loved one, it is usually referred to as ‘mercy killing’.¹⁷ When referring to ‘euthanasia’ in general terms, there is no specific form of conduct implied, thus, the actual act of ‘euthanasia’ may take on various forms.

Under the broad umbrella of euthanasia, there are further distinctions that can be drawn between different forms of euthanasia such as ‘active’ and ‘passive’ euthanasia and ‘voluntary’, ‘involuntary’ and ‘non-voluntary’ euthanasia.

¹⁵ R Huxtable *All That Matters: Euthanasia* 1 ed (2013) 5.

¹⁶ DJJ Muckart *et al* ‘Palliative Care: Definition of Euthanasia’ (2014) 104 *SAMJ* 259.

DJ McQuoid-Mason ‘Emergency Medical treatment and ‘do not resuscitate’ orders: when can they be used?’ (2013) 103 *SAMJ* 223-225.

¹⁷ Huxtable (note 15 above) 5.

1.3.2 Active Euthanasia

‘Active euthanasia’ is used herein to denote a form of conduct that requires some ‘positive act’ to be performed with the intention to kill the person suffering from an incurable disease.¹⁸ Such an act could include administering a lethal dose of medication to a patient in order to end their life. Active euthanasia, however, fulfils the legal criteria for murder in South Africa, as there is intent, causation, a human victim and an unlawful act.¹⁹ Even if the person performing an act of active euthanasia has noble intentions to relieve the suffering of another person, the motive behind the act is immaterial²⁰ and does not change the fact that the killing was intentional and is thus considered murder.²¹

1.3.3 Passive Euthanasia

‘Passive euthanasia’, on the other hand, refers herein to the withholding of medical treatment or withdrawal of previously administered life-sustaining measures when treatment appears non-beneficial or futile.²² Although South African courts have held that instances of passive euthanasia are legal,²³ there is much contention around this point. The death of a patient is a foreseeable consequence of passive euthanasia, so if a person persists in their conduct and causes the death of the patient, it can be argued that they acted with intention in the form of *dolus eventualis*.²⁴ What saves a doctor from facing criminal liability, however, is that the element of ‘unlawfulness’ in the definition of murder²⁵ is not fulfilled and there appears to be a difference between intentional killing and merely allowing a person to die. It has been argued that in instances of passive euthanasia, the patient’s death is caused directly by the underlying disease or

¹⁸ Huxtable (note 15 above) 5.

¹⁹ Muckart *et al* (note 16 above) 259.

²⁰ CR Snyman *Criminal Law* 5 ed (2008) 190.

²¹ JM Burchell *South African Criminal Law and Procedure. Volume 1, General Principles of Criminal Law* 3 ed (1997) 225.

²² DJJ Muckart *et al* (note 16 above) 259.

²³ *Clarke v Hurst NO* 1992 (4) SA 630 (D).

²⁴ *Stransham-Ford* (note 9 above) 21.1.

²⁵ Murder is defined as the unlawful, intentional causing of the death of another person. See Snyman (note 20 above) 447.

terminal illness and only indirectly as a result of the withdrawal of life-sustaining measures.²⁶ Therefore, a doctor who withdraws life-sustaining treatment does not cause the patient's death but merely allows the patient to die.²⁷ Despite the legality of passive euthanasia being somewhat arguable, it is currently in line with South African law.

1.3.4 Voluntary euthanasia

'Voluntary euthanasia' herein refers to conduct that is performed at the request of the person to be euthanized in fulfilment of their informed wish to die if the person is a competent individual who has expressed their wishes personally or through a valid, written advance directive.²⁸

1.3.5 Involuntary Euthanasia

'Involuntary euthanasia' herein refers to euthanasia that is performed contrary to the wishes expressed by a competent person who has either not requested the euthanasia or perhaps objected outright thereto. The act of killing is therefore performed against the real and informed wishes of the patient.²⁹

1.3.6 Non-Voluntary Euthanasia

'Non-voluntary euthanasia' refers herein to instances where a person is unable to give or deny their consent and, as a result, the wishes of the person to be euthanized are unknown or unascertainable.³⁰ Non-voluntary euthanasia could be applied to cases where the person is in a coma, is too young or lacks mental capacity through brain damage, Alzheimer's or dementia.³¹

²⁶ D McQuoid-Mason 'Withholding or withdrawing treatment and palliative treatment hastening death: The real reason why doctors are not held legally liable for murder' (2014) 104 *SAMJ* 102.

²⁷ End of Life Care: An Ethical Overview, Center for Bioethics, University of Minnesota (2005) 40 accessed at: http://www.ahc.umn.edu/img/assets/26104/End_of_Life.pdf

²⁸ P Carstens *Legal Aspects Relating to Euthanasia and the Moment of Death in South African Medical Law: Some Reflections*.

²⁹ Grove (note 5 above) 9.

³⁰ Ibid.

³¹ BBC *Should Euthanasia or Physician-Assisted Suicide be Legal?* 20 August 2007 accessed online at <http://euthanasia.procon.org/view.answers.php?questionID=000145>

Therefore, one can see that for the sake of clarity in the law, it is unwise to use the term ‘euthanasia’ in a general sense, as one could be referring to a multitude of different scenarios, each with different legal consequences. If one wanted to refer to a situation in which a terminally ill patient is physically unable to end his/her own life and thus requests a doctor to perform an act³² that would end that patient’s life, one should use the term ‘voluntary active euthanasia’. When referring to a patient’s request to remove life-sustaining measures such as a feeding tube, one would use the term ‘voluntary passive euthanasia’.

1.3.7 Doctor-Assisted Suicide

As can be seen in the definitions above, euthanasia, in all its forms, requires the person performing the euthanasia (ie the doctor or healthcare professional) to administer the lethal agent or physically perform the act that ends the life of the patient him/herself. Direct participation on the part of the doctor in the death of the patient is required in order for the act to be considered euthanasia.

The degree of participation by the doctor is essential in differentiating between euthanasia and doctor-assisted suicide. ‘Doctor-assisted suicide’ and ‘physician-assisted suicide’ are terms that can be used interchangeably, however, one cannot use the terms ‘euthanasia’ and ‘doctor-assisted suicide’ interchangeably.

‘Doctor-assisted suicide’ thus differs from euthanasia in that the final, fatal act is performed by the suffering patient him/herself, and the act was merely facilitated by the assistance of a doctor.³³ An example of doctor-assisted suicide would be where a patient requests assistance in ending their own life and the doctor facilitates this request by making the requisite medication available to the patient, but the patient administers the medication him/herself and essentially take his/her own life. Should the doctor intervene and physically assist the patient to ingest the medication or administer the lethal agent, it is no longer an act of assisted suicide, but would be

³² Such an act could be injecting the patient with a lethal dose of opioid medication.

³³ Assisted suicide in the general sense could include assistance from any person, not necessarily a doctor. In South Africa, both assisted suicide and doctor-assisted suicide remain criminal offences.

considered euthanasia. The degree of participation by the doctor in facilitating the death of the patient becomes an important factor to consider when contemplating legislative safeguards.

The following example illustrates the importance of correctly determining the degree of participation by the doctor and the difference between euthanasia and doctor-assisted suicide. If a terminally ill patient experiences paralysis and loses control over basic bodily functions such as the ability to swallow, that person may be physically unable to ingest any lethal medication on his or her own. If doctor-assisted suicide, not euthanasia, was a legal practice, there would be no legal course of action that the aforementioned patient could take in order to end his/her own life. If legislation is enacted that includes such stringent safeguards that a patient has to end his/her life on his/her own (albeit enabled and facilitated by a doctor), many terminally ill patients with diminished physical capabilities would be excluded from the operation of the legislation. This will be discussed further under the analysis of proposed legislation.

1.3.8 Assisted Dying

When referring to both euthanasia and doctor-assisted dying in a broad sense, the term ‘assisted dying’ is used. ‘Assisted dying’ is used herein to refer to situations in which a patient wishes to end his/her life and requires the assistance of a doctor, physician or medical practitioner in order to do so. The degree of participation by the doctor is not relevant in ‘assisted dying’, so long as the doctor plays some role in bringing about the death of a patient who could not do so on his/her own.

It should, however, be noted that not all academics agree on the distinction between euthanasia and doctor-assisted suicide. Some academics argue that euthanasia and doctor-assisted suicide have so much in common that there can be no meaningful distinction between the two concepts.³⁴ Moreover, the Project 86 Report commented on the distinction between assisted suicide and euthanasia, asserting the proposition that in both instances, the person to whom the request is directed performs the act with the intention to cause death.³⁵

³⁴ Grove (note 5 above) 52.

³⁵ Project 86 (note 6 above) 4.108.

The SA Law Commission further asserted in the Project 86 Report that there is general consensus among commentators that there is ‘no intrinsic moral difference’³⁶ between doctor-assisted suicide and euthanasia, as both instances the patient gives informed consent to obtain the assistance of another to achieve the same outcome.³⁷ It was, however, conceded that there is an ‘important evidentiary difference’ between euthanasia and doctor-assisted suicide.³⁸ It was submitted that this distinction could have significant value in practice, as assisted suicide is a better test for the voluntariness of the choice to die or of the patient’s resolve to end his or her life.³⁹

The ultimate conclusion reached in the Project 86 Report on the distinction between euthanasia and doctor-assisted suicide was that both instances are, legally speaking, versions of active euthanasia and should be treated accordingly.⁴⁰ The only distinction drawn in the Report was between active euthanasia (encompassing both assisted suicide and euthanasia) and passive euthanasia, ie the cessation of medical treatment.⁴¹

For the purposes of this study, however, the distinction between euthanasia and doctor-assisted suicide will be maintained. As mentioned above, the term ‘assisted dying’ will be used to refer to both euthanasia and doctor-assisted suicide collectively wherever relevant.

1.3.9 Patient autonomy

Another concept worthy of clarification is the concept of patient autonomy. Respect for autonomy is one of the fundamental principles of health care⁴² and was introduced into South African law in the 1967 case of *Richter and another v Estate Hammann*⁴³ and secured in *Castell*

³⁶ Ibid.

³⁷ Ibid.

³⁸ Submission from Prof S Benatar and members of the UCT Bio-ethics Centre: David Benatar, Raymond Abratt, Lesley Henly, Mark Mason, Lance Michell, Eleanor Nash, Augustine Shutte and JP de V van Niekerk in Project 86 (note 6 above) 80.

³⁹ Submission by Dr W Landman in Project 86 Report (note 6 above) 80.

⁴⁰ Project 86 (note 6 above) 4.108.

⁴¹ Ibid 79.

⁴² End of Life Care: An Ethical Overview, Center for Bioethics, University of Minnesota (2005) 55. Accessed at http://www.ahc.umn.edu/img/assets/26104/End_of_Life.pdf

⁴³ *Richter and another v Estate Hammann* 1967 (3) SA 226 (C).

v De Greef.⁴⁴ In the context of medical decision-making, the concept of patient autonomy protects the patient's right to self-determination, informed consent and the right to make informed decisions without undue influence from the medical professional.⁴⁵ The 'best interests' of a patient cannot prevail over the patient's autonomy and self-determination.⁴⁶ These principles are all founded on the notion of respect for the right to bodily and psychological integrity and the right to security and control of one's body, as found in s12 of the 1996 Constitution.⁴⁷ Respect for patient autonomy and self-determination is an important concept that is central to many of the arguments in favour of legalising assisted dying.

Despite conflicting academic opinions as to the necessity of maintaining nuanced distinctions between the abovementioned concepts, the concepts delineated above remain central to the debate surrounding assisted dying both globally and within South Africa.

In order to give context to the abovementioned concepts and to highlight the relevance of the debate, it is helpful to look at recent cases that have grappled with issues pertaining to assisted dying. Through an analysis of this case law, it becomes evident why there is a need to keep the assisted dying debate alive and to keep working toward perfecting a permissive regime wherein the rights of all parties concerned will be respected and protected.

⁴⁴ *Castell v De Greef* 1994 (4) SA 408 (C).

⁴⁵ H Manyonga *et al* 'From informed consent to shared decision-making' (2014) 104 *SAMJ* 356.

⁴⁶ *Castell v de Greef* (note 44 above) 420J, 421 C-D, 427 D-E.

⁴⁷ R Britz & A le Roux-Kemp 'Voluntary informed consent and good clinical practice for clinical research in South Africa: ethical and legal perspectives' (2012) 102 *SAMJ* 746.

CHAPTER 2: RECENT LEGAL DEVELOPMENTS IN ASSISTED DYING

In 2015, three influential landmark judgments that dealt with requests for assisted deaths were handed down in Canada, South Africa and New Zealand in 2015. Each of the cases heard requests from terminally ill, mentally competent adults who sought permission for doctor-assisted deaths in order to die with dignity and prevent unbearable suffering. The cases all approached the issue of determining whether the request for an assisted death should be granted from a rights-based perspective, by determining whether the prohibition on assisted dying constitutes an unjustifiable infringement of constitutionally protected rights.

Although Canada and South Africa found in favour of the applicants and granted permission for assisted dying, New Zealand upheld the prohibition on assisted dying and denied the applicant the right to a doctor-assisted death. Although the cases have not signified a major change in legal thought globally on the matter of assisted dying, the rights-based analysis provides new insight into the assisted dying debate and indicates that there has been a gradual shift in thinking when it comes to matters concerning assisted dying. These cases are central to this study as the rights-based analysis is particularly relevant in a South African context and will be of great value to the Constitutional Court, should the matter of assisted dying reach the highest court in South Africa.

The cases shall be discussed in chronological order below as they serve as the point of departure for case analysis, and provide solid judicial precedent by representing the most recent legal developments in the debate surrounding assisted dying on request.

2.1 Carter v Canada (Attorney-General) 2015 SCC 5

On 6 February 2015, the Supreme Court of Canada handed down judgment in the case of *Carter v Canada (Attorney-General)*, a case on appeal from the British Columbia Court of Appeal, in which the prohibition of assisted suicide was challenged as being contrary to the Canadian Charter of Rights and Freedoms.

2.1.1 Background

The *Carter* case was preceded by a long period of suffering for the applicant which began in 2009 when Gloria Taylor was diagnosed with amyotrophic lateral sclerosis (ALS), a progressive muscular degenerative disease which results in a loss of the ability to perform basic bodily functions such as speaking, walking, chewing, swallowing and, eventually, the ability to breathe.⁴⁸ Gloria Taylor launched an application to challenge the constitutionality of the Canadian Criminal Code provisions that prohibited her from obtaining assistance in dying.⁴⁹ Joining Taylor in her claim were Hollis Johnson and Lee Carter who had previously assisted Carter's mother to die a dignified death by travelling with her to the assisted suicide clinic, Dignitas, in Switzerland.⁵⁰ These parties were also joined by Dr William Shoichet, a Canadian physician willing to offer his services in physician-assisted dying, should the practice no longer be prohibited.⁵¹ The British Columbia Civil Liberties Association (BCCLA) also joined as party to the claim, as the BCCLA advocates for education regarding end of life choices, including assisted suicide and has an interest in health policies and the rights of patients.⁵²

Gloria Taylor endured much pain and suffering as her physical condition deteriorated, rendering her dependent on assistance for basic daily tasks which Taylor described as 'an assault on her privacy, dignity and self-esteem.'⁵³ Taylor expressed her wishes to her family and friends and stated that she did not want to 'live in a bedridden state, stripped of dignity and independence.'⁵⁴

Taylor explained her wish for a physician-assisted death as follows:

⁴⁸ *Carter* (note 10 above) 11.

⁴⁹ Specific provisions of the Criminal Code that were challenged included: s14, s21, s22, s222 and s241.

⁵⁰ At Dignitas in Switzerland, Kathleen Carter was able to take the prescribed dose of sodium pentobarbital which caused her to die within 20 minutes, in the company of her loved ones. Dignitas is a Swiss non-profit organisation that advocates for self-determination, autonomy and dignity through education and support for the improvement of care and choice in life, particularly at the end of life. Dignitas allows its members who are suffering from illnesses which will inevitably lead to death to request an accompanied suicide and, provided all the correct procedures have been followed, Dignitas will assist its members to die in a dignified manner. <http://www.dignitas.ch/?lang=en>

⁵¹ *Carter* (note 10 above) 11.

⁵² *Ibid.*

⁵³ *Ibid* 12.

⁵⁴ *Ibid.*

I do not want my life to end violently. I do not want my mode of death to be traumatic for my family members. I want the legal right to die peacefully, at the time of my choosing, in the embrace of my family and friends.

I know that I am dying, but I am far from depressed. I have some down time - that is part and parcel of the experience of knowing that you are terminal. But there is still a lot of good in my life; there are still things, like special times with my granddaughter and family, that bring me extreme joy. I will not waste any of my remaining time being depressed. I intend to get every bit of happiness I can wring from what is left of my life so long as it remains a life of quality; but I do not want to live a life without quality. There will come a point when I will know that enough is enough. I cannot say precisely when that time will be. It is not a question of 'when I can't walk' or 'when I can't talk'. There is no pre-set trigger moment. I know that, globally, there will be some point in time when I will be able to say - 'this is it, this is the point where life is just not worthwhile'. When that time comes, I want to be able to call my family together, tell them of my decision, say a dignified goodbye and obtain final closure - for me and for them.

My present quality of life is impaired by the fact that I am unable to say for certain that I will have the right to ask for physician-assisted dying when that 'enough is enough' moment arrives. I live in apprehension that my death will be slow, difficult, unpleasant, painful, undignified and inconsistent with the values and principles I have tried to live by.

What I fear is a death that negates, as opposed to concludes, my life. I do not want to die slowly, piece by piece. I do not want to waste away unconscious in a hospital bed. I do not want to die wracked with pain.⁵⁵

A lack of funding prevented Taylor from travelling to Dignitas, consequently Taylor found herself facing the cruel choice of whether to kill herself while she was still physically able to do so, thereby ending her life prematurely, or giving up any degree of control she could have over the manner and timing of her death at a later stage due to the progression of her illness.

⁵⁵ *Carter* (note 10 above) 12.

2.1.2 Statutory Provisions: Canadian Criminal Code

As a result of this predicament, the appellants challenged the constitutionality of the following provisions of the Canadian Criminal Code:

- s14: No person is entitled to consent to have death inflicted on him and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.
- s21: (1)(b) Everyone is a party to an offence who does or omits to do anything for the purpose of aiding any person to commit it; or
(2) Where two or more persons form an intention in common to carry out an unlawful purpose and to assist each other therein and any one of them, in carrying out the common purpose, commits an offence, each of them who knew or ought to have known that the commission of the offence would be a probable consequence of carrying out the common purpose is a party to that offence.
- s22: (1) Where a person counsels another person to be a party to an offence and that other person is afterwards a party to that offence, the person who counselled is a party to that offence, notwithstanding that the offence was committed in a way different from that which was counselled.
(2) Everyone who counsels another person to be a party to an offence is a party to every offence that the other commits in consequence of the counselling that the person who counselled knew or ought to have known was likely to be committed in consequence of the counselling.
(3) For the purposes of this Act, 'counsel' includes procure, solicit or incite.
- s222: (1) A person commits a homicide when, directly or indirectly, by any means, he causes the death of a human being.
(2) Homicide is culpable or not culpable.
(3) Homicide that is not culpable is not an offence.
(4) Culpable homicide is murder or manslaughter or infanticide.
(5) A person commits culpable homicide when he causes the death of a human being (a) by means of an unlawful act; ...

- s241: Everyone who
- (a) counsels a person to commit suicide, or
 - (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

The Supreme Court of Canada was of the view that s241 and s14 formed the core of the constitutional challenge, as those were the two main provisions that ultimately prohibited the provision of assistance in dying.⁵⁶ The other provisions mentioned above, sections 21, 22 and 222, would only be engaged as long as assisted dying remains an ‘unlawful act’ or an offence.⁵⁷ It should be noted that although s241(a) did not directly contribute to the prohibition on assisted suicide, it was still included as one of the statutory provisions being challenged.

2.1.3 Constitutional Rights: Canadian Charter of Rights and Freedoms

Having examined the statutory provisions of the Canadian Criminal Code that were being challenged, the Court touched on the three main provisions of the Canadian Charter of Rights and Freedoms that were of relevance in the matter, namely:

- s1: The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.
- s7: Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
- s15(1): Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

⁵⁶ *Carter* (note 10 above) 20.

⁵⁷ *Ibid.*

2.1.4 Judicial History: British Columbia Supreme Court [2012 BCSC 886, 287 C.C.C (3d) 1]

The Supreme Court of Canada traced the judicial history of the matter, starting with the action that came before the British Columbia Supreme Court in 2012.⁵⁸ In the court *a quo*, the trial judge examined extensive evidence from Canada (as well as evidence from other permissive jurisdictions) on medical ethics and the then relevant 'end-of-life' practices.⁵⁹ The court *a quo* considered the associated risks as well as the feasibility of implementing safeguards to combat the risks that arise from permitting assisted suicide.

An interesting finding made by the court *a quo*, based on the evidence of ethicists, was that there is 'no ethical distinction between physician-assisted death and the other end-of-life practices whose outcome is highly likely to be death.'⁶⁰ These end-of-life practices include palliative sedation and the withholding or withdrawing of life-sustaining medical treatment.⁶¹ The trial court found further that, despite a lack of formal societal consensus on the matter of physician-assisted dying, there was strong consensus that it would only be ethical to respect voluntary adults who are 'competent, informed, grievously and irremediably ill'⁶² and where the assistance would be 'clearly consistent with the patient's wishes and best interests',⁶³ and provided for the purpose of relieving suffering.⁶⁴

The trial judge then examined evidence from other jurisdictions that currently permit doctor-assisted death, such as the state of Oregon in the USA, Belgium and the Netherlands. The court reviewed the safeguards that had been implemented in each jurisdiction as well as the effectiveness of each regulatory regime. It was concluded that although none of the other jurisdictions had achieved a perfect regime, there had been general compliance with regulations and evidence indicated that a system could be designed and implemented to ensure protection for the vulnerable in society.⁶⁵ Moreover, this finding was supported by experienced empirical

⁵⁸ *Carter v Canada (Attorney General)* 2012 BCSC 886.

⁵⁹ *Carter* (note 10 above) 22.

⁶⁰ *Carter* (note 58 above) 335.

⁶¹ *Ibid.*

⁶² *Carter* (note 10 above) 24.

⁶³ *Carter* (note 58 above) 358.

⁶⁴ *Ibid.*

⁶⁵ *Carter* (note 58 above) 685.

researchers and practitioners who concurred that safeguards can operate effectively to protect patients from abuse, while still affording competent patients the right to control the timing of their deaths.⁶⁶

Having assessed evidence pertaining to the implementation and effectiveness of safeguards and regulatory regimes from other jurisdictions, the trial judge paid careful consideration to the risks arising from permissive regimes and the feasibility of implementing effective safeguards. The trial judge reached the conclusion that doctors are capable of reliably assessing the competence of a patient who requests an assisted death, and that it is possible for a doctor to detect ‘coercion, undue influence and ambivalence’⁶⁷ during an examination of the patient.

Further evidence of physicians and experts in patient assessments was examined and the trial judge found that the ‘informed consent standard could be applied in the context of doctor-assisted dying,’⁶⁸ provided that care is taken to ensure a patient is ‘properly informed of his diagnosis and prognosis’, and that the treatment options presented to the patient include all reasonable palliative care options and interventions that are available to the patient.⁶⁹

The trial judge ultimately concluded that the risks associated with a doctor-assisted death can be identified and substantially minimised by means of a ‘carefully designed system’⁷⁰ with strict limitations that are meticulously monitored and enforced.

2.1.4.1 Trial Judge’s Charter Analysis: s15

The trial judge then proceeded with an analysis of the relevant provisions of the Canadian Charter of Rights and Freedoms. The first issue addressed by the trial judge was whether the prohibition on doctor-assisted dying violates the equality guarantee enshrined in s15 of the Charter. In summary, it was found that persons with physical disabilities, including those suffering from terminal illnesses, are subject to a disproportionate burden, as they are often

⁶⁶ Ibid.

⁶⁷ *Carter* (note 58 above) 815 and 843.

⁶⁸ *Carter* (note 10 above) 27.

⁶⁹ Ibid.

⁷⁰ Ibid.

restricted to embarking on hunger strikes and self-imposed dehydration as methods by which they can end their own lives.⁷¹ This was found to be a discriminatory distinction and could not be justified under s1 of the Charter which allows for the reasonable limitation of rights.⁷²

Despite the broad objective of the prohibition on assisted dying being ‘to protect the vulnerable from being induced to commit suicide at a time of weakness,’⁷³ the trial judge found that Parliament’s objectives could equally be achieved by a 'stringently limited, carefully monitored system of exceptions.'⁷⁴

Permission for physician-assisted death for grievously ill and irremediably suffering people who are competent, fully informed, non-ambivalent, and free from coercion or duress, with stringent and well-enforced safeguards, could achieve that objective in a real and substantial way.⁷⁵

2.1.4.2 Trial Judge’s Charter Analysis: s7

In an analysis of s7 of the Canadian Charter, the trial judge found that all three of the core elements of s7 (namely: life, liberty and security of the person) were impacted by the prohibition on doctor-assisted dying.⁷⁶ When looking at the first element of s7, the right to life, the argument of a qualitative approach to life was rejected and the trial judge found that a person’s right to life will only be engaged by a threat of death.⁷⁷ It was concluded, however, that a person’s right to life will be engaged when the prohibition on doctor-assisted death forces one to take one’s own life earlier than one otherwise would have if one were permitted to request a doctor-assisted death.

⁷¹ *Carter* (note 58 above) 1076.

⁷² *Carter* (note 10 above) 29.

⁷³ *Carter* (note 10 above) 101.

⁷⁴ *Ibid.*

⁷⁵ *Carter* (note 58 above) 1243.

⁷⁶ *Carter* (note 10 above) 30.

⁷⁷ *Carter* (note 58 above) 1322.

In looking at the second core element of s7, liberty, the trial judge found that a deprivation of liberty (encompassing the right to ‘non-interference by the state in fundamentally important and personal medical decision-making’⁷⁸) is caused by the prohibition on doctor-assisted dying.⁷⁹

With regard to the third core element of s7, security of the person, it was found in the court *a quo* that the prohibition on doctor-assisted death affected Taylor’s security of the person, as it restricted her control of bodily integrity.⁸⁰

The trial judge therefore concluded that the deprivation of Taylor’s s7 rights was not in line with the principles of fundamental justice (more specifically, over-breadth and gross disproportionality)⁸¹ and thus found that neither the infringement of s15 rights, nor the infringement of s7 rights could be justified in terms of s1 of the Charter.⁸²

The trial judge ultimately declared the prohibition on doctor-assisted death unconstitutional and granted a one-year suspension of validity, providing Gloria Taylor with a constitutional exemption for use during the period of suspension. Taylor, however, died before the matter went on appeal without accessing the constitutional exemption granted to her by the trial judge.⁸³

2.1.5 Judicial History: British Columbia Court of Appeal [2013 BCCA 435, 51 B.C.L.R (5th) 213]

The decision of the trial judge was challenged by the Crown and taken on appeal to the British Columbia Court of Appeal⁸⁴ on the grounds that the trial judge was bound to follow the Supreme Court of Canada’s decision in the earlier case of *Rodriguez*.⁸⁵

⁷⁸ *Carter* (note 58 above) 1302.

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ *Carter* (note 10 above) 31.

⁸² Although South African jurisprudence does not use the same terminology, there are fundamental similarities between the reasoning followed by the trial judge and the South African limitation of rights enquiry. These similarities shall be explored in greater detail under the analysis of the limitation of rights below.

⁸³ *Ibid.* 32.

⁸⁴ *British Columbia Court of Appeal, 2013 BCCA 435, 51 B.C.L.R (5th) 213.*

⁸⁵ *Rodriguez v British Columbia (Attorney General)* [1993] 3 S.C.R 519.

Sue Rodriguez was diagnosed with ALS in 1992 and was informed that her condition was rapidly deteriorating. With a short life-expectancy and knowledge of the symptoms of her condition, Rodriguez wanted to control the ‘circumstances, timing and manner of her death’⁸⁶ and thus sought an order to allow her to end her own life with the assistance of a qualified medical practitioner.⁸⁷ Rodriguez applied for an order to declare s241(b) of the Canadian Criminal Code invalid, pursuant to s24(1) of the Canadian Charter of Rights and Freedoms, on the basis that her rights in terms of sections 7, 12 and 15(1) of the Charter were violated. The Supreme Court of Canada, however, upheld the relevant provisions in the Criminal Code and denied Rodriguez the right to an assisted death.

Despite substantial factual similarities between *Rodriguez* and *Carter*, the majority of the British Columbia Court of Appeal read *Rodriguez* as a rejection of the notion that the prohibition on assisted dying infringes a person’s right to life in terms of s7 of the Charter.⁸⁸ Moreover, it was held that the principles of fundamental justice that were introduced subsequent to the *Rodriguez* decision (namely over-breadth and gross disproportionality) did not create a new legal framework under s7 and the majority of the Court of Appeal found that the outcome would not have changed.⁸⁹

In the *Rodriguez* decision, it was held that the prohibition on physician-assisted suicide deprived the appellant of her security of the person, in a manner consistent with the principles of fundamental justice, and further, that the appellant’s s15 rights were also violated but this limitation was justified in terms of s1 of the Charter.⁹⁰

The majority of the British Columbia Court of Appeal in the *Carter* judgment noted that the s15 equality argument was disposed of in *Rodriguez*, and the Court of Appeal ultimately concluded that ‘the trial judge was bound to find that the plaintiff’s case had been authoritatively decided by *Rodriguez*.’⁹¹

⁸⁶ Ibid 1.

⁸⁷ Ibid.

⁸⁸ *Carter* (note 10 above) 35.

⁸⁹ Ibid.

⁹⁰ Ibid 42.

⁹¹ *Carter* (note 10 above) 324.

The main issue raised in the *Carter* appeal was whether s241(b)⁹² of the Canadian Criminal Code (which expressly prohibits physician-assisted dying)⁹³ violated Gloria Taylor’s rights under s7 and s15 of the Charter.⁹⁴ Two claims were advanced by the appellants, first, that competent adults are deprived of their right to life, liberty and security of the person in terms of s7 of the Charter when grievous and irremediable medical conditions cause them to endure intolerable physical or psychological suffering. The second claim advanced by the appellants was that physically disabled adults are deprived of their right to equal treatment under s15 of the Charter as a result of the prohibition.

Before analysing the abovementioned claims under the Charter provisions, there were two preliminary issues to be dealt with: (i) whether the Supreme Court of Canada’s decision in *Rodriguez* could be revisited, and (ii) whether the prohibition falls beyond the scope of Parliament’s power.⁹⁵

Although the doctrine of *stare decisis* is a fundamental legal principle, it is not absolute and a trial court may reconsider the findings of a higher court under two circumstances: first, when a new legal issue is raised and second, where there is a ‘change in the circumstances or evidence that fundamentally shifts the parameters of the debate.’⁹⁶ Both of these circumstances were seen to be fulfilled in the present case, as there had been changes in the legal framework pertaining to s7 and new evidence was presented on combatting the risks that arise in relation to assisted suicide.⁹⁷

⁹² 241(b) Everyone who aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

⁹³ The appellants used the terms ‘physician-assisted death’ and ‘physician-assisted dying’ in a context where a physician provides or administers medication that intentionally brings about the patient’s death, at the request of the patient.

⁹⁴ *Carter* (note 10 above) 40.

⁹⁵ *Carter* (note 10 above) 41.

⁹⁶ *Canada (Attorney-General) v Bedford* 2013 SCC 72, [2013] 3 S.C.R. 1101 42.

⁹⁷ Since the *Rodriguez* decision in 1993, there had been material advancements in the law relating to principles of fundamental justice, such as overbreadth and gross disproportionality. Previously, the principle of overbreadth sought to identify whether the prohibition was “arbitrary or unfair in that it is unrelated to the state’s interest in protecting the vulnerable and that it lacks a foundation in the legal tradition and societal beliefs which are said to be represented by the prohibition.” The law has subsequently developed and now the principle of overbreadth asks whether the law interferes with conduct that has no connection to the objectives of the law (*Bedford* 101). The majority of the Supreme Court of Canada did not even consider whether the prohibition was grossly disproportionate.

The evidence before the Court in *Rodriguez* was based on three pillars: (i) the ‘widespread acceptance of a moral or ethical distinction between active and passive euthanasia;’⁹⁸ (ii) the lack of viable alternative measures to protect the vulnerable (‘halfway measures’)⁹⁹ and (iii) the ‘substantial consensus in Western countries’¹⁰⁰ that a blanket prohibition against assisted dying should be implemented to guard against the ‘slippery slope.’¹⁰¹ The trial judge, however, had evidence on record that was able to undermine each of these three conclusions.

2.1.6 Analysis of s7: Does the Law Infringe the Right to Life, Liberty and Security of the Person?

Having traced the judicial history of the matter, the Supreme Court of Canada then proceeded to analyse s7 of the Charter and explained the two stage enquiry used to demonstrate a violation of the rights contained in the Charter. First, one must establish that the right has been engaged by showing that the law interferes with, or deprives one of their life, liberty or security of the person. Once it has been established that s7 has been engaged, it must then be shown that the interference with or deprivation of rights is incongruent with the principles of fundamental justice, namely arbitrariness, over-breadth, gross disproportionality and parity.¹⁰²

2.1.6.1 Life

Each of the three core components of s7, namely life, liberty and security of the person were analysed in turn, starting with the right to life. The Court declined to interfere with the trial judge’s conclusion that the prohibition on doctor-assisted death effectively forced some individuals to commit suicide prematurely (fearing that they would be physically incapable of

⁹⁸ *Rodriguez* (note 85 above) 605-607.

⁹⁹ *Rodriguez* (note 85 above) 613-614.

¹⁰⁰ *Ibid* 601-606 and 613.

¹⁰¹ *Rodriguez* (note 85 above) 601-6 and 613.

Carter (note 10 above) 47.

The slippery slope argument is one of the most common arguments raised by those who oppose legalised assisted dying. It is argued that if assisted dying is permitted, then society will be lead down a slippery slope to permitting other actions that are morally wrong, such as extending the range of cases in which assisted dying is permitted or allowing people to commit murder and justify their actions under the guise of involuntary euthanasia or simply euthanasia lacking consent. The slippery slope argument is complex and shall be elucidated under the limitation of rights enquiry.

¹⁰² This two stage approach to the limitation of rights in Canadian jurisprudence has influenced the development of the South African jurisprudence pertaining to the limitation of rights, as South Africa also follows a similar two stage approach, as shall be discussed in further detail in Chapter 3.

ending their lives themselves upon reaching a point of intolerable suffering), and that this engaged one's right to life under s7 of the Charter.¹⁰³ This finding established that the prohibition effectively deprives some individuals of life¹⁰⁴, and thus engages the right to life in s7 of the Charter.

The argument for a qualitative approach to the right to life¹⁰⁵ was raised by the appellants. The trial judge had rejected this qualitative approach to the right to life and held that the right to life is only engaged when there is a 'threat of death as a result of government action or laws'¹⁰⁶, and that the right to life is limited to a right 'not to die.'¹⁰⁷ The qualitative approach to the right to life was supported in dissenting judgments by Finch CJBC in the Court of Appeal and by Cory J in *Rodriguez*.¹⁰⁸

The Supreme Court of Canada stated that 'the sanctity of life is one of the most fundamental societal values'¹⁰⁹ but further noted that 's7 is rooted in a profound respect for the value of human life'¹¹⁰, and that s7 also encompasses life, liberty and security of the person during the passage to death. The Court thus concurred with the finding in *Rodriguez*, that the sanctity of life 'is no longer seen to require that all human life be preserved at all costs.'¹¹¹ It was therefore concluded that, in certain circumstances, one's choice regarding the end of one's life is a choice that is entitled to respect.¹¹²

¹⁰³ *Carter* (note 10 above) 57-58.

¹⁰⁴ *Ibid*.

¹⁰⁵ It was argued that the right to life encompasses more than just the mere preservation of life. The right to life, as argued by the appellants, protects personal autonomy and the notions of self-determination and dignity. It was argued that the right to determine whether or not to take one's own life is included in the right to life.

¹⁰⁶ *Carter* (note 10 above) 61.

¹⁰⁷ *Carter* (note 58 above) para 1322.

¹⁰⁸ In a dissenting judgment at the British Columbia Court of Appeal, Finch CJBC accepted the argument that the right to life protects more than just one's physical existence, expressing the view that: 'the life interest is intimately connected to the way a person values his or her lived experience.' It was stated that the meaning of life is lost at the point when life's positive attributes have diminished to such an extent that life is rendered valueless. Moreover, in a dissenting judgment of Cory J in *Rodriguez*, it was accepted that the right to life includes a right to die with dignity on the basis that dying is an integral part of living.

¹⁰⁹ *Carter* (note 10 above) para 63.

¹¹⁰ *Ibid*.

¹¹¹ *Rodriguez* (note 85 above) 595.

¹¹² *Carter* (note 10 above) para 63.

2.1.6.2 Liberty and Security of the Person

The Court then turned its focus to the other fundamental components of s7, namely: liberty and security of the person.¹¹³ It was held that there is ‘concern for the protection of individual autonomy and dignity’¹¹⁴ underpinning the rights to liberty and security of the person, as ‘liberty’ protects the right to ‘make fundamental personal choices, free from state interference’¹¹⁵ and ‘security of the person’ encompasses ‘a notion of personal autonomy involving... control over one’s bodily integrity free from state interference.’¹¹⁶

The Court examined (and agreed with) the trial judge’s conclusion that Gloria Taylor’s right to liberty and security of the person was limited by the prohibition on doctor-assisted dying, as it interfered with ‘fundamentally important and personal medical decision-making’¹¹⁷, and deprived her of control over her bodily integrity through the imposition of pain and psychological stress.¹¹⁸ Moreover the prohibition on doctor-assisted death impinged on Taylor’s security of the person by imposing stress, physical suffering and psychological pain upon her.¹¹⁹ The trial judge had further noted that persons who are ‘seriously and irremediably ill’¹²⁰ are unable to make a choice that is integral to one’s sense of dignity and personal integrity and that is ‘consistent with one’s lifelong values.’¹²¹

The Court held further that an individual’s response to a grievous and irremediable medical condition is a matter ‘critical to their dignity and autonomy.’¹²² The inconsistency in the law was highlighted in instances where a terminally ill person, facing a grievous and irremediable medical condition, is permitted to access palliative sedation, reject artificial nutrition and hydration, or request the withdrawal or removal of life-sustaining measures, yet that person is denied the right to request the assistance of a doctor in facilitating their death. This inconsistency

¹¹³ Despite these two rights being distinct interests, they were considered together for the purposes of the appeal.

¹¹⁴ *Carter* (note 10 above) 64.

¹¹⁵ *Blencoe v British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307 54.

¹¹⁶ *Rodriguez* (note 85 above) 587-588, referring to *R v Morgentaler* [1988] 1 S.C.R. 30.

¹¹⁷ *Carter* (note 58 above) 1302.

¹¹⁸ *Carter* (note 10 above) 65.

¹¹⁹ *Ibid.*

¹²⁰ *Ibid.*

¹²¹ *Carter* (note 58 above) 1326.

¹²² *Carter* (note 10 above) 66.

interferes with one's ability to make important decisions regarding one's bodily integrity and medical care, thus infringing one's liberty. Moreover, one's security of the person is impinged upon when one is subjected to such enduring intolerable suffering, as Taylor was forced to endure.

In summary, the Court acknowledged that s7 recognises the value of life, but also honours the role of autonomy and dignity at the end of one's life. The Court concluded that s241(b) and s14 of the Criminal Code infringe the rights to liberty and security of the person, 'insofar as they prohibit physician-assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering.'¹²³

2.1.7 Principles of Fundamental Justice

Having confirmed the deprivation of rights under s7, the Court had to complete the second stage of the enquiry and determine whether this deprivation of rights was in line with the principles of fundamental justice. It should be noted that s7 of the Charter does not guarantee that there will never be state interference in a person's life, liberty or security of the person, but rather ensures that, should there be any state interference, it does not violate the principles of fundamental justice.¹²⁴

Although there are numerous principles of fundamental justice, the Court highlighted three principles that are central to the jurisprudence of s7 adjudication. These principles ensure that laws that impinge on life, liberty and security of the person must not be: (i) arbitrary, (ii) overbroad or (iii) have consequences that are grossly disproportionate to their object.¹²⁵

The Court referred to the Reference Question of *In Re B.C. Motor Vehicle Act*¹²⁶ to comment on the origins of the principles of fundamental justice. The core principles of fundamental justice, as referred to above, were derived from the essential elements of the Canadian system of justice,

¹²³ Ibid 68.

¹²⁴ Ibid 71.

¹²⁵ Ibid 74.

¹²⁶ *In Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R 486.

which was founded on a belief in the dignity and worth of every human person.¹²⁷ Hence, should a person be deprived of their constitutional rights arbitrarily or in a manner that is overbroad or grossly disproportionate, that such a deprivation would amount to diminishing that person's worth and dignity.

In accordance with Canadian jurisprudence, the first step in determining whether a law that impinges on a person's right to life, liberty or security of the person does so in a way that violates the abovementioned three principles of fundamental justice, is to first identify the object of the law that is being challenged.

The trial judge initially concluded that the object of the prohibition on assisted dying was the protection of vulnerable persons who may be 'induced to commit suicide at a time of weakness.'¹²⁸ All parties to the proceedings, except the Attorney-General of Canada, agreed to that formulation of the object. While accepting that the prohibition was intended to protect the vulnerable, it was argued that the object should be formulated and defined in broader terms as simply: 'the preservation of life.'¹²⁹ The Supreme Court, however, did not accept this submission, as the justices argued that stating the object too broadly has the potential to 'short circuit'¹³⁰ the analysis, making it too difficult to accurately assess whether the means used to further the object are overbroad or grossly disproportionate. The Supreme Court of Canada ultimately concluded that the object of the prohibition on assisted dying is the rather narrow goal of protecting vulnerable persons¹³¹ by preventing them from being induced to commit suicide at a time of weakness.¹³²

¹²⁷ *Carter* (note 10 above) 81.

¹²⁸ *Rodriguez* (note 85 above) 1190.

Carter (note 10 above) 74.

¹²⁹ *Ibid* 75.

¹³⁰ *Carter* (note 10 above) 77.

¹³¹ Canada argued that it is difficult to positively identify the 'vulnerable' and, as such, it cannot be said that the prohibition is overbroad. Canada further asserted that every person has the potential to be vulnerable, and thus a blanket prohibition on assisted dying is necessary.

¹³² *Carter* (note 10 above) 78.

2.1.7.1 Arbitrariness

The first principle of fundamental justice analysed by the court was that of arbitrariness. Arbitrariness, as a principle of fundamental justice, focuses on the rational connection between the object of the law and limitation that is imposed on one's constitutional rights (in this instance, the rights being life, liberty or security of the person).¹³³ Should a law not fulfil its objectives (or if it exacts a constitutional price without furthering the public good that is said to be in the interest of the law), it shall be deemed to be arbitrary.¹³⁴

In the specific context of the prohibition on doctor-assisted dying, the object of the law, as mentioned above, is to protect the vulnerable from being induced to end their lives in a time of weakness. It was submitted that a complete blanket ban on assisted suicide successfully achieves this object, therefore the Court held that the limitation of one's rights under s7 of the Charter is not arbitrary.¹³⁵

2.1.7.2 Over-breadth

The enquiry into over-breadth, as explained by the Court, asks whether a law, 'that takes away rights in a way that generally supports the object of the law, goes too far by denying the rights of some individuals in a way that bears no relation to the object.'¹³⁶ In the trial court, the Attorney-General of Canada had conceded that not every person who wishes to commit suicide is a vulnerable person and thus, the law catches people outside of the class of persons that the object of the law seeks to protect.¹³⁷ Moreover, the trial judge had accepted that Gloria Taylor was one such person: 'competent, fully informed and free from coercion or duress.'¹³⁸ The Supreme Court of Canada ultimately concluded that the prohibition on assisted dying was over-broad.¹³⁹

¹³³ Ibid 83.

¹³⁴ Ibid.

¹³⁵ Ibid 84.

¹³⁶ *Bedford* (note 96 above) 101 and 112-113.

Carter (note 10 above) 85.

¹³⁷ *Carter* (note 58 above) 1136.

¹³⁸ *Carter* (note 58 above) 16 and *Carter* (note 10 above) 86.

¹³⁹ *Carter* (note 10 above) 86.

2.1.7.3 Gross Disproportionality

Finally, the Court turned to the principle of gross disproportionality. In order to assess whether the principle of gross disproportionality has been infringed, the Court needs to determine whether the impact of the restriction on the individual's life, liberty or security of the person was grossly disproportionate to the object of the measure.¹⁴⁰ This enquiry draws comparison between the apparent purpose of the law and the negative impact on the claimant's rights. From this comparison, it should be determined whether or not the impact is 'completely out of sync with the object of the law.'¹⁴¹ The standard, however, is very high and not every law that has an object incommensurate with its impact will reach the standard for gross disproportionality.¹⁴²

The Court agreed with the findings of the trial judge who held that the negative impact on a person's life, liberty and security of the person caused by the prohibition on assisted dying was 'very severe' and, therefore, grossly disproportionate to its objective.¹⁴³ The Court held further that the prohibition on assisted dying creates 'unnecessary suffering'¹⁴⁴ for affected individuals and deprives one of the ability to determine what to do with one's own body and how one's body should be treated. This, in the opinion of the Court, may cause an affected individual to take their own life sooner than they would if they were permitted to lawfully obtain the assistance of a doctor in facilitating their death when suffering becomes unbearable.

2.1.8 Analysis of s15

Having reached the conclusion that the prohibition on assisted dying violated s7 of the Charter and was not in line with all of the core principles of fundamental justice, the Court found it unnecessary to determine whether the prohibition further violated s15 of the Charter and did not consider this question.

¹⁴⁰ Ibid 89.

¹⁴¹ Ibid 89 and *Bedford* 125.

¹⁴² *Bedford* (note 96 above) 120, *Suresh v Canada (Minister of Citizenship and Immigration)* 2002 SCC 1, [2002] 1 S.C.R 3 47.

¹⁴³ *Carter* (note 58 above) 1378 and *Carter* (note 10 above) 90.

¹⁴⁴ *Carter* (note 10 above) 90.

2.1.9 Analysis of s1: Justification of the Infringement

The Court proceeded to examine whether or not Canada could justify the infringement of Taylor's s7 rights under the limitation clause found in s1 of the Charter by showing: first, that the law has a pressing and substantial object and second, that there is proportionality between the selected means and the object.

On the issue of proportionality, a law will be deemed proportionate if it meets the following three criteria: (i) there is a rational connection between the means adopted and the objective; (ii) there is minimal impairment of the right in question and (iii) there is proportionality between the deleterious and salutary¹⁴⁵ (the damaging and the beneficial) effects of the law.¹⁴⁶ The Court further stated that proportionality does not require perfection, but that s1 only requires the limits to adhere to a standard of reasonableness.¹⁴⁷

2.1.9.1 Rational Connection

The first criterion of proportionality, a rational connection between the means adopted and the objective, requires the government to show there is a causal connection 'on the basis of reason or logic'¹⁴⁸ between the infringement of Taylor's rights and the benefit sought by the law. This connection should demonstrate that the means adopted by the law are a rational way for the legislature to pursue its objective, and that the absolute prohibition on doctor-assisted dying is rationally connected to the ultimate goal of protecting the vulnerable from being induced to take their own lives in a time of weakness.

The Court agreed with the findings of the British Columbia Court of Appeal, that the prohibition of a risky activity is a rational method of curtailing the risks involved,¹⁴⁹ thereby concluding that there was a rational connection between the prohibition on doctor-assisted dying and the objective of protecting the vulnerable from being induced to commit suicide at a time of

¹⁴⁵ *R v Oakes* [1986] 1 S.C.R. 103.

¹⁴⁶ *Carter* (note 10 above) 94.

¹⁴⁷ *Saskatchewan (Human Rights Commission) v Whatcott* 2013 SCC 11, [2012] 1 SCR 467 78.

¹⁴⁸ *Carter* (note 10 above) 99.

¹⁴⁹ *Ibid* 100.

weakness. Despite the appellants arguing that the absolute nature of the prohibition was not logically connected to the object of the provision (and claiming that the prohibition goes too far) the Court found a logical connection between the means and the objective. It was suggested that it is rational to conclude that the vulnerable will be protected from being induced to commit suicide at a time of weakness if there is a law in place that bars all persons from accessing assistance in committing suicide.¹⁵⁰

2.1.9.2 Minimal Impairment

The second criterion of proportionality, minimal impairment of the right in question, essentially determines whether the limit on the right is ‘reasonably tailored to the objective.’¹⁵¹ The question at the core of the enquiry is whether there are ‘less harmful means of achieving the legislative goal’,¹⁵² thus imposing a burden on the government to prove that there are no means which are less drastic that could achieve the ultimate objective in a real and substantial manner. The deprivation of rights, therefore, should be confined to only what is reasonably necessary to achieve the government’s object.

The trial judge had been tasked with determining whether a system that was less restrictive of life, liberty and security of the person could combat the risks associated with doctor-assisted death or whether the Attorney-General of Canada was correct in asserting that the risks could not be adequately addressed through the implementation of safeguards. As indicated above, the trial judge had assessed a plethora of evidence and concluded that ‘the risks inherent in permitting physician-assisted death can be identified and substantially minimised through a carefully designed system imposing stringent limits that are scrupulously monitored and enforced.’¹⁵³

The trial judge found further that an absolute prohibition on doctor-assisted dying would only be necessary if there was evidence to show that doctors are incapable of accurately assessing the ‘competence, voluntariness and non-ambivalence in patients.’¹⁵⁴ Similarly if there was evidence

¹⁵⁰ Ibid 101.

¹⁵¹ Ibid 102.

¹⁵² *Carter* (note 10 above) 102.

¹⁵³ *Carter* (note 58 above) 883.

¹⁵⁴ *Carter* (note 10 above) 104.

that permissive jurisdictions enabled the abuse of patients, carelessness, callousness or a slippery slope leading to the casual termination of life,¹⁵⁵ or that doctors are incapable of applying the informed consent standard required for medical treatment, an absolute prohibition on doctor-assisted dying would be necessary.¹⁵⁶ The evidence presented at trial, however, led the trial judge to reject these possibilities and it was concluded by the trial judge that there was no evidence to support the notion that vulnerable persons, such as the elderly and disabled, were at heightened risk of accessing physician-assisted dying,¹⁵⁷ or that there was an inordinate impact on socially vulnerable populations,¹⁵⁸ or that a permissive regime would result in a slippery slope.

The Supreme Court of Canada confirmed these conclusions drawn by the trial judge and agreed that the absolute prohibition on doctor-assisted dying was not minimally impairing.¹⁵⁹

With regard to the vulnerability of patients, the Court concluded that concerns about decisional capacity and vulnerability arise in all matters concerning end-of-life medical decision-making and that the vulnerability of a patient can be ‘assessed on an individual basis using the procedures that are applied by doctors in their assessment of informed consent and decisional capacity.’¹⁶⁰

2.1.9.3 Deleterious Effects and Salutory Benefits

Given the Court’s conclusion that the law prohibiting doctor-assisted dying is not minimally impairing, the Court found it unnecessary to analyse the final criterion which would weigh the impact of the law on protected rights against the ‘beneficial effect of the law in terms of the greater public good.’¹⁶¹

¹⁵⁵ *Carter* (note 58 above) 1365-1366.

¹⁵⁶ *Ibid.*

¹⁵⁷ *Carter* (note 58 above) 852 and 1242.

¹⁵⁸ *Carter* (note 10 above) 107.

¹⁵⁹ *Ibid* 121.

¹⁶⁰ *Ibid* 115.

¹⁶¹ *Ibid* 122.

2.1.10 Conclusion and Remedy

Ultimately the Court concluded that s241(b) and s14 of the Canadian Criminal Code could not be saved by s1 of the Charter and justified as a reasonable limitation of the rights protected by the Canadian Charter of Rights and Freedoms.

The Supreme Court of Canada declared:

s241(b) and s14 of the Criminal Code unjustifiably infringe s7 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 (i) clearly consents to the termination of life and (ii) has a grievous and irremediable¹⁶² medical condition (including illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.¹⁶³

With regard to the constitutional exemption granted by the lower court, the Supreme Court of Canada found the exemption was not the appropriate remedy as it would ‘create uncertainty, undermine the rule of law and usurp the role of Parliament.’¹⁶⁴ The appropriate remedy, as determined by the Court, was to declare s241(b) and s14 of the Criminal Code ‘void insofar as they prohibit physician-assisted death for a competent adult person’¹⁶⁵ who meets the abovementioned criteria.

The scope of the declaration, however, was intended to deal with the factual circumstances of the *Carter* case only, and the Court clearly stated that they would make no pronouncement on any other situations where physician-assisted dying may be sought.¹⁶⁶ The declaration of invalidity was suspended for a period of 12 months and the onus was shifted to Parliament and the provincial legislatures to respond by ‘enacting legislation consistent with the constitutional parameters’ established by the Court.¹⁶⁷

¹⁶² It was added by the Court that ‘irremediable’ does not require a patient to have undergone treatments that are unacceptable to that patient.

¹⁶³ *Carter* (note 10 above) 147.

¹⁶⁴ *Ibid* 125.

¹⁶⁵ *Ibid* 127.

¹⁶⁶ *Ibid* 127.

¹⁶⁷ *Ibid* 126.

The Court clarified that the declaration of invalidity would not compel any physicians to provide assistance in dying, it simply renders the criminal prohibition invalid. Drawing parallels with the topic of a doctor's role in abortions, the Court confirmed that a doctor's participation in assisted dying is a matter of conscience and/or religious belief.¹⁶⁸ The Court stated explicitly that they did not wish to pre-empt the legislative response to the judgment, but simply underlined that there needs to be reconciliation between the rights of patients and the rights of physicians.¹⁶⁹

Therefore, the Supreme Court of Canada's thorough analysis of the limitation of rights pertaining to assisted dying and end of life decisions provides a solid foundation upon which further analysis and debate can be structured. The *Carter* case is a landmark decision that has left an indelible impression on the international discourse on assisted dying, and represents progress toward a society in which terminally ill patients can have their right to live and die with dignity respected and protected.

Historically, Canadian jurisprudence has had an important influence on the drafting of the South African Bill of Rights as well as the South African position on the limitation of rights and, as such, the South African Bill of Rights bears great similarity to the Canadian Charter of Rights and Freedoms.¹⁷⁰ Due to the similarities between the Canadian Charter of Rights and Freedoms and the South African Bill of Rights, it should be noted that there are certain congruencies between the trial judge's Charter analysis and the limitation of rights enquiry that is used to determine whether an infringement of rights is justifiable in a South African context. Although the structure of the enquiry is not identical to that previously followed by the Constitutional Court in South Africa, the findings of the trial judge in the *Carter* case will be useful and informative when determining whether the prohibition on assisted suicide constitutes a justifiable limitation of rights in a South African context.

Modern legal developments in Canadian jurisprudence pertaining to the prohibition on assisted dying have also served to inform the most recent South African case dealing with assisted dying:

¹⁶⁸ Ibid 132.

¹⁶⁹ Ibid.

¹⁷⁰ Du Bois *et al Willes Principles of South African Law* 9th ed (2007) 111.

the Supreme Court of Canada's decision in *Carter v Canada (Attorney General)*¹⁷¹ proved highly persuasive in the case of *Stransham-Ford v Minister of Justice and Correctional Services and Others*.¹⁷²

2.2 *Stransham-Ford v Minister of Justice and Correctional Services and Others*

2.2.1 Background

Subsequent to the Canadian decision of *Carter*, the North Gauteng High Court handed down a controversial landmark ruling in April 2015 that sparked both national and international debate as the court found in favour of the applicant, Robin Stransham-Ford, granting him the right to die with dignity with the assistance of a qualified medical doctor.

Like Gloria Taylor, Robin Stransham-Ford died of natural causes before judgment was handed down in his favour, thus rendering the successful outcome of the case a hollow victory, but a small victory nonetheless for all those in support of doctor-assisted dying for the terminally ill.

The matter was brought before Judge Fabricius in the North Gauteng High Court as an urgent application which the judge agreed required an immediate decision.¹⁷³ Although judgment on the matter was handed down by the High Court, Judge Fabricius asserted the view that it would be preferable for the Constitutional Court to pronounce on the relevant principles, and that the ideal course of action would be for the legislature to consider the whole topic and produce a Bill which could be subject to the scrutiny of the Courts. These sentiments echo the Supreme Court of Canada's judgment in *Carter*.

After establishing that the matter of doctor-assisted suicide should ultimately be dealt with by the legislature, Judge Fabricius drew attention to the Project 86 Report which was submitted to the Minister of Health in 1998. The Minister and/or the legislature did not give the Report, or the

¹⁷¹ *Carter* (note 10 above).

¹⁷² *Stransham-Ford* (note 9 above).

¹⁷³ *Stransham-Ford* (note 9 above) 1.

proposed legislation, sufficient attention because there were other, more urgent, matters that required attention.¹⁷⁴

It was noted that it has been 16 years since the Project 86 Report was submitted to the Minister of Health, and Fabricius J suggested that the topic of euthanasia is now important enough to be given due regard. Moreover, Fabricius J was of the opinion that serious consideration should be given to introducing a Bill on the basis of the SA Law Commission's Project 86 Report which supports the development of the common law in the context of assisted dying and specifically in the context of the Bill of Rights.¹⁷⁵

Fabricius J commenced with an analysis of the profile and status of the Applicant, looking at his education, qualifications and experience. It was established that the Applicant was well educated, holding a number of law degrees amongst other qualifications, and had many years of experience both as an advocate and as an accountant and a tax practitioner. The Court further relied on confirmatory affidavits from dependents, and a report from a clinical psychologist to establish a well-rounded understanding of the Applicant's character. These reports stated the Applicant showed no evidence of any psychiatric disorders, that he had no cognitive impairments and that he was of rational temperament. It was also confirmed by the clinical psychologist that the Applicant displayed a 'good understanding and appreciation of the nature, cause and prognosis of his illness'¹⁷⁶ as well as the clinical, ethical and legal aspects of assisted suicide.¹⁷⁷

¹⁷⁴ The third respondent in the matter, the Health Professional Council of South Africa (HPCSA), submitted that more urgent matters took precedence over euthanasia and these matters included the AIDS epidemic. In an affidavit made by an Acting Chief Director of Legal Services on behalf of the Minister of Justice and Correctional Services, it was reiterated that the Report was handed to the Minister of Health in 1999 but was unattended to because of more urgent matters such as the HIV and the AIDS epidemic, but it did not say why the Report has not received any legislative attention since then.

¹⁷⁵ *Stransham-Ford* (note 9 above) 1.

¹⁷⁶ *Ibid* 2.

¹⁷⁷ *Ibid* 2.

2.2.2 Order sought by Applicant

The order sought by the Applicant was essentially threefold. First, to declare that the Applicant may request a registered medical practitioner¹⁷⁸ to end his life, or to enable the Applicant to end his own life by the administration or provision of some or other lethal agent. Second, the Applicant sought a declaration that the aforementioned medical practitioner should not be held accountable, and would be free from any civil, criminal or disciplinary liability that may arise from either the administration or provision of a lethal agent or from the cessation of the Applicant's life as a result of the administration or provision of a lethal agent to the Applicant. Third, to develop the common law to the extent required by declaring that the conduct mentioned above lawful and constitutional in the circumstances of this particular matter.¹⁷⁹

Several pertinent questions, which are central to the debate concerning end of life decisions, were raised by the Applicant. These questions included:

- (i) Is it conceivable that the health of a person may deteriorate to a level where that person would be justified in wishing to take their own life?
- (ii) Ought this suffering person be permitted to take his/her own life?
- (iii) Should another person be allowed to assist the sufferer to end his life?
- (iv) May this person be a medical practitioner?
- (v) What safeguards need to be in place?¹⁸⁰

2.2.3 Analysis of Applicant's health, quality of life and imminent future

The Court proceeded with an analysis of the Applicant's health, taking into account his full medical history and the rapid deterioration of his health in the weeks preceding the application. The Court made mention of a report of Dr RAG De Muelenaere,¹⁸¹ obtained by the Health

¹⁷⁸ The medical professional must be registered as such in terms of the Health Professions Act 56 of 1974.

¹⁷⁹ *Stransham-Ford* (note 9 above) 3-4.

¹⁸⁰ *Stransham-Ford* (note 9 above) 5.

¹⁸¹ Dr R.A.G De Muelenaere is a radiation oncologist of 26 years standing, having worked in private practice since July 1998. He did not examine Stransham-Ford personally. Dr De Muelenaere's opinion and the abovementioned report were compiled based on the contents of the documents contained in the Court application alone.

Professions Council of South Africa (HPCSA), which was not under oath, but the Court quoted the following extract from the report:

There are palliative and medical treatments available which can improve the situation for a lengthy period of time. I have sympathy for a patient with widespread metastatic cancer and in my work I have to deal with such situations on a regular basis. I understand the patient asking for “an easy way out” but there are important factors to consider in a case like this. Wider societal aspects need to be addressed, as in the debate preceding abortion legislation. All moral, legal and ethical aspects need to be discussed. With modern medicine including high doses of opioid (morphine-like) drugs less than 10% of patients will die in pain, regardless of kidney function. Hospice doctors and staff specialise in symptom control of terminal patients and this service can be provided at home in the vast majority of patients. Most medical funds will allow home nursing as a benefit and terminal care definitely does not need to be provided in a hospital setting for the majority of cases if that would be the patient’s wish. All in all, I consider this request for “assisted suicide” to be against current medical practice.

Stransham-Ford, however, responded to this report by arguing that palliative care was inadequate to satisfy his need and his right to die in dignity whilst being fully aware of the moment of his death.¹⁸² This is an argument raised by many who are opposed to palliative care, as a loss of consciousness and awareness of one’s surroundings constitutes a severe impairment of one’s dignity and patient autonomy.¹⁸³

Having examined the status of Stransham-Ford’s health, Fabricius J proceeded to discuss Stransham-Ford’s quality of life, looking at the physical symptoms of suffering, the changes in his lifestyle as well as the effect that pain medication had had on him.¹⁸⁴ The deterioration in Stransham-Ford’s quality of life was illustrated by an extensive list of his physical ailments which included: severe pain, nausea, vomiting, stomach cramps, constipation, disorientation, weight loss, loss of appetite, high blood pressure, increased weakness and frailty related to

¹⁸² *Stransham-Ford* (note 9 above) 6.

¹⁸³ D Benatar ‘A legal right to die: responding to slippery slope and abuse arguments’ (2011) 18 *Current Oncology* 206.

¹⁸⁴ *Stransham-Ford* (note 9 above) 7.

kidney metastasis, an inability to get out of bed, anxiety and an inability to sleep without morphine or other painkillers.¹⁸⁵

Fabricius J established that Stransham-Ford's diagnosis and prognosis had been confirmed by both a general practitioner (who lectures and specialises in palliative care) as well as a specialist urologist, both of whom had personally examined Stransham-Ford.¹⁸⁶ Fabricius J further listed the medicine, procedures and traditional remedies that Stransham-Ford had undergone which included: dendritic cell therapy, traditional Chinese medicine, surgery, cannabis, the insertion of a renal stent for his kidneys from his kidneys to his bladder, the insertion of a catheter fitter, morphine, buscopan and other pain inhibitors and finally palliative care.¹⁸⁷

With regard to Stransham-Ford's imminent future, Fabricius J acknowledged that Stransham-Ford was acutely aware and had accepted his death was imminent, however, this was not an issue in dispute. Fabricius J further elaborated on Stransham-Ford's worsening condition and agreed that his physical condition would continue to deteriorate with the progression of time and that he would, at a later stage, require stronger doses of opioid drugs and painkillers such as morphine with a possibility of hospitalisation.¹⁸⁸

Stransham-Ford's increased frailty was also highlighted, as Fabricius J made mention of the fact that he was in need of constant assistance with regular daily activities including getting out of bed, bathing, brushing his teeth and eating. It was further acknowledged that, with the progression of his disease, Stransham-Ford would become increasingly more confused and afraid and that there was a possibility that his last breath would require the aid of a machine.

A powerful statement made by Stransham-Ford summed up the feelings of many of those who are dying of a terminal illness by saying that he was 'not afraid of dying, he was afraid of dying while suffering.'¹⁸⁹ This statement strikes at the heart of the debate surrounding assisted dying, as no person should be faced with such a fear in the final months, weeks or days of their life.

¹⁸⁵ Ibid.

¹⁸⁶ Ibid 8.1.

¹⁸⁷ Ibid 8.2.1 - 8.2.8.

¹⁸⁸ Ibid 9.2.

¹⁸⁹ Ibid 9.5.

2.2.4 Current Legal Position in South Africa

Having analysed Stransham-Ford's physical condition and medical history, Fabricius J proceeded with an analysis of the current legal position in South Africa.¹⁹⁰ It was undisputed that, as the law stands, assisted suicide or voluntary active euthanasia is unlawful.¹⁹¹ Relying on s39 ('Interpretation of the Bill of Rights') and s8 ('Application') of the 1996 Constitution, it was argued by the Applicant that a development of the law was required.¹⁹² Emphasis was placed on s39(2) which reads: 'When interpreting any legislation, and when developing the common or customary law, every Court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.'

Moreover, attention was drawn to s8(3) of the 1996 Constitution which reads:

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 the rules of the common law to limit the right, provided the limitation is in accordance with s36(1)'

With regard to the interpretation of s8(3), reference was made to the case of *Bel Porto School Governing Body v Premier Western Cape*¹⁹³ in which it was held:

Section 8(3) requires that the court should develop a suitable remedy. No particular remedy, apart from the declaration of invalidity, is dictated for any particular violation of a fundamental right. Because the provision of remedies is open-ended and therefore inherently flexible, Courts may come up with a variety of remedies in addition to a declaration of constitutional invalidity.¹⁹⁴

¹⁹⁰ It should be noted, however, that the current legal position was predominantly established in a pre-constitutional era and that under South Africa's present constitutional dispensation, the law has to be developed in order to give effect to the Applicant's constitutional rights.

¹⁹¹ *S v De Bellocq* 1975 (3) SA 538 (T) 539 d; *S v Marengo* 1991 (2) SACR 43 (W) 47 A-B; *Ex Parte Minister van Justisie: in re S v Grotjohn* 1970 (2) SA 355 (A).

¹⁹² *Stransham-Ford* (note 9 above) 10.

¹⁹³ *Bel Porto School Governing Body v Premier Western Cape* 2002 (3) SA 265 (CC).

¹⁹⁴ *Ibid* 108.

Thus, as indicated by the Court, the appropriateness of the remedy would be determined by the facts of the particular case. Fabricius J stated explicitly that his personal thoughts and feelings were irrelevant and would not influence his decision-making.¹⁹⁵

2.2.5 Basis of the Applicant's relief

Fabricius J highlighted the four main provisions of the 1996 Constitution upon which the Applicant's argument was founded. These provisions included s1,¹⁹⁶ s7,¹⁹⁷ s8; and s12.¹⁹⁸

2.2.6 Freedom, security and control to die with dignity

Before proceeding with the Applicant's argument, Fabricius J deemed it necessary to comment on the role of dignity in the constitutional dispensation of South Africa, relying on the judgment of *S v Makwanyane*¹⁹⁹ and *Human Dignity: Lodestar for Equality in South Africa*.²⁰⁰ Fabricius J quoted from the *Makwanyane* judgment to highlight the importance of human dignity in South Africa as he confirmed: 'the recognition and protection of human dignity is the touchstone of the new political order and is fundamental to the new Constitution.'²⁰¹ Fabricius J further agreed with Ackermann in saying that, in the context of s10 read with s1 and s7(2), human dignity, apart from being just a value and a right, is also a categorical imperative.²⁰²

The *amici curiae* admitted prior to the hearing of the case, Doctors for Life and Cause for Justice, submitted affidavits which were considered by the court. One of the arguments raised by Cause for Justice was that Stransham-Ford had merely expressed a 'subjective view of dignity and his medical condition, whereas the values enshrined in the Constitution had to be looked at

¹⁹⁵ *Stransham-Ford* (note 9 above) 10.

¹⁹⁶ The founding provision of the Constitution which provides that the Republic of South Africa is founded on the values of human dignity, the achievement of equality and the advancement of human rights and freedoms.

¹⁹⁷ Which provides that the Bill of Rights is the cornerstone of democracy in South Africa, enshrining the rights of all people in the country and affirming the democratic values of human dignity, equality and freedom which should be respected, protected, promoted and fulfilled by the State.

¹⁹⁸ Freedom and security of the person, a right afforded to all persons which includes the right not to be treated or punished in a cruel, inhuman or degrading way. The provision also includes the right to bodily and psychological integrity, which includes the right to security and control over one's own body.

¹⁹⁹ *S v Makwanyane* 1995 (3) SA 391 (CC).

²⁰⁰ L Ackermann *Human Dignity: Lodestar for Equality in South Africa* 1st ed (2012).

²⁰¹ *S v Makwanyane* 1995 (3) SA 391 (CC) 329.

²⁰² *Stransham-Ford* (note 9 above) 12.

and determined objectively.²⁰³ This argument, however, was not accepted, as Fabricius J held that as a practical necessity, a court must look at the subjective views and the condition of a person who claims that their constitutional rights have been impaired.

Fabricius J further referred to *Carmichele v Minister of Safety and Security and the Minister of Justice and Constitutional Development*²⁰⁴ wherein the Constitutional Court held that the rights of individuals guaranteed under the Bill of Rights are also subjective rights and it was also iterated that persons should be regarded as recipients of rights rather than as objects of statutory mechanisms.²⁰⁵

Fabricius J quoted further from The Bill of Rights Handbook²⁰⁶ on the concept of human dignity:

Human dignity is not only a justiciable and enforceable right that must be respected and protected, it is also a value that informs the interpretation of possibly all other fundamental rights and it is further of central significance in the limitations enquiry.

Having looked at the role of human dignity, Fabricius J then raised the question of *dolus eventualis* with regard to the removal or withdrawal of life-sustaining treatment.²⁰⁷ As the law currently stands in South Africa, it is entirely permissible within the law to withdraw or remove any life-sustaining treatment that a patient is reliant on, even if it would cause the patient to die from natural causes.²⁰⁸ However, Fabricius J considered whether such a course of action could be regarded as a good example of intention in the form of *dolus eventualis*. In order for a person to have acted with intention in the form of *dolus eventualis*, that person must subjectively foresee the possibility, however remote, of his/her actions resulting in the death of another person, yet he/she persists in that course of action whether or not death ensues.²⁰⁹ Therefore, a person must

²⁰³ *Stransham-Ford* (note 9 above) 12.

²⁰⁴ *Carmichele v Minister of Safety and Security and the Minister of Justice and Constitutional Development* 2001 (4) SA 938 (CC) 54.

²⁰⁵ *Stransham-Ford* (note 9 above) 12.

²⁰⁶ I Currie & J de Waal *The Bill of Rights Handbook* 6th ed (2005) 253.

²⁰⁷ *Stransham-Ford* (note 9 above) 12.

²⁰⁸ *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D).

²⁰⁹ *S v de Bruyn and another* 1968 (4) SA 498 (A) 510.

have reconciled him/herself with the possibility of causing the death of another person when pursuing a course of conduct.²¹⁰

A philosophical argument raised by the Applicant was that there is essentially no difference between assisted suicide, in the form of providing the suffering patient with a lethal agent, or by switching off a life-supporting device or removing life-sustaining treatment²¹¹ or injecting the suffering patient with a strong dose of morphine or other opioid drugs, with the intention of relieving their pain but in the knowledge that death will ensue as a result of their respiratory system closing. The Applicant called the distinction between the withdrawal of treatment to allow a natural process of death, and physician-assisted death ‘intellectually dishonest’²¹² as there is no real logical or ethical distinction between the two concepts. Fabricius J expressed a view that there is merit to this contention, but that it is best left to the philosophers and thus confined the matter to the constitutional debate.

It should be noted that, at a later stage in the judgment, Fabricius J returned to the consideration of *dolus eventualis* and the differences between active and passive euthanasia, and agreed with the contention that the withdrawal of life-sustaining measures is a good example to illustrate *dolus eventualis*.²¹³ Moreover, it was reasoned that the act of withdrawing previously administered life-sustaining treatment remains an active and positive step taken by the doctor which directly causes the death of the patient, and Fabricius J further found the argument that the duty of a medical practitioner to respect a patient’s dignity remains the same in instances of active and passive euthanasia to be sound.²¹⁴

In further analysis of the notion of dignity, Fabricius J endorsed the view of O’Reagan J in *Makwanyane* when it was held that the right to life must be a life worth living.

²¹⁰ *Stransham-Ford* (note 9 above) 12.

²¹¹ With reference to *Clarke v Hurst NO and others* 1992 (4) SA 630 (D).

²¹² *Stransham-Ford* (note 9 above) 12.

²¹³ Should a doctor withdraw life sustaining measures that were previously administered to the patient, knowing that the result of these actions would hasten the death of the patient which could have been avoided, yet the doctor reconciles him/herself with this result and proceeds with this course of action anyway, this is an illustration of *dolus eventualis*.

²¹⁴ *Stransham-Ford* (note 9 above) 21.2.

The right to life is, in one sense, antecedent to all other rights in the Constitution. Without life in the sense of existence, it would not be possible to exercise rights or be the bearer of them. But the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, not the right to human life: the right to share in the experiences of humanity. This concept of human life is at the centre of our constitutional values. The Constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society. The right to life, thus understood, incorporates the right to dignity. So the rights to dignity and to life are intertwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity.²¹⁵

In addition, Fabricius J noted that separating moral concerns from the reality of human and animal suffering has caused great harm to mankind throughout history.²¹⁶

Fabricius J then endorsed²¹⁷ the belief asserted by Carstens and Pearmain²¹⁸ that the underlying values, spirit and purport of the applicable sections of the 1996 Constitution support the introduction of the practice of voluntary active euthanasia in South Africa. Such a permissive regime requires a system, along the lines of the recommendations made by the South African Law Commission in the Project 86 Report, that should be strictly monitored and regulated in order to ensure respect for the autonomy of competent terminally ill patients and to guard against any possible abuse of the system.²¹⁹ The aforementioned authors state that euthanasia is a matter of patient autonomy and individual choice. This averment, however, is too narrow in its scope and should be expanded to include all end of life decisions, and not simply euthanasia.

The notion of dying as a part of living was then analysed by the judge. It was submitted by the Applicant's Counsel that death is not the opposite of life; it is an important part of life and the

²¹⁵ *S v Makwanyane* 1995 (3) SA 391 (CC) 325.

²¹⁶ *Stransham-Ford* (note 9 above) 12.

²¹⁷ *Stransham-Ford* (note 9 above) 13.

²¹⁸ P Carstens & D Pearmain *Foundational Principles of Medical Law* (2007) 210.

²¹⁹ P Carstens & D Pearmain *Foundational Principles of Medical Law* (2007) 210. *Stransham-Ford* (note 9 above) 12.

completion thereof.²²⁰ It therefore follows that it is a fundamental human right to be able to die with dignity, a right which the courts are obliged to advance, respect, promote, protect and fulfil in terms of s 1(a), s7(2) and s8(3)(a) of the 1996 Constitution. Fabricius J agreed with this contention raised by the Applicant's Counsel. Moreover, Fabricius J agreed that the sacredness of the quality of life should be accentuated rather than the sacredness of life itself.

In further contemplation of dying as a part of living, Fabricius J highlighted the assertion made by the South African Law Commission that a dying person is still a living person and is still entitled to all the rights of a living person.²²¹

Fabricius J further noted that there is a large degree of irony in the prohibition on assisted dying, particularly with regard to the issue of personal autonomy.²²² We are always told to take responsibility for our lives, yet we cannot take responsibility for our own deaths. We are afforded the right to choose our education, career, lifestyle, whether or not to get married, whether to have children or to abort a pregnancy, to practise birth control or to refuse birth control and we can even die at war for our country, yet we cannot decide how to die.

The moral beliefs or doubts of third parties should not be the main point in the context of end of life decisions, it is the personal choice and autonomy of the patient that should be respected. This is consistent with the values underlying the Bill of Rights in an open and democratic society. Moreover, there is no duty or positive obligation to live. A person can waive their right to life at any stage, yet when they are physically unable to do so, they are denied assistance. There are several such ironies in the SALC report that were pointed out by Fabricius J.

A further inconsistency in the State's position toward legalising assisted dying is that in the *Soobramoney v Minister of Health*²²³ decision, the deliberate withholding of kidney dialysis treatment lead to the death of Mr Soobramoney. Fabricius J noted how it is sadly ironic that the State can justify and sanction death when it is bad for a person, yet deny a good and merciful

²²⁰ *Stransham-Ford* (note 9 above) referring to *Cruzan v Director, Missouri Department of Health et al* 497 US 261 (1990) (American Supreme Court).

²²¹ *Stransham-Ford* (note 9 above) 14 with reference to Project 86 (note 6 above).

²²² *Stransham-Ford* (note 9 above).

²²³ *Soobramoney v Minister of Health* 1998 (1) SA 765 (CC).

death to another.²²⁴ Public opinion, however, is no substitute for the duty vested in the Courts to interpret the Constitution and hold up its provisions without fear or favour,²²⁵ thus the ultimate decision lies with the Court and not with public opinion. Judge Fabricius made this very clear in the *Stransham-Ford* judgment when stating that due consideration had been given to the views expressed in the SALC report and in the affidavits presented by Doctors For Life, but that the order had to be made in accordance and compliance with the constitutional imperative.²²⁶

With regard to the Applicant's undignified death, Fabricius J agreed with several of the contentions made by the Applicant, namely that there is 'no dignity in having severe pain all over one's body; being dulled with opioid medication; being unaware of your surroundings and loved ones; being confused and dissociative; being unable to care for one's own hygiene; dying in a hospital or hospice away from the familiarity of one's own home; dying, at any moment, in a dissociative state unaware of one's loved ones being there to say goodbye.'²²⁷

2.2.7 Humanity of euthanasia to cease unbearable suffering

It has long been recognised and accepted that with regard to the treatment of animals, it is only humane to euthanize a 'severely injured or diseased animal.'²²⁸ There is a statutory obligation incumbent on an owner of an animal to end the life of a seriously diseased or injured animal that is in such a serious condition that prolonging its life would be cruel and would cause unnecessary suffering for the animal. It is therefore more than just merciless and cruel, but a crime to permit an injured or sick animal to suffer through pain, yet such a dignified death cannot be afforded to human beings. Animals that are irremediably ill and are suffering through pain and illness are afforded a greater level of humanity in being relieved from their pain and suffering than humans are.

²²⁴ Ibid.

²²⁵ Makwanyane (note 199 above) 431.

²²⁶ *Stransham-Ford* (note 9 above) 14.

²²⁷ *Stransham-Ford* (note 9 above) 15.1-15.7.

²²⁸ s2(1)(e) read with s5(1) and s8(1)(d) of the Animals Protection Act 71 of 1962.

2.2.8 The core concern regarding the legalisation of euthanasia

One of the core concerns that is central to the debate surrounding the legalisation of voluntary active euthanasia in South Africa is the protection of the weak and vulnerable in society.²²⁹ This concern was also raised in the abovementioned case of *Carter v Canada (Attorney General)* as the object behind the prohibition on assisted dying. It was proposed by the SALC and submitted by the Applicant in the *Stransham-Ford* case that, ‘but for the risk posed to the weak and vulnerable, voluntary active euthanasia should be legalised in South Africa.’²³⁰ The most pragmatic solution that arises for this issue of protecting the weak and vulnerable in society, however, is to ensure there are sufficient safeguards in the legislation envisaged to regulate and control the practice of legal assisted dying. These safeguards would prevent a ‘ripple effect’²³¹ and would combat the slippery slope argument raised by many opponents of assisted dying.

With regard to the best interests of the patient in the context of assisted dying, the Court is usually inclined to interpret the best interests of the patient in favour of the preservation of life, however, there have been instances where the courts find that the preservation of life does not extend as far as requiring that life should be maintained at all costs, regardless of the quality of life. In the aforementioned case of *Clarke v Hurst NO*²³² an application for the cessation of life sustaining treatment was granted by the Court to end the life of a patient in accordance with his wishes contained in an advance healthcare directive, thus placing the best interests of the patient above the preservation of life.

2.2.9 International developments of the law pertaining to euthanasia

Counsel for the Applicant submitted proof of at least eleven foreign jurisdictions in which assisted dying in some form (assisted suicide or voluntary active euthanasia) is not considered unlawful.²³³ Fabricius J then referred to the decision of *Carter v Canada (Attorney-General)*, highlighting the Supreme Court of Canada’s duty to balance competing values of great

²²⁹ *Stransham-Ford* (note 9 above) 17.

²³⁰ *Ibid* 17.

²³¹ *Ibid*.

²³² *Clarke v Hurst NO* 1992 (4) SA 630 (D).

²³³ These jurisdictions included: Albania, Belgium, Canada, Columbia, Luxembourg, the Netherlands, Switzerland and the American states of Oregon, Vermont, Washington, New Mexico and Montana.

importance, namely the autonomy and dignity of a competent adult with the sanctity of life and the need to protect the vulnerable.

Fabricius J expressly noted the substantial similarities between the Canadian Charter of Rights and Freedoms and the South African Bill of Rights and as such, found the Supreme Court of Canada's reasoning in *Carter* not only enlightening, but also very persuasive. Moreover, Fabricius J noted that the findings with regard to the limitation of rights in *Carter* were consistent with the limitation clause found in s36 of the 1996 Constitution. Specific reference was made to the Supreme Court of Canada's finding that the total prohibition on assisted dying was overbroad and Fabricius J drew parallels between this finding and s36(1)(e) of the 1996 Constitution which provides that when a Court is considering the rights contained in the Bill of Rights, it must take into account, amongst others, 'less restrictive means to achieve the stated purpose.'²³⁴

Although the finer details of a limitation of rights enquiry were not explored, several parallels were drawn between Canadian and South African law and, as a result, Fabricius J endorsed and liberally applied the reasoning of the Supreme Court of Canada and the dictum of *Carter v Canada (Attorney General)*. Moreover, Fabricius J noted how great emphasis was placed on the concepts of dignity and personal autonomy in the context of assisted dying and it was reasoned that if proper safeguards were to be instated, there would be no need for a total prohibition on assisted dying.²³⁵ It was asserted that the State should not have the power to dictate to a terminally ill patient that he has to make use of other options available to him, such as well managed palliative care.

Although there is no South African legislation that directly mirrors the Canadian laws that impinge on life, liberty or security of the person, Fabricius J agreed that any relevant legislation on the matter should not be arbitrary, overbroad or have grossly disproportionate consequences. Fabricius J further agreed with the findings of the Supreme Court of Canada in respect of the effect of the total prohibition on assisted suicide. The severity of the impact on terminally ill patients, the imposition of unnecessary suffering and denying terminally ill patients the right to

²³⁴ s36(1)(e) of the Constitution of the Republic of South Africa.

²³⁵ *Stransham-Ford* (note 9 above) para 18.

determine what to do with their own bodies could cause affected persons to take their own lives sooner than they would have if they were allowed lawful access to a doctor's assistance in dying.²³⁶

2.2.10 The South African Law Commission's Report on Euthanasia and the Artificial Preservation of Life

The South African Law Commission's Project 86 Report was referred to several times throughout the *Stransham-Ford* judgment and Fabricius J agreed with the Counsel for the Applicant's submission that the Commission's approach and public opinion were of limited value. The ultimate question to be determined was not based on public opinion, but rather what was provided for in the Constitution. The safeguards proposed in the Project 86 Report were not dealt with expressly in the *Stransham-Ford* judgment, but Fabricius J stated that he had considered the proposed safeguards and agreed that they were valuable and appropriate in most cases, but definitely not all.²³⁷

The argument raised by the Respondents, that the Court's 'facts-based development of the common law would leave a void which would ultimately lead to abuse,'²³⁸ was dispelled by Fabricius J.²³⁹ Any other court will also have to scrutinise the facts before it and determine on a case-by-case basis whether there are sufficient safeguards against abuse in the absence of legislation. Fabricius J was firm in his disagreement with the Respondents when stating that his case-by-case approach would not leave a void in the common law which could lead to abuse.²⁴⁰

The Applicant was able to show that sufficient safety measures had been employed to ensure that there could be no possibility of abuse.²⁴¹ These measures included: adequate knowledge of his illness, the prognosis of his condition and the treatment options available to him; full command of his mental faculties and thorough consideration of his request for an assisted death, as well as

²³⁶Ibid.

²³⁷ *Stransham-Ford* (note 9 above) 19.

²³⁸ Ibid.

²³⁹ Ibid.

²⁴⁰ Ibid.

²⁴¹ Ibid 20.

persistence in his decision to end his life with dignity and his request as contained in the Notice of Motion.²⁴²

2.2.11 Respondent's Argument

It was argued by the Respondents that the conduct of a medical practitioner who assists in the death of another person would amount to a criminal offence and the Respondents further denied that the Applicant's right to dignity was involved in the matter.²⁴³ It was argued that the application should be dismissed because, if the order were to be granted, it would equate to the promotion of 'inequalities and discrimination of the poor by way of limiting access to the Courts to the rich only.'²⁴⁴ This, it was argued, would be a violation of the Constitutional guarantee for the poor to have access to the Courts.²⁴⁵

The abovementioned argument was dismissed by the Court as being irrelevant, but it was said that it may become relevant at a later stage in future cases if no objective safeguards are put in place by a Court or by way of legislation.

The Respondents further argued that the manner of the Applicant's death was not undignified. Moreover, it was argued that the suffering endured by the Applicant was natural and therefore did not infringe on his constitutional right to dignity. Fabricius J deemed these comments, however, to be unjustified and lacking a factual basis.²⁴⁶

Fabricius J briefly returned to the Applicant's argument that there is no logical or justifiable distinction between the active and passive euthanasia. The Applicant asserted that in both instances, the primary intention of the doctor is ensuring the patient's quality of life and dignity and that the secondary result, the death or hastening of the death of the patient, remains the same in both instances.

²⁴² The court did not find it necessary for the Applicant to divulge who the doctor would be, when he would die or what the lethal agent would be. These aspects are considered private and a facet of the Applicant's dignity.

²⁴³ *Stransham-Ford* (note 9 above) 21.

²⁴⁴ *Ibid.*

²⁴⁵ *Ibid.*

²⁴⁶ *Ibid.*

With regard to conscientious objection, the Applicant submitted that his rights are ‘sacrosanct to him’²⁴⁷ and ‘should not be sacrificed on the altar of religious self-righteousness.’²⁴⁸ Moreover, ‘conscientious objections’ to other issues such as homosexuality, same-sex marriages, mixed race marriages and abortion did not detract from the rights enshrined in the 1996 Constitution and, similarly, should not do so in the context of assisted dying.

2.2.12 Relief sought by the Applicant

It was submitted by the Applicant that the Court could grant the relief sought by the Applicants with the safeguards contained in the application, until the legislature could formulate statutory safeguards. Examples were made of foreign jurisdictions that have ruled on matters pertaining to assisted dying before legislation is promulgated, with particular reference to the Canadian decision of *Carter*.²⁴⁹

Fabricius J made further mention of s39(2) of the 1996 Constitution whereby careful consideration of the common law is required to determine whether the common law requires development in any particular case. It was noted that the legislature bears the primary responsibility for law reform, rather than the courts and that should a Court develop the common law, it should only be done incrementally.²⁵⁰ Section 39 does not merely provide a Court with discretionary powers, but rather imposes an obligation on the Court.²⁵¹

2.2.13 Findings of the Court

Fabricius J ultimately found that the absolute prohibition on assisted suicide, as prescribed by the common law, is not in line with the rights relied upon by the Applicant.²⁵² Life is sacrosanct, the

²⁴⁷ Ibid.

²⁴⁸ Ibid.

²⁴⁹ Ibid 22.

²⁵⁰ *Masiya v DPP Pretoria and Another* 2007 (5) SA 30 (CC) 31-33, it was held that the judiciary should only make incremental changes that are necessary in order to keep the common law in line with the evolving ‘fabric of society’. Vigilance is required of the Courts and Courts should not hesitate to develop the common law, ensuring that it is in line with the spirit, purport and objects of the Bill of Rights.

²⁵¹ In *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC) 953, the Constitutional Court discussed the obligation of the courts to develop the common law.

²⁵² *Stransham-Ford* (note 9 above) 23.

right to life is of paramount importance which is supported by s11 of the 1996 Constitution, but the right to life does not mean that an individual is obliged to live regardless of his quality of life. The order granted by the Court was as follows:

It is declared that:

- 1.1 The Applicant is a mentally competent adult;
- 1.2 The Applicant has freely and voluntarily, and without undue influence requested the Court to authorise that he be assisted in the act of suicide;
- 1.3 The Applicant is terminally ill and suffering intractably and has a severely curtailed life expectancy of some weeks only;
- 1.4 The Applicant is 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;
- 1.5 No medical doctor is obliged to accede to the request of the Applicant;
- 1.6 The medical doctor who accedes to the request of the Applicant shall not be acting unlawfully, and hence, shall not be subject to prosecution by the Fourth Respondent or subject to disciplinary proceedings by the Third Respondent for assisting the Applicant.
2. This order shall be read as endorsing the proposals of the *Draft Bill on End of Life Decisions* as contained in the Law Commission Report of November 1998 (Project 86) as laying down the necessary or only conditions for the entitlement to the assistance of a qualified medical doctor to commit suicide.
3. 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, (s10) and freedom to bodily and psychological integrity (s12(2)(b) read with s1 and s7), and to that extent are declared to be overbroad and in conflict with the said provisions of the Bill of Rights.
4. Except as stipulated above, the common law crimes of murder and culpable homicide in the context of assisted suicide by medical practitioners are not affected.

The *Stransham-Ford* judgment has marked a turning point in the South African jurisprudence pertaining to assisted dying, however, the judgment was somewhat lacking in its contribution to the analysis of the limitation of rights. Although the *Carter* judgment included an in-depth analysis of the rights infringed by the prohibition on assisted dying, and these rights are protected

by an instrument that is substantially similar to the South African Bill of Rights, there are certain nuances in the limitation of rights enquiry in a South African context that cannot be adequately captured through a direct application of the reasoning of the Supreme Court of Canada.

Despite its brief analysis of the prohibition on assisted dying and the implications thereof, the *Stransham-Ford* judgment has contributed greatly to the international discourse on assisted dying as it indicates a potential shift toward a permissive regime being implemented in South Africa and was referred to by the High Court of New Zealand in the subsequent case of *Seales v Attorney-General*.²⁵³

2.3 *Seales v Attorney-General*

2.3.1 Background

The case of *Seales v Attorney-General*,²⁵⁴ bearing remarkable similarities to the *Stransham-Ford* case, was brought before Justice Collins of the High Court of New Zealand at Wellington in June 2015. The Plaintiff, Lecretia Seales, was a high powered lawyer, passionate about law reform, who worked at the Law Commission in New Zealand, writing laws to improve the lives of people living in New Zealand. Seales was described by Former Prime Minister of New Zealand Sir Geoffery Palmer (with whom she had worked for six years in private practice as well as at the Law Commission) as a ‘law reformer par extraordinaire’ with a ‘developed social conscience and a feeling for how things should be made better.’

Lecretia Seales, however, was diagnosed with a brain tumour in 2011 which had gone through almost a quarter of her brain and required immediate surgery. Intense brain surgery and radiation treatment reduced the size of the tumour which enabled her to travel extensively and continue working. Although Ms Seales was able to return to work at the Law Commission on reduced hours, she began experiencing a loss of vision and weakness on the left side of her body which became partial paralysis, leaving her unable to use her left hand. The decline in Ms Seales' physical health continued, despite taking powerful drugs to reduce these effects. Ms Seales was

²⁵³ [2015] NZHC 1239 [4 June 2015].

²⁵⁴ *Seales* (note 12 above).

terminally ill and had exhausted all available remedies. Doctors informed Ms Seales that she had, at most, eighteen months to live and, should the tumour spread to vital parts of her brain, she would have less than three months to live.

As a result of her circumstances, Ms Seales was determined to challenge the Attorney General and sought a clarification of the law to declare that it would not be an offense for a doctor to assist her to die in her circumstances.²⁵⁵ The law in New Zealand, as it relates to assisted dying, was somewhat unclear. Assisting suicide is illegal under the Crimes Act 1961,²⁵⁶ but Ms Seales felt that it should not be so in her case because she was competent, consenting and terminally ill.²⁵⁷ Moreover, the New Zealand Bill of Rights Act 1990 (NZBORA) provides that Ms Seales had the right not to be deprived of life in terms of s8²⁵⁸, and the right not to be subjected to cruel and degrading treatment in terms of s9.²⁵⁹ Lecretia Seales' first affidavit in the proceedings is attached as Annexure A.

Ms Seales' legal team argued that denying her lawful access to a physician-assisted death amounted to a breach of her rights and fundamental freedoms under the NZBORA. The argument raised by Ms Seales' opponents claimed that the issue was unethical and impermissible within the law,²⁶⁰ stating that the purpose of the current law is to protect the sanctity of life as well as vulnerable members of society. Moreover, it was argued that if Ms Seales were to succeed, it would have far-reaching implications beyond just her own case and would apply to all persons with terminal illnesses, therefore the usual understanding of the Crimes Act (which prohibits physician-assisted suicide) should continue to apply unless it is altered by Parliament.

Lecretia Seales had become increasingly paralysed and was unable to speak by the time the matter came before the Court. Justice Collins ultimately decided against Ms Seales and denied

²⁵⁵ *Seales* (note 12 above) 4.

²⁵⁶ s160 of the Crimes Act 1961: Culpable Homicides.

s179(b) of the Crimes Act: Assisting Suicide.

²⁵⁷ *Seales* (note 12 above) 8.

²⁵⁸ s8 of the New Zealand Bill of Rights Act, 'Right not to be deprived of life', provides that no one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice.

²⁵⁹ s9 of the New Zealand Bill of Rights Act, 'Right not to be subjected to torture or cruel treatment' provides that everyone has the right not to be subjected to torture or to cruel, degrading or disproportionately severe treatment or punishment.

²⁶⁰ 160(2)(a) and (3) of the Crimes Act 1961; s179(b) of the Crimes Act.

her bid to be allowed assistance in dying.²⁶¹ The judgment confirmed that the Crimes Act is not incompatible with the NZBORA and that only Parliament can change the law pertaining to physician-assisted suicide.²⁶² Ms Seales died of natural causes shortly after her lawyers and family received the judgment and had relayed Justice Collins' decision to her, informing her that she would not be allowed to lawfully seek assistance in dying and would have to wait to die a natural death.

The *Seales* judgment is worthy of thorough analysis to determine why Justice Collins denied Ms Seales the right to a doctor-assisted death when, less than six months prior to the matter, judges in South Africa and Canada had found in favour of assisted dying.

2.3.2 Analysis of application and ruling

The application that was brought before Justice Collins sought to give Ms Seales the option of determining when she died by allowing her doctor to either administer a fatal drug to her or to provide her with a fatal drug which would enable her to end her life by herself without facing criminal charges.²⁶³

The application was twofold: first, Ms Seales sought a declaration that her doctor would not be committing murder or manslaughter under s160(2)(a) and (3) of the Crimes Act by 'administering aid in dying'²⁶⁴ to Ms Seales. In addition, a second declaration was sought that her doctor would not be assisting her to commit suicide which is prohibited by s179(b) of the Crimes Act if her doctor 'facilitated aid' in Ms Seales' death.²⁶⁵ In the alternative, it was asked that Justice Collins declare the abovementioned provisions of the Crimes Act inconsistent with the rights guaranteed by s8 and s9 of the NZBORA (the right not to be deprived of life and the right not to be subjected to cruel, degrading or disproportionately severe treatment respectively).

²⁶¹ *Seales* (note 12 above) 210.

²⁶² *Ibid* 211.

²⁶³ *Ibid* 2.

²⁶⁴ *Ibid* 5.

²⁶⁵ *Ibid* 6.

Thus, the declarations sought by Ms Seales were: first, that s160 of the Crimes Act be declared inconsistent with sections 8 and 9 of the NZBORA 'to the extent that administered aid in dying is unlawful under s160 for a competent adult who clearly consented to the administered aid in dying and has a grievous and terminal illness that causes enduring suffering that is intolerable to the individual in the circumstances of his or her illness'²⁶⁶ and second, that s179 of the Crimes Act is declared inconsistent with s8 and s9 of the NZBORA 'to the extent that it prohibits facilitated aid in dying for a competent adult who clearly consented to the facilitated aid in dying and has a grievous and terminal illness that causes enduring suffering that is intolerable to the individual in the circumstances of his or her illness.'²⁶⁷

Justice Collins, however, found that Ms Seales' right not to be deprived of life in terms of s8 of the NZBORA was engaged, but not breached and that her right not be subjected to cruel, degrading or disproportionately severe treatment in terms of s9 of the NZBORA was not engaged by her tragic circumstances.²⁶⁸ It was, therefore, held that the aforementioned provisions of the Crimes Act are not inconsistent with s8 and s9 of the NZBORA. It was further noted that the declarations sought by Ms Seales would have required Justice Collins to change the effect of the offence provisions of the Crimes Act and that issuing the criminal law declarations sought by Ms Seales would be a departure from the constitutional role of Judges in New Zealand.²⁶⁹ Justice Collins stated in no uncertain terms that the changes to the law could only be made by Parliament.²⁷⁰

²⁶⁶ Ibid 11.

²⁶⁷ Ibid.

²⁶⁸ Ibid 12.

²⁶⁹ Ibid 13.

²⁷⁰ Ibid 13.

It is interesting to note that the End of Life Choices Bill, a private member's bill by former Labour MP Maryan Street was in the ballot box for a period of eighteen months before it was withdrawn in 2013 due to a lack of support. This Bill would have permitted certain adult residents of New Zealand to have assistance in dying should they have a terminal illness or a physical or mental condition that makes their life unbearable. Lecretia's case sparked much debate and gave MPs confidence to address the issue, thus, the Bill will be tabled at the first opportunity in Parliament. Prime Minister John Key had previously stated that he supports voluntary euthanasia in certain circumstances but believed that Street's End of Life Choice Bill had gone too far. It remains to be seen how the Parliament of New Zealand will address the issue of legalising access to physician-assisted suicide for the terminally ill.

2.3.3 Key principles

Justice Collins highlighted four key principles which he felt the case engaged: (i) the sanctity of life; (ii) respect for human dignity; (iii) respect for individual autonomy; and (iv) protection of the vulnerable.²⁷¹ These four principles resonate with the global debate pertaining to assisted dying and are not case-specific or unique to the *Seales* case.

2.3.3.1 Sanctity of life

The first principle highlighted by Justice Collins, the sanctity of life, underpins the criminal law relating to murder and culpable homicide but is not an absolute principle.²⁷² Reference was made to both British and New Zealand cases²⁷³ pertaining to the limitation of the sanctity of life principle where acceptable standards of medical practice prevailed over the sanctity of life.²⁷⁴ These principles are mirrored in a South African context in the *Soobramoney*²⁷⁵ case where rational decisions, taken in good faith, concerning the distribution of medical resources deprived a patient of access to dialysis, which caused the patient to die.

2.3.3.2 Respect for human dignity

The principle of respect for human dignity was then discussed by Justice Collins, making reference²⁷⁶ to the *Stranham-Ford* case and quoting Justice Fabricius' reliance on Justice O'Reagan's words in *S v Makwanyane*:

The right to life... incorporates the right to dignity. So the rights to dignity and to life are intertwined. The right to life is more than existence, it is a right to be treated as a human being

²⁷¹ *Seales* (note 12 above) 62.

²⁷² *Seales* (note 12 above) 64.

²⁷³ *Airedale NHS Trust v Bland* [1993] All ER 821 HL and *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235.

²⁷⁴ *Ibid* para 65.

²⁷⁵ *Soobramoney v Minister of Health* 1998 (1) SA 765 (CC).

²⁷⁶ *Seales* (note 12 above) 66.

with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity.²⁷⁷

The reference to South African decisions by a New Zealand High Court judge highlights the transcendence of the principle of respect for human dignity, one of the most important founding principles of the South African Constitution.

Justice Collins further emphasised the importance of the principle of respect for human dignity by placing it in an international context, referring to the major international human rights instruments that respect and protect the right to human dignity, such as the Universal Declaration of Human Rights and the United Nations Charter,²⁷⁸ as well as other New Zealand human rights cases²⁷⁹ which emphasised the importance and significance of the principle of respect for human dignity.

In further analysis of the principle of respect for human dignity, Justice Collins referred to the *Carter*²⁸⁰ case by highlighting the Supreme Court of Canada's assertion that underlying the rights to liberty and security of the person is 'a concern for the protection of individual autonomy and dignity.'²⁸¹ Justice Collins held that an individual's sense of his or her own bodily integrity and dignity in response to a grievous and irremediable medical condition is 'critical to their dignity and autonomy.'²⁸²

2.3.3.3 *Respect for individual autonomy*

The third key principle discussed by Justice Collins was that of respect for individual autonomy.²⁸³ Although this is a multi-faceted concept, it was stated that individual autonomy

²⁷⁷ *Stranham-Ford* (note 9 above) 12; citing O'Reagan J in *S v Makwanyane* (note 199 above).

²⁷⁸ *Seales* (note 12 above) 67.

²⁷⁹ *Ibid* 68.

²⁸⁰ *Carter* (note 10 above).

²⁸¹ *Ibid* 64.

²⁸² *Ibid* 66.

²⁸³ *Seales* (note 12 above) 71.

encompasses 'self-rule that is free from both controlling interference by others and limitations that prevent [the individual from making] meaningful choice[s] [about his or her body].'²⁸⁴

Justice Collins then referred to s11 of the NZBORA which provides that: 'Everyone has the right to refuse to undergo any medical treatment.'²⁸⁵ Despite ethical and philosophical challenges to the notion of assisted suicide being viewed as an expression of individual autonomy, from a legal standpoint, the principles of freedom, liberty and security of the person are underpinned by the principle of respect for individual autonomy.²⁸⁶

It is interesting to note that in a South African context, the National Health Act 61 of 2003 mirrors the sentiments of s11 of the NZBORA by respecting the individual autonomy of a health care user. Section 7 of the National Health Act provides that 'a health service may not be provided to a user without the user's informed consent' and expressly provides that a healthcare user must be informed of their 'right to refuse health services.' Thus, the National Health Act allows for the user to retain a degree of control and their individual autonomy is respected by allowing a patient to partake in the decision-making process and by ensuring they are fully informed and aware of their right to refuse health services.

In addition, Justice Collins quoted further from the *Carter* case, in which s7 of the Canadian Charter of Rights and Freedoms (which encompasses the right to liberty and security of the person) was described as such:

Liberty protects the right to make fundamental personal choices, free from state interference... Security of the person encompasses a notion of personal autonomy involving control over one's bodily integrity free from state interference and it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering.²⁸⁷

²⁸⁴ *Seales* (note 12 above) 71 quoting from TL Beauchamp & JF Childress *Principles of Biomedical Ethics* 7th ed (2013) 101.

²⁸⁵ *Seales* (note 12 above) 72; NZBORA s11: Right to refuse to undergo medical treatment.

²⁸⁶ *Seales* (note 12 above) 74.

²⁸⁷ *Carter* (note 10 above) 64.

2.3.3.4 *Protection of the vulnerable*

The final of the four key principles identified by Justice Collins was the protection of the vulnerable. Vulnerability, however, is a multi-faceted concept which proves difficult to define as, it amalgamates numerous elements. Some of these elements, as delineated by Justice Collins, include: communication vulnerability (those with a diminished capacity to communicate as a result of distressing symptoms), institutional vulnerability (those existing under the authority of others), differential vulnerability (those who are subject to the informal authority or independent interests of others), medical vulnerability (those with distressing medical conditions) and social vulnerability (those who are members of an undervalued social group).²⁸⁸

Justice Collins then referred to the research of Oregon psychiatrist, Professor Ganzini, which aimed to determine whether the laws permitting physician-assisted dying in Oregon placed vulnerable members of society at risk. Professor Ganzini's research concluded that terminal illness in itself is not a factor that would make a person vulnerable.²⁸⁹

Vulnerability is of a highly personal nature and is context-specific which can be influenced by numerous factors. In cases dealing with requests for assisted deaths, one would have to analyse the vulnerability of the particular person making the request in order to determine whether or not to grant their request. Ms Seales consistently maintained that she was not vulnerable in any sense and that her wishes were carefully considered and reasoned, a self-assessment that was endorsed by her doctor.²⁹⁰ Justice Collins respected Ms Seales' statement of her belief that she was not vulnerable and declared it a 'rational and intellectually rigorous response to her circumstances.'²⁹¹

Justice Collins emphasised that all branches of government in New Zealand should be vigilant to protect the vulnerable in society as he noted the importance of ensuring that medical judgments are not based upon assumptions of vulnerability, as this would devalue the respect for the principle of individual autonomy.²⁹²

²⁸⁸ *Seales* (note 12 above) 77.

²⁸⁹ *Ibid* 78.

²⁹⁰ *Ibid* 81.

²⁹¹ *Ibid*.

²⁹² *Seales* (note 12 above) 80.

2.3.4 Analysis of the criminal law provisions

Having looked at the four key principles engaged by the case, Justice Collins proceeded with an analysis of the criminal law provisions relevant to the matter. In New Zealand, as in South Africa, no person may consent to death. Section 63 of the New Zealand Crimes Act provides that:

No one has a right to consent to the infliction of death upon himself; and, if any person has killed, the fact that gave any such consent shall not affect the criminal responsibility of any person who is party to the killing.

Further provisions of the Crimes Act relevant to the matter were:

s160 Culpable Homicide which provides:

‘(2) Homicide is culpable when it consists in the killing of any person (a) by an unlawful act... (3) culpable homicide is either murder or manslaughter.’

s164 Acceleration of Death, which provides:

‘Every one who by any act or omission causes the death of another person kills that person, although the effect of the bodily injury caused to that person was merely to hasten his death while labouring under some disorder or disease arising from some other cause.’

s179(b) Aiding and abetting suicide, which provides:

‘Every one is liable to imprisonment for a term not exceeding 14 years who aids or abets any person in the commission of suicide.’

These provisions of the Crimes Act were analysed extensively by Justice Collins to determine the content and scope of the prohibition on assisted dying in New Zealand. Justice Collins undertook his legislative analysis with a focus on the text and purpose of the relevant provisions

of the Crimes Act and noted that he would interpret the Crimes Act in the context of 'contemporary circumstances.'²⁹³

Drawing on jurisprudence from the United Kingdom and New Zealand, Justice Collins concluded that Ms Seales' consent to her death would not provide a lawful excuse for her doctor if aid in dying was administered to her.²⁹⁴ It was further held, however, that should a lethal dose of morphine be administered to Ms Seales, the doctor's actions may not be unlawful within the meaning of s160(2)(a) of the Crimes Act if the doctor's intention was to provide palliative relief, even if Ms Seales' life would be shortened as an indirect, but foreseeable, consequence.²⁹⁵ Furthermore, it was confirmed that the withdrawal or removal of life-sustaining measures (where continued support would be medically futile) does not constitute an unlawful act for the purposes of s160(2)(a) of the Crimes Act.

Justice Collins also looked extensively at the definition of suicide and noted the suggestion that the term 'suicide' in s179 of the Crimes Act could be interpreted to exclude 'rational decisions to die' from its ambit.²⁹⁶ It was in his assessment, however, that there is an important distinction to be made between those who end their lives by taking a lethal drug and those who refuse medical treatment and their death occurs as a result of natural causes. This distinction led Justice Collins to conclude that Ms Seales would be committing suicide if she died as a result of taking a fatal drug that was supplied to her by her doctor.²⁹⁷ Justice Collins concluded that if Ms Seales' doctor had supplied her with a fatal drug, with the intention that Ms Seales would use the drug to take her own life, then the doctor would have been exposed to prosecution under s179 of the Crimes Act.²⁹⁸

²⁹³ At para 88 of the *Seales* judgment, Justice Collins noted that s6 of the NZBORA allowed him to give legislation an interpretation that was not envisaged at the time of its enactment, as legislation is not fixed in perpetuity.

²⁹⁴ *Seales* (note 12 above) 99.

²⁹⁵ *Ibid* 106.

²⁹⁶ *Ibid* 135.

²⁹⁷ *Ibid* 144.

²⁹⁸ *Ibid* 147.

2.3.5 Analysis of the rights-based arguments: the right to life (s8)

Having analysed the offence provisions, it was necessary for Justice Collins to thoroughly examine s8 and s9 of the NZBORA in order to make the Bill of Rights declarations sought by Ms Seales.²⁹⁹

As stated above, section 8 of the NZBORA provides that 'No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice.'³⁰⁰ Despite the wording of this provision couching the right to life in negative terms, the fundamental principle of the right to life remains the same. Justice Collins explained the three essential components to the right enshrined in section 8: (i) the right to life (ii) the exceptions to that right established by law and (iii) consistency with the principles of fundamental justice.³⁰¹

Each of the three components of the section 8 right will be discussed in turn:

2.3.5.1 The right to life

Justice Collins made reference to how the right to life is embodied in various other jurisdictions with particular reference to the United Kingdom's Human Rights Act (and how the Act incorporates Article 2 of the European Convention on Human Rights into United Kingdom law), the Canadian Charter of Rights and Freedoms and the 14th Amendment of the United States Constitution. It was made clear in the judgment that there is a need for caution when relying on Canadian and American jurisprudence in the context of an inquiry into s8 of the NZBORA, however, assistance was nevertheless derived from the decision of *Carter v Canada (Attorney-General)*.³⁰²

As established above, the Supreme Court of Canada ultimately found that the provisions of the Canadian Criminal Code which prohibit assisted dying would be of no force and effect in the circumstances of a clearly consenting adult who has a grievous and irremediable medical

²⁹⁹ Declaring s179 and s160 of the Crimes Act inconsistent with s8 and s9 of the Bill of Rights Act.

³⁰⁰ s8 of the New Zealand Bill of Rights Act (Part 2, Civil and Political Rights: Life and Security of the Person).

³⁰¹ *Seales* (note 12 above) 152.

³⁰² *Carter v Canada* (note 10 above).

condition that causes enduring suffering that is intolerable to the patient in those circumstances and thus a declaration of invalidity was issued, but suspended for a period of 12 months in order to allow Parliament to devise an appropriate remedy. Despite this judgment being fundamentally different to the ultimate decision reached in the *Seales* case, Justice Collins referred to the Supreme Court of Canada's analysis of the right to life and its consideration of the principles of fundamental justice in s7 of the Canadian Charter.

The case put forward by Ms Seales with regard to her right to life bore substantial similarities to the approach taken in *Carter v Canada (Attorney-General)* and is comprised of three stages:

First, that the sanctity of life is one of the most fundamental values of society, underpinning the right to life in s8 of the NZBORA (as well as s7 of the Canadian Charter of Rights and Freedoms and s11 of the Constitution of the Republic of South Africa). Justice Collins, however, held that s8 of the NZBORA did not require human life to be preserved in all circumstances,³⁰³ citing New Zealand jurisprudence as authority for his finding.³⁰⁴

Second, that the right to life may be engaged where the law or the actions of the state impose an increased risk of death.³⁰⁵

Third, that the person suffering from a terminal illness (the applicant in the matter) would consider taking their own life earlier than they otherwise would if a general practitioner could lawfully assist them to die.³⁰⁶ It was in this regard where the most substantial similarities arose between the circumstances in *Seales* and *Carter*. The Supreme Court of Canada held that the right to life was engaged when '...the prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached a point where suffering was intolerable.'³⁰⁷

³⁰³ *Seales* (note 12 above) 163.

³⁰⁴ *Shortland v Northland Health Ltd* [1998] 1 NZLR 433.

³⁰⁵ *Seales* (note 12 above) 164, *Carter v Canada* (note 10 above) 62 and *Osman v United Kingdom* [1998] ECHR 101 (ECHR) 116.

³⁰⁶ *Seales* (note 12 above) 165.

³⁰⁷ *Carter* (note 10 above) 57.

The abovementioned reasoning of the Court in *Carter* was said to apply with equal force in the case of *Seales*.³⁰⁸ Such reasoning led Justice Collins to conclude that the impugned provisions of the Crimes Act may have had the effect of forcing Ms Seales to take her own life prematurely out of fear that she would no longer have been able to do so when her condition deteriorated further. It was therefore concluded that the right to life was engaged in the circumstances of the case.³⁰⁹

2.3.5.2 Exemptions established by law

The right enshrined in s8 of the NZBORA does not guarantee an absolute right.³¹⁰ Should the state have to deprive a person of their right to life, s8 provides a guarantee that the state will only do so if it can rely upon grounds established by law.

In the context of the case of *Seales v Attorney-General*, the state's interference with the applicant's right to life was based upon the aforementioned provisions of the Crimes Act which were passed by Parliament and are, therefore, grounds firmly established by law.³¹¹

2.3.5.3 Consistency with the principles of fundamental justice

Section 8 of the NZBORA further requires that there must be consistency with the principles of fundamental justice, thus, it would be considered insufficient for the interference with a person's right to life to rely solely on grounds established by law. Should s8 of the NZBORA be engaged, as it was in the case of *Seales*, the court would need to analyse the scope of the phrase 'consistent with the principles of fundamental justice', however, owing to a lack of New Zealand jurisprudence with regard to the interpretation of this phrase, Canadian case law was again relied upon for assistance in this regard.³¹²

³⁰⁸ *Seales* (note 12 above) 165.

³⁰⁹ *Ibid* 166.

³¹⁰ *Ibid* 167.

³¹¹ *Ibid* 168.

³¹² *Ibid* 169.

Justice Collins noted that in accordance with Canadian jurisprudence, there are three components for consideration when analysing whether there has been a breach of the principles of fundamental justice, namely: (i) arbitrariness; (ii) over-breadth; and (iii) gross disproportionality.

In the *Seales* judgment, Justice Collins laid out the components of the principles of fundamental justice as follows:

The first component considered was that of ‘arbitrariness’, as arbitrariness is prohibited by the principle of fundamental justice. Thus, situations that have no rational connection between the objective and the law must be targeted for arbitrariness.³¹³ Further, a law is considered arbitrary where it ‘bears no relation to, or is inconsistent with, the objective that lies behind it.’³¹⁴ Moreover, in order to be considered arbitrary, the limitations on life, liberty and security require a real connection on the facts and not merely a theoretical connection between the limitation and the legislative goal.³¹⁵

The second component for consideration, over-breadth, can be understood as laws that go further than necessary when denying the rights of individuals in a manner that has no bearing on the objective of the law.³¹⁶ Justice Collins noted his preference for the phrase ‘overly broad’ when addressing this component of the principles of fundamental justice.³¹⁷

The third component to consider in a possible breach of the principle of fundamental justice is whether there is gross disproportionality between the impact of the restriction on an individual’s life and the purpose of the law in question.³¹⁸

Upon analysing the abovementioned three components that need to be considered when determining whether there has been a breach of the principles of fundamental justice, it was held

³¹³ *Seales* (note 12 above) 171.

³¹⁴ *Chaoulli v Quebec (Attorney-General)*[2005] 1 SCR 791.

³¹⁵ This test was reaffirmed by the Supreme Court of Canada in the case of *Canada (Attorney-General) v Bedford* [2013] SCC 72, [2013] 3 SCR 1101 111 and *Carter v* (note 10 above) 83-84.

³¹⁶ *Ibid* 172.

³¹⁷ *Ibid*.

³¹⁸ *Ibid* 173.

that there was no arbitrariness in the case of *Seales*.³¹⁹ This was because the purpose of s160(2)(a) the Crimes Act, to protect all human life, is the objective of the law and is therefore not arbitrary. Moreover, s179(b) of the Crimes Act is aimed at protecting the lives of both the vulnerable in society as well as those who are not vulnerable which means the objective of s179 is also not arbitrary. Thus, it was concluded that Ms Seales' rights under s8 of the NZBORA were not limited arbitrarily by s160(2)(a), s179 or s179(b) of the Crimes Act.

Similarly, the 'over-breadth' component of the enquiry was not fulfilled, as the purpose of the relevant sections of the Crimes Act is directed at the protection of human life³²⁰ and does not overreach its objective. Thus, it was held that the abovementioned sections of the Crimes Act are not overly broad and do not satisfy the 'over-breadth' component. This finding differed from the conclusion reached in *Carter*, as the Supreme Court of Canada found that the Canadian Criminal Code's prohibition against assisting suicide transgressed the 'over-breadth' component due to a narrower interpretation of the objectives of the law prohibiting assisted suicide.

Lastly, Justice Collins considered the 'gross disproportionality' component. Although gross disproportionality was not considered in the *Carter* judgment, Canadian jurisprudence dictates that the standard for 'gross disproportionality' is high, as it asks a different question from the first two components, arbitrariness and over-breadth.³²¹ Gross disproportionality analyses the law's effects on life, liberty or security of the person and asks whether these effects can rationally be supported or whether they are grossly disproportionate to the purpose of the law.³²² In the case of *Seales*, it was held that the objectives of s160(2)(a) and s179(b) are not grossly disproportionate because they achieve a fair objective of protecting all human life.³²³

Although Justice Collins reached the conclusion that there had not been a breach in the principles of fundamental justice, as there was no arbitrariness, the law was not overbroad and there was no evidence of gross disproportionality, it was emphasised that this conclusion was reached on the

³¹⁹ *Seales v* (note 12 above) 178.

³²⁰ *Ibid* 185.

³²¹ In the case of *Carter*, the Supreme Court of Canada did not consider the component of gross disproportionality in analysing the impact on the principles of fundamental justice, as the Court found that the law prohibiting assisted suicide was overbroad and overreached the objectives of the law.

³²² *Canada (Attorney-General) v Bedford* (note 96 above) 120.

³²³ *Seales* (note 12 above) 190 and 191.

basis of a purely legal analysis that somewhat clinical in its application and detached from Ms Seales' plight. Justice Collins acknowledged that the consequences of the current law were 'extremely distressing for Ms Seales'³²⁴ and that 'she [was] suffering because that law does not accommodate her right to dignity and personal autonomy.'³²⁵

Despite Ms Seales' right to life under s8 of the NZBORA being engaged, it was found that there was no inconsistency with the fundamental principles of justice and that there were legitimate exemptions therefrom established by law.

2.3.6 Analysis of the rights-based arguments: the right not to be subjected to torture or cruel treatment (s9)

Having decided on Ms Seales' right to life, it was necessary for Justice Collins to determine her rights under s9 of the NZBORA and decide whether the circumstances of her illness amounted to cruel, degrading or disproportionately severe treatment.³²⁶ This right enshrined in s9 of the NZBORA is not specific to New Zealand, but is found in numerous international instruments³²⁷ and the bills of rights of various countries.³²⁸

The argument presented in the case of *Seales* was that suffering from a terminal illness constitutes a form of suffering if it can be prevented.³²⁹ By depriving a person of the opportunity to bring their suffering to an end, the state subjects that person to cruel, degrading or disproportionately severe treatment.

It was similarly argued in *Rodriguez*³³⁰ that the Canadian Criminal Code's prohibition of assisted suicide breached Rodriguez's right not to be subjected to cruel and unusual treatment or punishment in terms of s12 of the Canadian Charter on Rights and Freedoms.³³¹ The Supreme

³²⁴ Ibid 192.

³²⁵ Ibid.

³²⁶ *Seales* (note 12 above) 194.

³²⁷ ICCPR Article 7, European Convention on Human Rights and Fundamental Freedoms Art 3.

³²⁸ s12 of the Canadian Charter on Rights and Freedoms, Art 40.3.2 of the Irish Constitution.

³²⁹ *Seales* (note 12 above) 196.

³³⁰ *Rodriguez v British Columbia (Attorney-General)* [1993] 3 SCR 519.

³³¹ s12 of the Canadian Charter of Rights and Freedoms provides that everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

Court of Canada, however, rejected this line of reasoning and ruled that there had to be some form of state control over an individual before there could be 'treatment.' Therefore, it was held that a person suffering from a terminal illness and the effects of a disease is not subjected to 'treatment' for the purposes of s12 of the Canadian Charter, owing to a lack of state control over the individual's circumstances. It should be noted that although many of the findings in *Rodriguez* have been subsequently overruled by *Carter*, the court's approach to interpreting s12 of the Canadian Charter was not put in issue in *Carter*.³³²

Justice Collins made further reference to decisions made by the House of Lords and the European Court of Human Rights and in doing so, referred to Article 8 of the European Convention on Human Rights.³³³ It was concluded, however, that there is no correlation between Article 8 of the European Convention on Human Rights and the relevant provisions of the NZBORA, but that s12 of the Canadian Charter of Rights and Freedoms equates to s9 of the NZBORA.

Justice Collins therefore concluded that Ms Seales' rights under s9 were not engaged in the circumstances of her case for the following reasons: her distressing circumstances were as a direct consequence of her tumour and not her treatment; the treatment she was receiving was designed to alleviate the worst effects of her tumour and the State's duty under s9 is not to subject persons to cruel, degrading or disproportionately severe treatment which is a positive obligation that is not engaged by the criminal law prohibition on assisted dying that has the effect of continued suffering for persons in Ms Seales' position.³³⁴

It was ultimately concluded that none of the declarations sought by Ms Seales could be issued by Justice Collins and it was emphasised that only Parliament can address the 'complex legal, philosophical, moral and clinical issues' that were raised in the court proceedings to pass legislation to remedy the effects of the Crimes Act.

³³² *Seales* (note 12 above) 197.

³³³ Article 8 of the European Convention on Human Rights is the right to respect for private and family life.

³³⁴ *Seales* (note 12 above) 207.

2.4 Concluding remarks

Despite the New Zealand High Court's decision to deny Ms Seales the right to an assisted death, the Canadian judgment of *Carter* remains in full force and effect and can have a significant influence on future judicial decisions in South Africa, should further cases concerning assisted dying appear before South African courts. The abovementioned cases collectively highlight the need for a legislative framework within which matters concerning assisted dying can be regulated, as it is impractical for the courts to deal with such matters on a case-by-case basis and for terminally ill patients to have to handle the strain of court proceedings in their final months or perhaps weeks of life. This legislative framework shall be discussed further in Chapter 4 on proposed legislation.

These cases are thus central to this study as they contextualize a rights-based analysis of the issues pertaining to assisted dying and provide fresh insight into the current legal position in South Africa and pave the way for future legal challenges against the constitutionality of the prohibition on assisted dying.

Having examined the most current foreign and domestic jurisprudence regarding the limitation of protected rights, it is necessary to analyse the limitation of rights that occurs as a result of the prohibition on assisted dying in a South African context in order to determine whether or not said limitation is justifiable in an open and democratic society based on the principles of freedom, equality and human dignity.

CHAPTER 3: RIGHTS-BASED ANALYSIS OF ASSISTED DYING

3.1 Introduction

As an essential element of the legal discourse on assisted dying in South Africa, it is necessary to analyse the limitation of rights that emerges as a result of the prohibition on assisted dying in order to determine whether there is a limitation of rights and, if so, whether such a limitation is justifiable. The outcome of this analysis will be influential when formulating legislation to regulate the practice of assisted dying, as the nature and scope of the procedures and safeguards implemented through the legislation would have to adequately remedy the limitation and infringement of rights that has occurred.

This chapter aims to analyse the limitation of rights in the context of the prohibition on assisted dying by first tracing the development of the limitation of rights enquiry in order to understand the relevance of Canadian and early South African jurisprudence in the limitation enquiry. The two-stage approach to the limitation of rights will then be followed in order to first determine whether there is an infringement or limitation of a constitutionally protected right and second to determine whether the limitation is justifiable.

Section 36 of the 1996 Constitution will provide the basic structure for the limitation of rights enquiry, using South African jurisprudence, the Interpretation Clause and international human rights law to analyse the effects and implications of the limitation.

3.2 Limitation of rights under the Constitution

3.2.1 Introduction

In defending our fledgling democracy, the importance of protecting and promoting human rights for all South Africans cannot be overstated, however, it must also be conceded that rights are not

absolute.³³⁵ The 1996 Constitution thus contains a limitation clause in s36 that enables the ‘constitutionally valid limitation of rights’³³⁶ should such a limitation be necessary.

Justifying the limitation of rights is not a simple process and bears significant consequences as a result of South Africa’s turbulent history, which saw the systematic violation of fundamental rights and freedoms which required a remedy of intense legal transformation and resulted in our present constitutional democracy. It can thus be very difficult to determine what constitutes a justifiable limitation of a person’s rights, considering how far the development of human rights has come in South Africa. The limitation of rights is therefore not an enquiry or a process that can be taken lightly and requires careful consideration and evaluation. The reasons for limiting a right need to be ‘exceptionally strong’³³⁷ and the limitation must serve a ‘compellingly important’³³⁸ purpose.

It should be noted that the burden of proving that the limiting measure is justifiable falls on the party who seeks to rely on the limiting measure, and it is thus not up to the party challenging the limiting measure to show that it is not justified.³³⁹ Therefore, the burden should not be on a terminally ill patient to prove that the prohibition on assisted dying is not justified, but the burden lies on the State to establish the justification of the prohibition. In the context of the assisted dying debate in South Africa, the government has made a somewhat unsatisfactory attempt to justify the limiting measure and the finding of the High Court in the *Stransham-Ford* judgment will make it even more difficult for the State to justify the prohibition on assisted dying.

3.2.2 Background

Before proceeding with an analysis of the South African approach to the limitation of rights, it is important to consider the development and evolution of the limitation analysis in South Africa.

³³⁵ I Currie & J de Waal *The Bill of Rights Handbook* 5 ed (2008) 163.

P de Vos & W Freedman (eds) *South African Constitutional Law in Context* 1 ed (2014) 347.

³³⁶ De Vos *et al* (note 335 above) 347.

³³⁷ Currie & de Waal (note 335 above) 164.

³³⁸ *Ibid.*

³³⁹ In *Makwanyane*, at para 102, it was held: ‘It is for the legislature, or the party relying on the legislation, to establish this justification and not for the party challenging it to show that it was not justified.’

The limitation clause found in s36 of the Bill of Rights developed from the s33 of the Interim Constitution, the drafting of which was influenced by the Canadian Charter of Rights and Freedoms.³⁴⁰ It thus stands to reason that, when interpreting s33 of the Interim Constitution, the Constitutional Court would rely on the Canadian Supreme Court's decision of *R v Oakes*³⁴¹ for guidance in its approach. It is important to take note of these developments in order to understand how they have shaped the current limitation enquiry based on s36 of the 1996 Constitution.

The case of *R v Oakes* established a test which is essentially an analysis of section 1 of the Canadian Charter of Rights and Freedoms, the limitations clause, which allows for the reasonable limitation of rights and freedoms, sanctioned through legislation if it can be 'demonstrably justified in a free and democratic society.'³⁴² The *Oakes* test is twofold and determines whether a person's rights can be justifiably infringed by first showing that the law has a 'pressing and substantial object'³⁴³ and second, that the means chosen are 'proportional'³⁴⁴ to that object. The law will be deemed proportionate if it satisfies three criteria: first, there is a 'rational connection'³⁴⁵ between the means adopted and the objective, second, whether the law is 'minimally impairing'³⁴⁶ of the right in question and third, whether there is 'proportionality between the effects of the measures which are responsible for limiting the right in question'³⁴⁷ and the objective thereof which is held to be of 'sufficient importance.'³⁴⁸

Essentially, once a court has established that a law or a legislative provision infringes on one or more of the rights guaranteed in the Bill of Rights, the court must then determine whether or not the infringement is justifiable.³⁴⁹ This infringement of rights is also referred to as a 'limitation'.³⁵⁰ The test to determine whether a person can prove that their rights have been limited is a complex one, but through an analysis of relevant jurisprudence, it appears as though the test for the

³⁴⁰ Du Bois *et al Willes Principles of South African Law* 9th ed (2007) 111.

³⁴¹ *R v Oakes* [1986] 1 SCR 103.

³⁴² Section 1 of the Canadian Charter of Rights and Freedoms.

³⁴³ *R v Oakes* [1986] 1 SCR 103 74 69.

³⁴⁴ *Ibid* 70.

³⁴⁵ *Ibid*.

³⁴⁶ *Ibid*.

³⁴⁷ *Ibid*.

³⁴⁸ *Ibid*.

³⁴⁹ *Ibid*.

³⁵⁰ Currie & de Waal (note 335 above) 164.

limitation of rights is essentially twofold: first, it must be determined whether there has been an infringement or limitation of rights and, if so, the court must then determine whether or not the limitation is 'justifiable in terms of the limitation clause.'³⁵¹

Early on, the South African Constitutional Court was somewhat inconsistent in its approach to the limitation of rights, as the enquiry that had to be followed was not applied identically in each case determined by the Court. The Constitutional Court elected not to follow the 'structured and sequential approach'³⁵² to determining the justifiability of a limitation of rights as established in *Oakes*. Instead, the Constitutional Court, in *S v Makwanyane*, adopted a 'singular global approach'³⁵³ and considered a list of factors together in a 'balancing test' which combined the requirements of reasonableness and necessity, introduced the notion of proportionality and omitted to address justifiability.

In the *Makwanyane* judgment, Chaskalson P asserted:

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 s33(1).³⁵⁴

It was further noted that although set of 'principles could be established, the application of those principles to particular circumstances could only be done on a case-by-case basis'³⁵⁵ which is an inherent requirement of proportionality and calls for the 'balancing of different interests.'³⁵⁶

When the 1996 Constitution came into effect, the limitation clause was included in s36 of the Bill of Rights and provides:

³⁵¹ Currie & de Waal (note 335 above) 166.

³⁵² De Vos *et al* (note 335 above) 386.

³⁵³ De Vos *et al* (note 335 above) 350.

³⁵⁴ Makwanyane (note 199 above) 104.

³⁵⁵ *Makwanyane* (note 199 above) 104.

³⁵⁶ De Vos *et al* (note 335 above) 350.

The rights in the Bill of Rights may be limited only in terms of the 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-

1. the nature of the right;
2. the importance of the purpose of the limitation;
3. the nature and extent of the limitation;
4. the relation between the limitation and its purpose;
5. less restrictive means to achieve the purpose.

South African jurisprudence regarding the limitation of rights has changed considerably since s36 came into operation and the Canadian jurisprudence concerning the limitation of rights has also developed substantially in the years following the *Oakes* judgment.

With particular reference to South African jurisprudence, the most significant change in the development of the limitation enquiry came about as a result of the structure of the s36 limitation clause. The 'sequential, structured approach'³⁵⁷ (which addressed a series of specific question) that was found in s33 of the Interim Constitution was abandoned in s36 of the 1996 Constitution. The drafters of the 1996 Constitution followed the approach that was taken in the *Makwanyane* judgment, by taking a more global approach that required the consideration of certain factors and used the terms 'reasonable and justifiable'³⁵⁸ rather than the language of 'balancing and proportionality'.³⁵⁹ Section 36 also included new factors such as 'less restrictive means'³⁶⁰ as well as the factors relevant to balancing,³⁶¹ as found in *S v Makwanyane*.³⁶²

3.2.3 *The structure of the limitation of rights*

Section 36 shall be used in conjunction with jurisprudence from the Constitutional Court as the basis for the analysis of the limitation of rights, following the two-stage approach that has been taken by the Court to deal with the limitation of rights. As explained in broad terms by the Court

³⁵⁷ De Vos *et al* (note 335 above) 350.

³⁵⁸ Ibid 352.

³⁵⁹ Ibid.

³⁶⁰ S36(1)(e) of the Constitution.

³⁶¹ *S v Makwanyane* (note 199 above) 104.

³⁶² De Vos *et al* (note 335 above) 352.

in *South African National Defence Union v Minister of Defence*,³⁶³ the two-stage approach first asks ‘whether the provision in question infringes the rights protected by the substantive clauses of the Bill of Rights’³⁶⁴ and, if so, it must then be determined whether or not that ‘infringement is justifiable.’³⁶⁵

A more detailed explanation of the two-stage approach was set out by the Constitutional Court in *Ex Parte Minister of Safety and Security and Others: In Re S v Walters and another*. The Court stated:

First, there is the threshold enquiry aimed at determining whether or not the enactment in question constitutes a limitation on one or another guaranteed right. This entails examining (a) the content and scope of the relevant protected right(s) and (b) the meaning and effect of the impugned enactment to see whether there is any limitation of (a) by (b). Subsections (1) and (2) of s39 of the Constitution give guidance as to the interpretation of both the rights and the enactment, essentially requiring them to be interpreted so as to promote the value system of an open and democratic society based on human dignity, equality and freedom. If upon such analysis no limitation is found, that is the end of the matter. The constitutional challenge is dismissed there and then. If there is a limitation, however, the second stage ensues. This is ordinarily called the limitations exercise. In essence, this requires a weighing up of the nature and importance of the right(s) that are limited together with the extent of the limitation as against the importance and purpose of the limiting enactment. Section 36(1) of the Constitution spells out these factors that have been put into the scales in making a proportional evaluation of all the counterpoised rights and interests involved.³⁶⁶

In order to determine the ‘content and scope of the rights in question,’³⁶⁷ three essential elements need to be taken into consideration, namely: s39 of the 1996 Constitution (the Interpretation Clause), a contextual interpretation of the rights and international human rights law. The

³⁶³ *South African National Defence Union v Minister of Defence* 1999 (4) SA 469 (CC).

³⁶⁴ *Ibid* 18.

³⁶⁵ *Ibid* 18.

³⁶⁶ *Ex Parte Minister of Safety and Security and Others: In Re S v Walters and another* 2002 (4) SA 613 (CC) 26-27.

³⁶⁷ *Ex Parte Minister of Safety and Security and Others: In Re S v Walters and another* 2002 (4) SA 613 (CC) 26-27.

contextual interpretation of rights was advocated for by the Constitutional Court in *Bernstein and Others v Bester NO and Others*.³⁶⁸

It should be noted that if rights are interpreted in an excessively narrow way, this could hinder the limitation enquiry process. Similarly, an interpretation that is too broad or ‘insufficiently discerning’³⁶⁹ would undermine the value of the substantive approach to the enquiry. Therefore, it is necessary to ensure that the first stage of the enquiry clearly and accurately defines the content and scope of the rights that will form the basis of the enquiry, as this will be important at a later stage when determining whether the limitation or infringement strikes at the core of the right or whether it merely infringes upon the periphery of the right.

Therefore, in following the same structure of the limitation enquiry that is followed by the Constitutional Court, it is necessary to begin by first looking at the substantive rights in question and determining whether there was an infringement or limitation of the relevant rights.

3.3 Assisted dying: a constitutional, rights-based analysis

3.3.1 Introduction

In light of the *Stransham-Ford* decision and the apparent trend in foreign legislation toward approaching the issue of legalising assisted dying from a rights-based perspective, the limitation of rights analysis is relevant in the context of assisted dying as it serves to highlight the most pertinent issues and emphasises the impact of the limitation on terminally ill patients who wish to die with dignity. The enquiry allows us to see the shortfalls of the prohibition on assisted dying which simplifies the process of finding a remedy to the infringement of rights.

In the context of assisted dying, the prohibition on assisted dying is a limiting measure that has an impact on several rights enshrined in the Bill of Rights as well as certain ‘analogous rights’ that exist by virtue of the operation of the substantive rights protected by the Bill of Rights. Such an analogous right would be the right to autonomy which, although not expressly protected or

³⁶⁸ 1996 (2) SA 751 (CC).

³⁶⁹ De Vos *et al* (note 335 above) 357.

provided for in the Bill of Rights, exists by virtue of respecting one's right to dignity, privacy and bodily and psychological integrity.³⁷⁰ While analogous rights remain controversial, courts have relied on autonomy on more than one occasion in order to assist in reaching decisions.³⁷¹ For the purposes of analysis, autonomy will thus be considered an analogous right. This shall be discussed below in further detail.

The first step that needs to be taken in order to determine whether or not the prohibition on assisted dying constitutes a limitation on one or another of the guaranteed rights is to 'examine (a) the content and scope of the relevant protected right(s) and (b) the meaning and effect of the impugned enactment³⁷² to see whether there is any limitation of (a) by (b).'³⁷³ The protected rights that will be examined for the purposes of this limitation enquiry are the right to life and the right to dignity, with reference to the analogous right to autonomy.

3.3.2 *Does the prohibition on assisted dying limit a constitutionally protected right?*

This enquiry will commence by considering the content and scope of three affected rights, namely life, dignity and autonomy. Although there are other rights affected by the prohibition on assisted dying, such as bodily and psychological integrity, the rights to life, dignity and autonomy are the most fundamental and all-encompassing rights affected by the prohibition on assisted dying. The enquiry will then consider the impugned provision, namely the common law prohibition on assisted dying in order to determine whether the prohibition has infringed the aforementioned rights which will complete the first half of the two-stage approach to the limitation of rights enquiry.

³⁷⁰ *State v Jordan and others (Sex worker Education and Advocacy Task Group and others as Amicus Curiae)* 2002 (6) SA 642 (CC) 52.

³⁷¹ In the case of *AB and another v Minister of Social Development as amicus curiae: Centre for Child Law* (40658/13) [2015] ZAGPPHC 580 (12 August 2015) it was stated at 68: "autonomy is a Constitutional value that should be considered in deciding this question before the court." In the same judgment [65 – 69] reference was made to the role of autonomy in deciding other cases such as *Barkhuizen v Napier* 2007 (5) SA 323 (CC), *NM v Smith* 2007 (5) SA 250 (CC) and *State v Jordan and others (Sex worker Education and Advocacy Task Group and others as Amicus Curiae)* 2002 (6) SA 642 (CC)

³⁷² Although there is no specific legislative enactment that prohibits the practice of assisted dying in South Africa, the development of the criminal law that prohibits assisted dying shall be discussed in further detail below.

³⁷³ *Walters* (note 366 above) 26-27.

3.3.2.1 *The Right to Life*

The right to life is the most fundamental of all human rights and can be seen as the ‘first of the absolute human rights.’³⁷⁴ The right to life is protected by s11 of the Bill of Rights which states that ‘everyone has the right to life.’³⁷⁵ When examining the content and scope of the right to life, however, it becomes evident that the right to life is a complex and multifaceted right. In order to determine the meaning of the right to life, it is prudent to analyse the value of life and determine what implications the value of life has on the meaning and definition of the right to life.

The value of life can be conceptualised in numerous different ways, but for the purposes of this analysis, these conceptualisations have been grouped into three main categories: *intrinsic*, *instrumental* and *self-determined*.

The first possible conceptualisation of the value of life supports the notion that life has *intrinsic* value. This means that the value of life lies in simply being alive. This resonates with religious undertones and deontological thinking as it conveys the sanctity of life, the idea that life in itself is sacred, should ‘not be intentionally brought to a premature end’³⁷⁶ and that life/being alive is an end in itself. If the right to life is conceptualised as having *intrinsic* value, ‘quantity’ of life would have more importance than ‘quality’ of life. This means that those who believe in the intrinsic value of life would choose to prolong one’s existence, regardless of circumstances or quality of life. Even if a person is terminally ill and suffering through immense pain and diminished physical capabilities, the value of that person’s life lies in how long they live rather than how well they live.

Another conceptualisation of the value of life is that life has *instrumental* value. This means that life is viewed as a means to an end, the end being the ability to enjoy whatever it is that really makes life worth living.³⁷⁷ Thus, the notion of *quality of life* becomes a central concept in determining the value and meaning of the right to life. If a person loses their quality of life, their ability to enjoy the amenities of life and/or their ability to live with dignity (through disability,

³⁷⁴ *Blackstone’s Commentaries on the Laws of England* vol 1 (1765) 101.

³⁷⁵ S11 of the Constitution.

³⁷⁶ M Cholbi & J Varelius *New Directions in the Ethics of Assisted Suicide and Euthanasia* 1 ed (2015) 154.

³⁷⁷ R Huxtable *All That Matters: Euthanasia* 1 ed (2013) 7.

illness or old age), it may be argued that one's right to life has been eroded to such an extent that one would prefer to bring one's life to a premature end as life has no value if one is unable to enjoy one's life. In such instances, respect should be given to a person's decision to end their life if they are unable to enjoy or realise their right to life when they have no quality of life and thus feel life has no value.

A third conceptualisation of the value of life is that life has a *self-determined* value. In accordance with this proposition, decisions pertaining to the way in which a person's life ends should be left to the individual in question to decide independently. This conceptualisation resonates with the notion that the right to life actually means the right to life with dignity, as shall be discussed further below.

The landmark judgment of *S v Makwanyane* may be interpreted in a manner that finds favour with the notion of life having *instrumental* or even *self-determined* value rather than *intrinsic* value. In *Makwanyane*, life and dignity were highlighted as the two 'most important'³⁷⁸ human rights that should be valued 'above all others.'³⁷⁹ This raises the prospect that the right to life should be interpreted to mean a life with dignity.

The Constitutional Court further endorsed this notion of an 'inherent fusion'³⁸⁰ between the rights to life and dignity and affording everyone the right to a life with dignity by stating:

It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity. This concept of human life is at the centre of our constitutional values. The Constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society. The right to life, thus understood, incorporates the right to dignity. So the right 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.³⁸¹

³⁷⁸ *Makwanyane* (note 199 above) 144.

³⁷⁹ *Ibid.*

³⁸⁰ Grove (note 5 above) 20.

³⁸¹ *S v Makwanyane* (note 199 above) 326.

Moreover, the Interpretation Clause provides that: ‘(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.’³⁸² This bolsters the notion that the right to life should be interpreted through the lens of human dignity and that the right to life exists as a right to a dignified life.

If ‘life’ is to be understood as ‘life with dignity’, this interpretation finds favour with the notion that life has an *instrumental* or *self-determined value*. If one merely exists, with no dignity or quality of life, it cannot be said that one is truly living and, as such, one is unable to realise one’s right to life.

The notion that the right to life should be understood as life with dignity is thrown into stark relief in cases where a person is so severely injured they are left unconscious or in a permanent vegetative state yet remain, biologically speaking, alive.³⁸³ An illustration of this concept can be found in the case of *Clarke v Hurst NO*³⁸⁴ where the court held that:

As it was put in 58 US Law Week 4936 “medical advances have altered the physiological conditions of death in ways that may be alarming: highly invasive treatment may perpetuate human existence through a merger of body and machine that some might reasonably regard as an insult to life rather than its continuation.” Patients may be resuscitated and maintained alive when there is not the remotest possibility that they would ever be able to consciously experience life.³⁸⁵

In instances where a person has experienced damage to the cortex of the brain³⁸⁶ rather than the brain stem,³⁸⁷ the person will be left in a permanent vegetative state and is thus not legally

³⁸² s39(1) of the Constitution.

³⁸³ Grove (note 5 above) 29.

³⁸⁴ *Clarke v Hurst NO* 1992 (4) SA 630 (D).

³⁸⁵ *Ibid* 697 e-g.

³⁸⁶ The cortex of the brain controls cognitive, conative and affective functions, as opposed to the brain stem which controls respiration and other bodily functions. If a person suffers damage to the cortex of the brain rather than the brain stem, their body will continue to perform vegetative functions such as breathing, but the person will be permanently unconscious and unable to speak, think, feel or experience sensation, thus being left in a permanent vegetative state.

³⁸⁷ The National Health Act 61 of 2003 defines ‘death’ as ‘brain death’ which is understood to mean irreversible damage to the brain stem which constitutes death for legal purposes. Previously, a person was considered dead as a result of the permanent cessation of heart and lung functioning. As a result of the development of technology and medical interventions that can maintain the heartbeat and lung functioning artificially, the law had to develop and

dead.³⁸⁸ In the case of *Clarke v Hurst NO*, the patient sustained damage to the cortex of the brain and was maintained in a permanent vegetative state through naso-gastric feeding, a process whereby feeding tubes are introduced to the stomach through the nose. The patient's wife approached the court seeking an order authorising her to withhold this nourishment and, as a result, the patient would starve and die.³⁸⁹

The patient's life expectancy was uncertain and undeterminable, but the court found that there was no reasonable expectation of the patient emerging from the permanent vegetative state as his brain had 'permanently lost the capacity to induce a physical and mental existence at a level which qualifies as human life.'³⁹⁰

It becomes evident from this dictum that there is a strong nexus between life and dignity, as the court refers to a level of existence which can qualify as human life, alluding to the importance of quality of life for human existence. *Clarke v Hurst NO* established the judicial precedent that 'human life amounts to more than mere biological functions but must also be accompanied by both cortical and cerebral functioning.'³⁹¹ This calls into question the importance of quality of life and highlights the inextricable link between life and dignity.

It should also be noted that international instruments such as the International Covenant on Civil and Political Rights³⁹² and the European Convention on Human Rights³⁹³ ensure the right to life is respected and protected on an international level. Moreover, numerous states have enshrined the right to life in their bills of rights such as the United States of America's Constitution (14th

consequently, a person is considered dead for the purposes of the law if they are brain dead and have suffered irreversible damage to the brain stem.

³⁸⁸ J Milton *South African Criminal Law and Procedure: Common-law Crimes* 3 ed (1996) 349.

³⁸⁹ *Ibid.*

³⁹⁰ *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) 659 A-B. Although the case of *Clarke v Hurst NO* was decided before the 1996 Constitution came into effect and did not examine the right to life in the context of the 1996 Constitution, the court's analysis of what constitutes life assists in determining the content and scope of the right to life for the purposes of the limitation enquiry.

³⁹¹ 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* 342.

³⁹² International Covenant on Civil and Political Rights: Article 6: 'Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.'

³⁹³ European Convention on Human Rights: Article 2: 'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally, save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.'

Amendment), the Irish Constitution (Art 40.3.1), the South African Constitution (s11), Germanic basic law (Art 2.2), the Canadian Charter of Rights and Freedoms (s7) and the UK Human Rights Act (s1 and schedule 1, incorporating article 2 of the European Convention on Human Rights).

These international and foreign instruments have a significant influence on the interpretation of the right to life in South Africa as s39(1)(b) and s39(1)(c) of the Constitution place a ‘court, tribunal or forum under an obligation to consider international and foreign law when interpreting the Bill of Rights.’³⁹⁴ Moreover, s233 of the Constitution provides that: ‘When interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law.’

3.3.2.2 *The Right to Dignity*

For the purposes of the limitation enquiry, it should be noted that although the right to dignity can be viewed simply as a ‘value that informs the interpretation of other rights,’³⁹⁵ such as the right to life, the right to dignity should also be examined as an independent substantive right which can form the basis of the limitation enquiry in the context of assisted dying in order to determine whether or not said prohibition constitutes a justifiable limitation of the right to dignity. In order to do so, it is first necessary to analyse the content and scope of the right to dignity.

The right to dignity, as provided for in s10 of the Bill of Rights, states: ‘[e]veryone has inherent dignity and the right to have their dignity respected and protected.’³⁹⁶ Therefore, as alluded to

³⁹⁴ s39(1) of the Constitution: ‘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.’

³⁹⁵ *Stransham-Ford* (note 9 above) referring to *De Vos et al* (note 335 above) at 352.

³⁹⁶ s10 of the Constitution.

above, dignity is both a constitutional value³⁹⁷ and a right³⁹⁸ and has been identified as central in both the founding provisions of the Constitution and by the Constitutional Court.³⁹⁹

In *S v Makwanyane*,⁴⁰⁰ the Constitutional Court acknowledged the importance of dignity which is highlighted in the statement made by O'Regan J:

The importance of dignity as a founding value of the new Constitution cannot be overemphasised. Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings; human beings are entitled to be treated as worthy of respect and concern. This right therefore is the foundation of many other rights that are specifically entrenched in chapter 3.⁴⁰¹

This view is bolstered by many prominent academics, such as Devenish who asserted that dignity is even more of a pre-eminent value than the right to life in the 1996 Constitution.⁴⁰² Moreover, Devenish noted that dignity 'constitutes the moral premise for the existence and operation of other cognate rights.'⁴⁰³ Joubert affirms that human dignity is probably the most important right in the Constitution⁴⁰⁴ and Grove concurs that human dignity is a pre-eminent and core constitutional right.⁴⁰⁵

Despite the right to dignity being protected by the Constitution and numerous international instruments, as evidenced above, as well as having judicial and academic authorities pronounce on the importance and supremacy of the right to dignity, it remains difficult to formulate a workable definition for the right to dignity. One of the possible reasons why the right to dignity proves difficult to define is that, as stated by O'Regan J in the *Makwanyane* judgment, the right to dignity is the 'foundation of many other rights'⁴⁰⁶ and, as such, is intricately linked to these

³⁹⁷ s1 of the Constitution.

³⁹⁸ s10 of the Constitution.

³⁹⁹ P Carstens & D Pearmain *Foundational Principles of South African Medical Law* 1 ed (2007) 29.

⁴⁰⁰ Devenish notes that although the *Makwanyane* case was decided before the 1996 Constitution was in place, the formulation of the right to dignity in the 1996 Constitution is substantially the same as the formulation of the right to dignity in the interim Constitution, the only difference being the inclusion of the term 'inherent' in the 1996 Constitution.

⁴⁰¹ *S v Makwanyane* 1995 (3) SA 391 (CC) 451.

⁴⁰² G Devenish *A Commentary on the South African Bill of Rights* (1999) 81.

⁴⁰³ Ibid.

⁴⁰⁴ Joubert *The Law of South Africa* (2004) 56.

⁴⁰⁵ LB Grove (note 5 above) 14.

⁴⁰⁶ *Makwanyane* (note 199 above) 328.

rights. It is therefore challenging to isolate the right to dignity and identify the scope and content thereof independently from all other rights.

Considering the difficulty of separating the right to dignity from other fundamental rights, dignity can be conceptualised as a lens through which other rights must be viewed. As evidenced above, there are inextricable links between the right to dignity and the right to life as well as other rights such as freedom and security of the person, privacy and equality. Even if a particular right is not expressly protected in the Constitution, there is evidence to support the fact that the Constitutional Court will protect that right if it is related to dignity.⁴⁰⁷

In the case of *Dawood*,⁴⁰⁸ no right existed in the Bill of Rights that specifically protected the right to marry and the right to family life for individuals. The right to dignity was thus relied upon as there was not a more specific right available to protect persons who wished to ‘enter into and sustain permanent intimate relationships.’⁴⁰⁹ It is therefore evident that the right to dignity can be used by the courts to deal with infringements of human rights that are not specifically addressed by other rights explicitly included in the Bill of Rights.⁴¹⁰

Although dignity can be seen as merely a value that informs the interpretation of other rights in the Bill of Rights, the justiciability and enforceability of dignity as a self-standing independent right should not be forgotten. The right to dignity, as formulated in s10 of the Constitution as an independent substantive right, can be viewed in two ways: narrowly, as a personal right associated with one’s own identity, autonomy and moral agency or broadly, as a means to create an opportunity for all persons to reach their full potential and experience complete freedom, securing space for the fulfilment of self-actualisation.⁴¹¹ Thus, the scope of the constitutional right to dignity is determined by the constitutional value of dignity.⁴¹²

⁴⁰⁷ Joubert *The Law of South Africa* (2004) 58.

⁴⁰⁸ *Dawood and another v Minister of Home Affairs and others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* 2000 (1) SA 997 (C).

⁴⁰⁹ Ibid 36.

⁴¹⁰ De Vos (note 335 above) 461.

⁴¹¹ Ibid 458.

⁴¹² A Barak *Human Dignity: The Constitutional Value and the Constitutional Right* (2015) 267.

The right to dignity has been further informed by international jurisprudence as Chaskalson P used the Canadian Supreme Court's judgment in the case of *Law v Canada (Minister of Employment and Immigration)*⁴¹³ to inform his interpretation of the right to dignity. In the case of *Law v Canada* it was held:

Human dignity means that an individual or group feels self-respect and self-worth. It is concerned with physical and psychological integrity and empowerment. Human dignity is harmed by unfair treatment premised upon personal traits or circumstances which do not relate to individual needs, capacities or merits. It is enhanced by laws which are sensitive to the needs, capacities or merits of different individuals, taking into account the context of their differences. Human dignity is harmed when individuals and groups are marginalised, ignored, or devalued, and is enhanced when laws recognise the full place of all individuals and groups within society.⁴¹⁴

The right to dignity has also been enshrined in numerous international instruments such as the United Nations' Universal Declaration of Human Rights (UDHR) which, in its preamble, recognises 'inherent dignity and equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world.'⁴¹⁵ The UDHR further provides that all human beings are 'born free and equal in dignity and rights.'⁴¹⁶ In addition, the Organisation of African Unity's Charter on Human and People's Rights, in its preamble, considers the Charter of the Organisation of African Unity which stipulates that 'freedom, equality, justice and dignity are essential objectives for the achievement of the legitimate aspirations of the African peoples'⁴¹⁷ and further provides that:

[E]very individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man, particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

⁴¹³ 1 SCR 497 (1999).

⁴¹⁴ *Law v Canada (Minister of Employment and Immigration)* 1 SCR 497 (1999) 53.

⁴¹⁵ Preamble to the Universal Declaration of Human Rights.

⁴¹⁶ Article 1 of the Universal Declaration of Human Rights.

⁴¹⁷ Preamble to the African Charter on Human and People's Rights.

South African courts would thus be obliged to consider these international instruments when interpreting the right to dignity in accordance with s39(1)(b) and s233 of the Constitution, as mentioned above.

3.3.2.3 *Autonomy*

It should also be noted that, although a right to autonomy is not explicitly provided for in the Bill of Rights, the constitutional rights to dignity,⁴¹⁸ privacy⁴¹⁹ and bodily and psychological integrity⁴²⁰ cumulatively indicate that there is an argument to be made for the existence of an analogous right to autonomy.

It has previously been held that autonomy is not recognised as an independent right, but rather as an underlying constitutional value.⁴²¹ The constitutional value of autonomy is understood to mean the 'ability to independently form opinions and act on them'⁴²² which is 'the very essence of freedom and a vital part of dignity.'⁴²³ When attempts have been made to elevate the value of autonomy to a right, it has been argued that although there is considerable 'overlap'⁴²⁴ between the rights to dignity, freedom and privacy, it is not useful for the purposes of constitutional analysis to 'posit an independent right to autonomy'⁴²⁵ and further, that it is 'not appropriate to base constitutional analysis on a right not expressly included within the Constitution.'⁴²⁶

It has been argued, however, that it is a matter of 'extreme significance'⁴²⁷ for all persons to be able to determine how they live their lives. Moreover, it is the right and the ability to make decisions that matters more than the content of the decision itself and the State 'should not be empowered to make judgments concerning good or bad life, provided that the conduct in

⁴¹⁸ s10 of the Constitution.

⁴¹⁹ s14 of the Constitution.

⁴²⁰ s12(2) of the Constitution.

⁴²¹ *AB and Another v Minister of Social Development as Amicus Curiae: Center for Child Law* (40658/13) [2015] ZAGPPHC 580 (12 August 2015) 65.

⁴²² *Ibid* 66.

⁴²³ *Barkhuizen v Napier* 2007 (5) SA 323 (CC) 57.

⁴²⁴ *State v Jordan and Others (Sex Worker Education and Advocacy Task Group and others as Amicus Curiae)* 2002 (6) SA 642 (CC) 52.

⁴²⁵ *State v Jordan and Others (Sex Worker Education and Advocacy Task Group and others as Amicus Curiae)* 2002 (6) SA 642 (CC) 53.

⁴²⁶ *Ibid*.

⁴²⁷ *Ibid* 52.

question does not harm others.⁴²⁸ Patient autonomy is thus more than a mere ethical concept, an abstract philosophical notion or an underlying value but should be considered a right afforded to all persons, especially in the context of health care. Despite the role and significance of autonomy in the assisted dying debate, the right to autonomy is not a substantive right provided for in the Bill of Rights, and thus jurisprudence dictates it should not be used as a right for the purposes of this limitation enquiry analysis.⁴²⁹ Should the courts decide otherwise, it can be assumed that for the purposes of analysis, the right to autonomy would be limited in a similar fashion to the other rights expressly provided for in the Bill of Rights.

Having touched on the content and scope of the right to life and the right to dignity, it is necessary to analyse the ‘meaning and the effect of the impugned enactment’⁴³⁰ in order to determine whether there has been an infringement or limitation of the rights to life and dignity.

3.3.3 The meaning and effect of the prohibition on assisted dying

In the context of assisted dying in South Africa, there exists no legislative enactment that expressly prohibits the practice of assisted dying. As indicated above, other countries such as Canada and New Zealand have express legislative provisions that prohibit the practice of assisted dying.

The prohibition on assisted dying in South Africa is therefore not a statutory prohibition, but a common law prohibition that is found embedded in the case law and jurisprudence of criminal law. Although there are no specific legislative provisions that can be analysed, the development of the prohibition on assisted dying, as found in criminal case law, shall be analysed to determine the meaning and effect of the limiting measure.

Accordingly, it is necessary, at this stage of the limitation enquiry, to determine the meaning and effect of the prohibition on assisted dying and to see whether this limiting measure infringes the right to a dignified life and the independent right to dignity. This analysis shall be fact specific

⁴²⁸ Ibid.

⁴²⁹ *State v Jordan and Others (Sex Worker Education and Advocacy Task Group and others as Amicus Curiae)* 2002 (6) SA 642 (CC) 53.

⁴³⁰ In this context, the impugned enactment is the prohibition on assisted dying.

and shall focus on the nature and breadth of the prohibition on assisted dying in order to determine whether the limiting measure strikes at the heart of the rights or merely on the periphery.

In order to understand the current legal position pertaining to assisted dying in South Africa, it is necessary to note important legal developments that took place and that have influenced the law as it stands today.

3.3.3.1 Development of the Prohibition on Assisted Dying in Criminal Law

In the 1955 case of *R v Davidow*,⁴³¹ the accused's mother was suffering from unbearable pain as a result of an incurable illness. Davidow requested the assistance of a friend to inject his mother with a lethal dose of medication to relieve her from her suffering, but the friend refused to do so. Evidence was led that indicated Davidow's mother had said, on numerous occasions in his presence, that she wished she could be dead as she could no longer bear the pain and suffering. Davidow eventually visited his mother in hospital and shot her in the head with a revolver, killing her instantly. A letter, written by Davidow to his brother the night before, indicated that he intended to relieve their mother of her suffering 'without causing her pain.' Despite his merciful intentions, Davidow was charged with murder. Psychiatric evidence was led which indicated Davidow had developed an obsession to 'help' his mother which led him to act automatically and involuntarily and he was subsequently acquitted by the jury that tried him.⁴³²

Suicide was decriminalised in South Africa in 1962 in the case of *S v Gordon*⁴³³ which was subsequently upheld by the then Appellate Division in the case of *S v Grotjohn*.⁴³⁴ Despite the decriminalisation of suicide, the then Appellate Division, in the *Grotjohn* case, held that it is unlawful to assist a person to commit suicide if the assistance provided to that person is considered the effective cause of death.⁴³⁵ The principles of the *Grotjohn* case clearly established that a person will be held liable for murder if they provide assistance to another person who

⁴³¹ Unreported, June 1955 WLD.

⁴³² A Carmi *Euthanasia* 1 ed (2012).

⁴³³ *S v Gordon* 1962 (4) SA 727 (N) 729.

⁴³⁴ *Ex Parte Die Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A) 363D, 366.

⁴³⁵ JM Burchell & J Milton *Principles of Criminal Law* 4 ed (2014) 567.

commits suicide.⁴³⁶ It is somewhat anomalous that, as a result of the decriminalisation of suicide, every person has the right to commit suicide, but the assistance thereof remains unlawful.

In 1968 the case of *S v De Bellocq*⁴³⁷ highlighted legal issues pertaining to active euthanasia and the role played by an accused person in facilitating the death of another. De Bellocq gave birth to a premature child who, within three weeks of birth, was admitted to hospital and diagnosed with toxoplasmosis. De Bellocq, having studied medicine in Paris, was aware of the disease and its prognosis and thus understood that the child would not be able to drink and would have to be fed with a tube through the nose and into the stomach. There was no reasonable chance that the child would live for any length of time, and evidence was led by a professional pediatrician who testified that he would not have treated the child medically if it were his own child. When it was ascertained that nothing more could be done for the child, De Bellocq took her child home and, while bathing the child, drowned it. De Bellocq was charged with murder, as she confessed her intention was to kill her child and the court held that the law does not permit the killing of any person, irrespective of whether the person is very ill or an imbecile. Although De Bellocq was charged with murder and the court found that killing her child was an unlawful act that amounted to murder in the law, De Bellocq was never called upon to come up for sentence and thus no sentence was ever imposed.

The next major criminal case that dealt with assisted dying and mercy killing in South Africa was the case of *S v Hartmann*.⁴³⁸ Hartmann was a medical practitioner whose elderly father had been suffering from prostate cancer for several years, which had spread throughout his body and, after treatment in Pretoria, was admitted as a private patient of his son, Dr Hartmann, in Ceres. By the time Hartmann's father was admitted into his care, there was no hope for a cure as he was completely bedridden, incontinent, emaciated and was suffering tremendous pain for which he was administered analgesic drugs. The patient's condition continued to deteriorate and he was reliant on intravenous food as he was unable to swallow without choking and was in a critical state, near to death. Dr Hartman injected additional morphine and a rapid onset barbiturate general anaesthetic into his father's drip which caused his father's death within seconds.

⁴³⁶ J Milton *South African Criminal Law and Procedure: Common-law Crimes* 3 ed (1996) 356.

⁴³⁷ 1975 (3) SA 538 (T).

⁴³⁸ 1975 (3) SA 532 (C).

Evidence led at the trial indicated that his father would have probably died a few hours later as a result of his critical condition, but the court found Dr Hartmann guilty of murder because the law is clear that even if an accused person merely hastens the death of a person who was about to die anyway, the actions of the accused nevertheless constitute the crime of murder. Although Dr Hartmann's sentence consisted of a period of imprisonment for one year, he was only detained until the rising of the court. Dr Hartmann was granted a suspension of his sentence for the remaining period.⁴³⁹

Subsequent to the aforementioned mercy killing cases was the case of *S v Marengo*⁴⁴⁰ in which the accused intentionally killed her father by shooting him twice in the head with a firearm he kept next to his bed for self-defence. Marengo pleaded guilty to murder, but claimed that her actions were motivated by her desire to put an end to her father's suffering, as he was 81 years old and had been suffering from cancer. She was convicted and sentenced to three years imprisonment which was suspended for a period of five years.

A somewhat more recent criminal case dealing with assisted dying was the case of *S v Nkwanyana*⁴⁴¹ in which the deceased, suffering from a severe psychiatric disorder, wanted to kill herself and had attempted to do so on numerous occasions. The deceased requested assistance from Nkwanyana and, after initially refusing, the accused finally agreed to her persistent requests. Nkwanyana obtained a firearm illegally and shot the deceased for which he pleaded guilty as a first time offender. It was evident that the accused was not a threat or danger to society and the court held that the deceased wanted to be killed and had planned her own death. These amounted to exceptional and compelling circumstances which justified a lesser sentence than what was provided for in terms of the Criminal Law Amendment Act 105 of 1997. Nkwanyana was convicted of murder and sentenced to five years imprisonment, suspended conditionally.

⁴³⁹ A Carmi *Euthanasia* 1 ed (2012).

⁴⁴⁰ 1991 2 SACR 43.

⁴⁴¹ 2003 (1) SA 303 (W).

3.3.3.2 Effect of the Prohibition on Assisted Dying

Although the courts have been firm in their application of the law in cases that deal with assisted-dying and mercy killing, as we see in all these cases, there has been a noticeable trend toward lenient sentencing. Lenient sentencing, however, does little to detract from the severity of criminal charges against a person who has attempted to relieve another person of their suffering, either at their request or out of compassion. By charging a person with murder for assisting another person to end their life, the courts have upheld the prohibition on assisted dying which has serious implications for both the person suffering from a terminal illness as well as the doctor or loved one who attempts to relieve the terminally ill patient from their suffering.

The prohibition on assisted dying has a serious impact on the lives of those who are enduring unbearable suffering as a result of a terminal illness and wish to end their lives. If terminally ill patients require assistance to fulfil their wishes, the prohibition on assisted dying denies them the right to commit suicide. Moreover, the prohibition on assisted suicide places great emotional strain on the families of terminally ill patients who are put in a quandary when they are asked to assist a loved one to end their life, but are unable to do so and are forced to watch their loved ones suffer through pain and a loss of dignity and autonomy if palliative care is inaccessible or ineffective.

It is difficult to make a general statement with regard to the symptoms and effect that a terminal illness will have on a patient. Various factors such as the nature of the illness, the chosen course of treatment, the patient's medical history and the patient's personal traits will influence the nature and outcome of the case, therefore, it is difficult to make broad assertions as to the physical and psychological effect a degenerative terminal illness will have on a person. It is, however, common among all terminal illnesses that the patient will suffer from a diminishing state of health and will lose strength and physical control over one's own body. The very nature of a terminal illness erodes one's quality of life and impacts severely on one's dignity as one loses control and independence as a result of decreased physical capabilities. Moreover, intense treatment options, such as chemotherapy and palliative sedation, can also erode one's dignity and quality of life as shall be discussed below.

Evidence led in the *Stransham-Ford* case illustrates some of the effects that a terminal illness and related treatment options can have on a person. The applicant in the *Stransham-Ford* case suffered from stage four cancer which began as adenocarcinoma and spread to his ‘lower spine, kidneys and lymph nodes.’⁴⁴² It was reiterated in the judgment that the ‘applicant’s quality of life [had] deteriorated markedly’⁴⁴³ as a result of his terminal illness, and the court acknowledged that the Applicant’s imminent future included a ‘worsening condition’, ‘increased frailty’ and ‘progression of the disease.’⁴⁴⁴

There are countless cases where patients who suffering from terminal illnesses endure the degeneration of their physical strength and gradually lose their dignity as their quality of life diminishes when they are no longer able to perform basic daily tasks and bodily functions independently. Although treatment options exist which aim to relieve these symptoms and ease the discomfort of a patient suffering from a terminal illness, not all patients are willing or able to access such palliative care and treatment.

In extreme cases, some patients continue to experience intolerable and unrelieved pain and suffering, despite extensive palliative care, and thus turn to palliative sedation.⁴⁴⁵ Palliative sedation treats pain, dyspnoea (shortness of breath and/or laboured breathing), nausea and vomiting, delirium and myoclonus (involuntary jerking or twitching of muscles) to enable a person to die comfortably.⁴⁴⁶ Palliative sedation is achieved by decreasing the level of the patient’s consciousness by ‘inducing varying degrees of unconsciousness, but not death, in order to relieve their physical distress and unendurable symptoms’⁴⁴⁷ when that patient is expected to die within hours or days. Should a person reach the stage where palliative sedation is required, they will no longer be able to communicate with their loved ones or those around them who are managing their care and treatment in the final moments before they die.

⁴⁴² *Stransham-Ford* (note 9 above) 4.

⁴⁴³ *Ibid* 5.

⁴⁴⁴ *Ibid* 7-11.

⁴⁴⁵ SD Bruce *et al* ‘Palliative Sedation in End-of-Life Care’ (2006) 8 *Journal of Hospice and Palliative Nursing* 320.

⁴⁴⁶ LA Jansen *et al* ‘Sedation, Ailmentation, Hydration and Equivocation: Careful Conversation about Care at the End of Life’ (2002) 136 *Annals of Internal Medicine* 845-849.

⁴⁴⁷ NI Cherney *et al* ‘Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment’ (1994) 11 *Journal of Palliative Care* 31-38.

Although palliative sedation is not ultimately required by all persons suffering from terminal illnesses, it is an unfortunate reality that many people are faced with this loss of autonomy and control at the end of their lives. By refusing to allow terminally ill patients the option of assisted dying, one is ultimately limiting the options available to a person suffering through sickness and pain and condemning them to choose between: (i) palliative care (ii) a loss of dignity and autonomy through palliative sedation, (iii) suffering through intolerable pain and unbearable symptoms, (iv) committing suicide, while still physically able to do so, which often results in a traumatic and premature death.

It must, however, be acknowledged that advancements and developments in the field of palliative care have allowed for the majority of terminally ill patients receiving palliative care to die peaceful and dignified deaths,⁴⁴⁸ but not all emotional and psychological suffering can be remedied by these medical advancements. The loss of control over one's body and physical capabilities and the loss of dignity experienced by many patients receiving palliative care can often only be remedied by enabling a patient to choose the manner and timing of his/her own death.

It is clearly evident, therefore, that the prohibition on assisted dying results in unnecessary physical and emotional suffering for terminally ill patients who are denied assistance in ending their lives in a dignified manner. By forcing terminally ill patients to remain alive against their will and to fight through weeks, months or even years of pain and suffering strips these patients of their dignity and autonomy. This prohibition on assisted dying therefore strikes at the heart of the right to a dignified life and the right to dignity.

As expounded above, the right to life is not merely the right to exist, but to live with dignity. It has been said that death should not be viewed as the opposite of life, but rather the completion thereof.⁴⁴⁹ Similarly, the opposite of assisted dying is not life, but rather pain, isolation, dependence and indignity. By refusing to allow terminally ill patients the right to end their lives

⁴⁴⁸ World Palliative Care Alliance, WHO Global Atlas of Palliative Care at the End of Life (2014).

⁴⁴⁹ *Stransham-Ford* (note 9 above) 14, referring to the American Supreme Court in *Cruzan vs Director, Missouri Department of Health, et al* 497 US 261 (1990) 343.

when they feel they have endured enough pain and suffering, the state strips these patients of their autonomy and dignity and strikes at the core of the right to life by forcing the terminally ill to endure a physical existence with little to no quality of life even after they feel they have had enough and expressed a desire to end their own lives. Naturally, the manner in which the value of life is conceptualised will have significant bearing on the outcome of this analysis. However, regardless of whether the value of life is conceptualised as being *intrinsic*, *instrumental* or *self-determined*, the effect of pain and suffering on a person's life remains the same. How one chooses to conceptualise the value of their life thereafter remains a personal view. Taking into account all of the aforementioned conceptualisations of the value of life, the fact remains that one should retain the right and the power to control all decision-making with regard to end of life care and practices, particularly in circumstances wherein your dignity and autonomy is severely impaired as a result of terminal illness.

The prohibition on assisted dying, therefore, does not merely infringe on the periphery of the right to life, the right to dignity and patient autonomy, but strikes at the heart of these rights causing a significant infringement and limitation at the core of these rights.

3.3.4 Can the limitation of these rights be justified under section 36?

3.3.4.1 Introduction

Having established that the prohibition on assisted dying significantly limits the right to life and the right to dignity, it must be determined whether or not this limitation can be constitutionally justified. Should it be found that the limitation is legitimately justifiable, the limitation will pass the test of constitutionality.⁴⁵⁰ If, however, the limitation is found to be unjustifiable, the prohibition on assisted dying will be unconstitutional and, therefore, invalid.

In order for the limitation to be constitutionally justifiable, the following criteria entrenched in s36 should be fulfilled: the limitation must be in terms of the law of general application and must be 'reasonable and justifiable in an open and democratic society based on equality, freedom and

⁴⁵⁰ CG van der Merwe *et al Introduction to the Law of South Africa* (2004) 94.

human dignity.⁴⁵¹ The factors listed in s36 of the Constitution shall provide guidance as to what should be considered in the justification stage of the enquiry.

3.3.4.2 *Law of General Application*

The first criterion that needs to be fulfilled in the justification stage of the enquiry is that the limiting measure, the prohibition on assisted dying, should be sourced in a law of general application.⁴⁵² The requirement that a measure must be in terms of the law of general application is an effective tool to prevent the legislature from singling out a particular group of persons for punishment without trial and also respects the principle of the rule of law more generally.⁴⁵³

Although the Constitutional Court has not clarified exactly what is required at this stage of the enquiry and has not enunciated a list of requirements to be met, it is evident that the limiting measure must be in terms of the law of general application in both its form and content.⁴⁵⁴

The ‘form’ of the limiting measure is a requirement that said limiting measure must be in the form of something recognised by the Court as law. Specific administrative decisions that are not sourced in the law of general application will not be recognised by the Court, but legislation, common law, customary law, municipal by-laws,⁴⁵⁵ domesticated international conventions⁴⁵⁶ and rules of court⁴⁵⁷ can be considered law for the purposes of this stage of the enquiry. The prohibition on assisted dying, entrenched in the common law, will therefore be recognised by the Court as law for the purposes of this stage of the enquiry and thus satisfies the requirement of ‘form’.

With regard to the content of the limiting measure, the prohibition on assisted dying applies generally to all persons who seek an assisted death, regardless of their circumstances. The

⁴⁵¹ J Sarkin-Hughes *et al Resolving the Tension between Crime and Human Rights: An Evaluation of European and South African Issues* (2001) 318.

⁴⁵² M Pieterse *Can Rights Cure? The Impact of Human Rights Litigation on South Africa's Health System* (2014) 165.

⁴⁵³ De Vos *et al* (note 335 above) 361.

⁴⁵⁴ *Ibid.*

⁴⁵⁵ *Du Toit v Minister of Transport* 2006 (1) SA 297 (CC).

⁴⁵⁶ *Sonderup v Tondelli and Another* 2001 (1) SA 1171 (CC).

⁴⁵⁷ *Ingledeu v Financial Services Board* 2003 (4) SA 584 (CC).

prohibition does not seek to target specific individuals, but applies to all persons, and thus the content of the limiting measure is also sourced in the law of general application.

3.3.4.3 *Is the limiting measure reasonable and justifiable?*

In addition to the law of general application, s36 of the Constitution requires that a limiting measure be ‘reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.’⁴⁵⁸ Although no mention is made of proportionality in the text of the s36 limitation clause, the jurisprudence that has emerged from the Constitutional Court indicates that the limitation of rights enquiry turns on the notion of proportionality and balancing.⁴⁵⁹ There is no clear definition of the concept of proportionality in the context of the limitation enquiry, however, it is generally understood to mean ‘reasonable and justifiable’.⁴⁶⁰

Although the limitation clause underwent much transformation from the Interim Constitution to the 1996 Constitution and drew inspiration from foreign jurisprudence, there are two questions from the *Oakes* formulation of the limitation enquiry that have remained an essential part of the limitation enquiry today, namely: ‘does the limiting measure serve a legitimate purpose?’⁴⁶¹ and ‘is there a rational connection between the limiting measure and its stated purpose?’⁴⁶² These questions are comparable to s36(1)(b) and s36(1)(d) and function as a kind of threshold test that should be satisfied before proceeding with the balancing of competing rights.

Essentially, these two ‘threshold questions’⁴⁶³ are distinct from the notion of proportionality and balancing and can be answered independently from the other factors listed in the limitation clause. The remaining factors found in the limitation clause of the Constitution are the factors that make up the proportionality aspect of the enquiry. Even though the abovementioned threshold questions are generally considered first in a limitation enquiry, the factors listed in s36 of the Constitution are not always considered sequentially by the Court. Although there are

⁴⁵⁸ S36(1) of the Constitution.

⁴⁵⁹ M Pieterse (note 447 above) 165.

⁴⁶⁰ De Vos *et al* (note 335 above) 362.

⁴⁶¹ *Ibid.*

⁴⁶² *Ibid.*

⁴⁶³ De Vos *et al* (note 335 above) 364.

certain drawbacks to dealing with the justification stage of the limitation enquiry with an ‘all-at-once’ approach, there is nothing in the text of s36 that mandates a strict sequential or ordered approach to the enquiry.

For the purposes of analysing whether the prohibition on assisted dying can be justified in the limitation enquiry, the following structure, based loosely on s36, shall be adhered to: first, the threshold requirements shall be dealt with by asking what the purpose of the prohibition on assisted dying is, and whether it is legitimate in an ‘open and democratic society based on equality, freedom and human dignity.’⁴⁶⁴ Second, the relationship between the prohibition on assisted dying and the purpose thereof shall be analysed, to determine whether they are rationally connected. Thereafter, it shall be asked whether there are clear, alternative means available that would be less restrictive on the full enjoyment of the right. Finally, it shall be determined whether the legitimate, rationally based limiting measure, the prohibition on assisted dying, is a proportionate limitation on the right to life and the right to dignity, taking into account the degree of the infringement, the nature of the right, the breadth of the measure and the social good it achieves.⁴⁶⁵

a. What is the purpose of the limiting measure?

First, in dealing with the purpose of the limiting measure, the prohibition on assisted dying, it is important to note that there are two components to this factor, namely the purpose of the measure and the importance of the measure in an ‘open and democratic society.’⁴⁶⁶ The purpose of the limiting measure must constitute a legitimate constitutional purpose,⁴⁶⁷ however, there are no set guidelines or rules for determining the constitutional legitimacy of a limiting measure. Rather, the underlying constitutional values, such as freedom, democracy, equality and dignity inform the notion of what constitutes a legitimate constitutional purpose.

⁴⁶⁴ S36(1) of the Constitution.

⁴⁶⁵ Ibid 366.

⁴⁶⁶ s36(1)(b) of the Constitution.

⁴⁶⁷ *S v Jordan and Others* 2002 (6) SA 642 (CC) 15.

The purpose of the prohibition on assisted dying has been defended around the world for centuries by those who oppose the practice of assisted dying.⁴⁶⁸ Subsequent to the *Stransham-Ford* judgment in South Africa, the Minister of Health, Dr Aaron Motsoaledi, expressed his support for the prohibition on assisted dying and gave reasons relevant in a South African context to illustrate the purpose of the prohibition.

One of the reasons that is often voiced as the main purpose of the prohibition on assisted dying is for the protection of the vulnerable in society. Although protecting the vulnerable in society is generally understood to mean protecting those who are more prone to becoming victims of undue influence or pressure, such as the elderly, the disabled or the very young, in the *Seales* judgment, the concept of vulnerability was broken down into numerous subcomponents such as communication vulnerability, institutional vulnerability, differential vulnerability, medical vulnerability, and social vulnerability (Refer to 2.3.3.4 above).

Assessing the vulnerability of a person, however, is a difficult task. As argued in the *Seales* judgment, an individual's vulnerability to influence is highly personal and context-specific. Ms Seales consistently maintained that despite her illness, she did not feel vulnerable in any sense and that her wish for an assisted death was carefully considered and reasoned.⁴⁶⁹ This self-assessment of non-vulnerability was endorsed by Ms Seales' doctor who confirmed that she was pursuing her request in a positive, rational manner, and showed 'no signs of depression or a lack of understanding of her condition.'⁴⁷⁰

In a South African context, the protection of the vulnerable in society would certainly be considered a legitimate constitutional purpose. Unfortunately, however, the State's current failure to protect the vulnerable in society outside the realm of assisted dying was highlighted in the *Stransham-Ford* judgment when it was stated:

⁴⁶⁸ For example, those who oppose the practice of assisted dying have defended the purpose thereof by arguing that the vulnerable in society need protection, that death should be a natural process, no person or doctor should play God by intervening with the manner and timing of one's death, allowing assisted-dying will result in a slippery slope leading to abuse and that the healthcare system is ill-equipped to deal with the practice of assisted dying.

⁴⁶⁹ *Seales* (note 12 above) 81.

⁴⁷⁰ *Ibid.*

They seem to even tolerate a horrendous murder rate in a number of countries, including ours. They seem to tolerate the yearly slaughter on our roads because, despite the statistics, thousands of people drive like lunatics on our roads every single day. People die of AIDS, from malaria by the hundreds of thousands, from hunger, from malnutrition and impure water and insufficient medical facilities. The State says it cannot afford to fulfil all socio-economic demands, but it assumes the power to tell an educated individual of sound mind who is gravely ill and about to die, that he must suffer the indignity of the severe pain and is not allowed to die in a dignified, quiet manner with the assistance of a medical practitioner.⁴⁷¹

It could be argued, therefore, that the idea of protecting the vulnerable has become somewhat skewed. Instead of focusing on what groups of persons should be classified as vulnerable and worthy of protection, greater consideration should be given to what it is that vulnerable persons require protection against. Rather than deciding who, in the opinion of the State, is considered a vulnerable person, the State should focus on protecting all persons against undue pain, suffering and indignity instead of prolonging life without dignity against the will of those who do not wish to suffer through such an existence. As stated by Terry Pratchett in his lecture entitled *Shaking Hands with Death*, ‘Most men don’t fear death. They fear those things - the knife, the shipwreck, the illness, the bomb - which precede, by microseconds if you’re lucky, and many years if you are not, the moment of death.’⁴⁷²

Not all terminally ill patients seek an assisted death out of depression or as a result of undue pressure or duress. As evidenced in the *Carter, Stransham-Ford* and *Seales* cases, the respective patients who had requested assisted deaths were deemed by expert witnesses, to be of sound mind and having clear and settled intentions, with no evidence of being vulnerable or in need of protection against a third party. As observed by Pratchett:

I have reached the conclusion that a person may make a decision to die because the balance of their mind is level, realistic, pragmatic, stoic and sharp. And that is why I dislike the term ‘assisted suicide’ being applied to the carefully thought out and weighed up process of having one’s life ended by gentle medical means. The people who thus far have made the harrowing trip

⁴⁷¹ *Stransham-Ford* (note 9 above) 14.

⁴⁷² T Pratchett "Shaking Hands with Death" Presented as the Richard Dimbleby Lecture (2010) published by Corgi Books (2015) 47.

to Dignitas in Switzerland to die seemed to me to be very firm and methodical of purpose, with a clear prima facie case for wanting their death to be on their own terms. In short, their mind may well be in better balance than the world around them.

The State's position on prohibiting doctor-assisted dying for the terminally ill is thus based on the paternalistic assumption that all terminally ill patients who request assisted deaths do so from a vulnerable position, an assumption based merely on anecdotal evidence that does not provide a sound basis for the limitation of a constitutionally protected right.

Those who are opposed to assisted dying, and assert the view that the vulnerable must be protected, say that 'as if it would not have occurred to anyone else.'⁴⁷³ Although evidence has been sought, there is little to no evidence to prove that 'the sick or elderly have ever been cajoled into assisted death by relatives anywhere in the world where assisted dying is [lawfully] practised.'⁴⁷⁴ Moreover, it is oftentimes the case that the family members of a terminally ill patient would prefer to keep their loved one alive and 'beg to keep Granny alive even when Granny is indeed, by all medical standards, at the end of her natural life,'⁴⁷⁵ an assertion made by Pratchett, based on the experiences of doctors.⁴⁷⁶

Therefore, although it seems as though protecting the vulnerable in society is a constitutionally valid purpose for maintaining the prohibition on assisted dying in South Africa, there are inherent flaws to the reasoning behind this given purpose, as the mere assumption that the prohibition achieves its purpose is problematic. Carefully drafted legislation with sufficient safeguards can function to protect persons who may be vulnerable (or may be at risk of coercion) while simultaneously protecting the rights to life and dignity of those who request an assisted death.

⁴⁷³ T Pratchett "Shaking Hands with Death" Presented as the Richard Dimpleby Lecture (2010) published by Corgi Books (2015) 52.

⁴⁷⁴ Ibid 53.

⁴⁷⁵ Ibid 53.

⁴⁷⁶ Ibid.

Another reason given as the purpose for the prohibition on assisted dying was articulated by the Minister of Health in an interview with John Perlman in 2015⁴⁷⁷ when the Minister argued against the legalisation of voluntary euthanasia by stating that it is still too soon to legalise the practice of assisted dying for the terminally ill in South Africa because the health care system in South Africa is insufficiently developed to deal with such complexities. The Minister cited the United Kingdom as an example of a country with a health care system that is more developed than the health care system in South Africa, but despite being more advanced and well-established, was still unequipped to deal with the complexities of lifting a prohibition on assisted dying which was why the debate, at that stage, remained unsolved in the United Kingdom and many other developed European countries.

This view is supported by academics who assert that legalising euthanasia can only be justified in countries with the ‘best [healthcare] for all, a well-organised and universally accessible palliative care and support system’⁴⁷⁸ and a ‘strong culture of respect for human life.’⁴⁷⁹ It is suggested that if doctor-assisted dying is legalised in South Africa, there is a risk of it becoming a substitute for real and proper health care for patients in ‘dire medical straits’⁴⁸⁰ as South Africa faces ‘severe constraints on health care facilities’⁴⁸¹ and an ‘inadequate allocation of resources for highly effective medical treatments.’⁴⁸²

Although there may be merit to the Minister’s argument that one cannot put a roof on a house if the house has no foundation, one needs to do a pragmatic analysis and a comparison of the options available to a person diagnosed with a terminal illness who is facing an imminent death in order to dispel the myth that assisted dying is too complex for the South African health care system to cope with.⁴⁸³ In addition, one can draw parallels with the legalisation of abortion in

⁴⁷⁷ "Today With John Perlman" 5 May 2015. Interview accessible online at: <http://www.kayafm.co.za/morning-news-wrap-up-5-may-2015/>

⁴⁷⁸ DJ Ncayiyana 'Euthanasia - no dignity in death in the absence of an ethos of respect for human life' (2012) 102 *SAMJ* 334.

⁴⁷⁹ Ibid.

⁴⁸⁰ Ibid.

⁴⁸¹ SR Benatar 'Dying and euthanasia (1992) 82 *SAMJ* 35-38.

⁴⁸² Ibid.

⁴⁸³ By advancing the argument that the South African healthcare system is significantly underdeveloped (and therefore incapable of implementing a permissive regime for assisted dying) the State abandons the principled argument to make a resource-based argument instead. This is a considerable shift in argument, with significant consequences for how it is to be justified, particularly in relation to private healthcare. If the government has

South Africa. Subsequent to the introduction of the Choice on Termination of Pregnancy Act,⁴⁸⁴ the South African health care system had to facilitate the practice of legal abortions in order to fulfil their statutory obligations in terms of the legislation. Similarly, once a secure legislative framework has been implemented to regulate and control the practice of assisted dying, the legislation will ensure that the health care system is not overburdened with obligations that it is not equipped to deal with.

b. Is the purpose of the limiting measure legitimate in an open and democratic society?

In looking at the importance of the limiting measure in an open and democratic society, it was argued by the Minister of Health that it is important to maintain the prohibition on assisted dying in order to ensure that doctors are not seen as people who kill, but rather to maintain the perception of doctors and health workers as healers.⁴⁸⁵ Although there is merit to preserving the image of doctors in society by viewing doctors as professionals who help with healing and prolonging life rather than wilfully ending life, allowing assisted dying in South Africa will not necessarily taint the perception of doctors as healers. The Minister further argued that medical students should never be taught that there is a time when, if they feel they have exhausted all options, they are allowed to consider killing their patient. This, however, would never be possible under a system of legalised assisted dying that is regulated by a statutory framework with strict safeguards and thus, this particular argument fails to prove the importance of the prohibition on assisted dying.

Doctors often have to perform procedures that initially harm patients in order to facilitate healing and prevent long-term suffering. If a patient is suffering from bone cancer and a surgeon has to amputate his/her leg as a life-saving measure in prevention of long-term suffering, this form of dismemberment does not taint the reputation of the surgeon and society does not view doctors and surgeons as barbaric for performing amputations, mastectomies or other painful procedures aimed at the long-term prevention of suffering. Similarly, the purpose of assisted dying is aimed

insufficient resources to provide doctor-assisted dying to the terminally ill, it does not follow that those who are able to fund the practice privately should be prevented from doing so.

⁴⁸⁴ Choice on Termination of Pregnancy Act 92 of 1996.

⁴⁸⁵ Judge Davis “Judge For Yourself: Discussing the Right to Die” 13 May 2015
<https://www.enca.com/media/video/judge-yourself-discussing-right-die-part-2>.

at relieving patients from their suffering and, although it does entail a loss of life, the doctors who facilitate the practice of assisted dying should not be viewed as murderers or people who kill, but rather as people who assist in relieving intolerable pain and suffering at the voluntary, informed request of a patient.

Another reason given by the Minister of Health to highlight the importance of the prohibition on assisted dying is that the Department of Health maintains that dying should be a natural process and that no person should interfere with the natural process of death by assisting another person to end his/her life. However, any medical intervention and any medical procedure performed by a doctor for the purpose of prolonging a patient's life interferes with the natural process of death. When a patient is suffering through intolerable pain and wishes to end his or her own life without causing any harm to any other person, that patient, with the assistance of a wilfully consenting doctor, should be allowed to do so without the undue imposition of other people's moral views. The death of a terminally ill patient should be a private matter and, any moral repercussions stemming from the assisted death should be dealt with by the patient him/herself and the doctor who consented to providing assistance. Therefore, if a patient wishes to interfere with the natural process of death by requesting assistance in dying, they should be entitled to do so, as it is a private matter based on one's own moral views and beliefs.

The Minister further argued that cultural differences in South Africa would make regulating the practice of assisted dying exceptionally difficult. It was argued that some cultures believe the most honourable way for a man to die is to die by the spear. It was asked whether an obligation could be placed on a doctor to respect the cultural beliefs of a patient who wishes to die by the spear and consequently whether you can expect a doctor to stab a man with a spear if that is how he wishes to end his life. These issues, however, would have to be dealt with by the legislature when drafting the necessary legislation to regulate the procedures involved in a doctor-assisted death.

The reasons advanced by the Minister of Health as to why the prohibition on assisted suicide should remain in place have thus far failed to prove the importance of the limiting measure in an open and democratic society, as carefully drafted legislation that institutes sufficient safeguards

can ensure that the practice of assisted dying takes place within controlled limits and can remedy each of the issues raised by the Minister of Health.

Another reason often used to illustrate the importance of prohibiting assisted dying is the ‘slippery slope’ argument. It is a widely-held belief by many who oppose assisted dying that once assisted dying in any form is permitted, there will be a slippery slope that leads to unauthorised non-voluntary or involuntary euthanasia and the indiscriminate killing of the weaker or more vulnerable members of society under a guise of assisted dying. Further argument is made that if legislation is enacted to permit assisted dying for only terminally ill patients who request it, the law will become steadily more permissive and result in euthanasia and assisted dying being permitted in a wider range of cases, even if they are morally wrong.⁴⁸⁶

Regions where assisted dying is permitted, however, have shown no evidence of such a slippery slope effect.⁴⁸⁷ Reports issued in the American states of Oregon and Washington have shown that there is no evidence of any abuse or misuse of legalised assisted dying and studies conducted by Vrije Universiteit in Amsterdam, University Medical Center Utrecht and Statistics Netherlands have shown that the number of people who died as a result of assisted dying decreased slightly subsequent to the introduction of legislation regulating assisted dying in 2002.⁴⁸⁸

An example of a purpose of a limiting measure that failed at this stage of the limitation enquiry is the enforcement of ‘private moral views.’⁴⁸⁹ In the case of *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*⁴⁹⁰ it was stated:

The enforcement of the private moral views of a section of the community, which are based to a large extent on nothing more than prejudice, cannot qualify as such a legitimate purpose. There is accordingly nothing, in the proportionality enquiry, to weigh against the extent of the limitation

⁴⁸⁶ D Benatar 'A legal right to die: responding to the slippery slope and abuse arguments' (2011) 18 *Current Oncology* 206.

⁴⁸⁷ V Hiley 'In Pursuit of a Good Death: Responding to Changing Sensibilities in the Context of the Right to Die Debate' (Thesis submitted for Doctor of Juridical Studies at the University of Sydney) (2008) 229.

⁴⁸⁸ B Onwuteaka-Philipsen 'Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey' (2012) 380 *The Lancet* 908-915.

⁴⁸⁹ De Vos *et al* (note 335 above) 370.

⁴⁹⁰ *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1999 (1) SA 6 (CC).

and its harmful impact on gays. It would therefore seem that there is no justification for the limitation.⁴⁹¹

It can therefore be argued that the reasons advanced by the Minister of Health as to why the prohibition on assisted dying should not be lifted are merely private moral views. The Minister of Health asserted that his department was of the belief that people should die in a ‘natural way’ and, despite intense pain and suffering, should not be allowed to end their lives with the assistance of a doctor when they wish to do so. This is merely the expression of a private moral view which does not represent the interests of South Africa as a whole. If a terminally ill patient is enduring intolerable pain and suffering and wishes to take control over the ending of his/her own life rather than dying through a ‘natural process’, that person will be stripped of their autonomy and will have no control over their own life because of the private moral views of other members of society who believe that death should occur naturally.

Provided a patient has the cooperation of a wilfully consenting doctor, the patient’s decision to end his or her own life in order to relieve intolerable pain and suffering should not be hampered by the moral beliefs of any other person who stipulates that death should be a ‘natural process’ and thereby ignores the patient’s pain and suffering which causes a severe impairment of their dignity and quality of life.

It is therefore difficult to conclude that the limiting measure, the prohibition on assisted dying, pursues a legitimate constitutional purpose. Although arguments raised by the Minister of Health and parties opposed to the legalisation of assisted dying may be valid and relevant in our South African society, they are not strong enough to constitute a constitutionally legitimate purpose for limiting the rights of those who seek an assisted death, as legislation can be enacted to sufficiently combat the risks associated with legalised assisted dying.

⁴⁹¹ Ibid 37.

c. Is there a rational connection between the limiting measure and the purpose thereof?

Having considered the purpose and the importance of the limiting measure, one needs to analyse the ‘rational connection requirement’⁴⁹² as part of the justification process within the limitation enquiry. This stage of the enquiry asks whether the means chosen as part of the limiting measure achieve their accepted purpose. This is somewhat narrow in focus when looking at whether there is a rational connection between the limiting measure and the purpose it seeks to fulfil. If the court is satisfied at this threshold stage, the limiting measure will be considered in more detail along with other, less restrictive, means to achieve those ends. It should be noted that, at this stage of the enquiry, the aim is not to determine whether the means chosen are the optimum means of achieving the measure not whether there are more appropriate means of doing so; as a result, there are very few instances where a measure has failed at this stage of the test.⁴⁹³

The case of *South African National Defence Union v Minister of Defence*⁴⁹⁴ illustrates an example where the means, a blanket ban on soldiers forming and joining trade unions, was not rationally connected to the constitutionally legitimate objective of maintaining a disciplined military.⁴⁹⁵ O’Regan J was not persuaded that allowing members of the Permanent Force to join a trade union would undermine the ‘discipline and efficiency’⁴⁹⁶ of the Defence Force. It was held that permitting members to join trade unions would ‘enhance rather than diminish discipline,’⁴⁹⁷ as members would have ‘proper channels for grievances and complaints,’⁴⁹⁸ but this, as noted by O’Regan J, would depend on the ‘nature of the grievance procedures established,’⁴⁹⁹ the activities permitted and the ‘attitude and conduct of those involved.’⁵⁰⁰

Similarly, a blanket ban on assisted dying is not rationally connected to the constitutionally legitimate purpose of protecting the vulnerable in society. The prohibition of assisted dying, rather than the closely regulated practise thereof, is not likely to provide any more protection to

⁴⁹² De Vos *et al* (note 335 above) 371.

⁴⁹³ Ibid.

⁴⁹⁴ *South African National Defence Union v Minister of Defence* 1999 (4) SA 469 (CC).

⁴⁹⁵ Ibid 35.

⁴⁹⁶ Ibid 34.

⁴⁹⁷ Ibid 35.

⁴⁹⁸ Ibid.

⁴⁹⁹ Ibid.

⁵⁰⁰ Ibid.

the vulnerable than a closely regulated system that permits assisted dying only for those who request it and meet strict criteria before it becomes applicable to them.

d. Alternative, less-restrictive means

For the sake of completeness, it is prudent to discuss any less-restrictive, alternative means for achieving the end. It is unlikely that a court would continue with the rest of the enquiry, as there is little sense in undertaking a complex consideration of the balance that should exist between a right and a limiting measure if the limiting measure is not rationally connected to its aim.⁵⁰¹

Should a court find that the reason for the limiting measure serves a legitimate constitutional purpose, and the limiting measure rationally achieves that end, the court would then consider the availability of ‘less restrictive means’⁵⁰² to achieve the same end. The question of whether there are less restrictive means of achieving the end is essentially twofold. First, it looks at whether there are less restrictive, alternative means of achieving the end, and second, looks at the chosen measure to determine whether or not it is ‘well-tailored’⁵⁰³ in light of all relevant circumstances.

Although it is not the Court’s duty to find the least restrictive means, the Constitutional Court has been less deferential when considering the proportionality of the means chosen by the legislature and determining whether the means are well-tailored to their purpose in light of all the relevant factors found in the limitation clause. The Court must, however, refrain from stepping into the realm of policy-making. This stage of the enquiry can be seen as ‘gentle enticement’⁵⁰⁴ to the courts as well as the legislature and the executive to look for alternative means, rather than resorting to the difficult balancing act required to remedy the infringement of rights.

At this stage of the enquiry, the Court could look to recent Canadian jurisprudence for guidance in applying the limitation of rights enquiry to the prohibition on assisted dying. In the final *Carter* judgment, reference was made to the trial judge’s finding that ‘the prohibition [of assisted dying] was broader than necessary, as the evidence showed that a system with properly designed

⁵⁰¹ De Vos *et al* (note 335 above) 371.

⁵⁰² S36(1)(e) of the Constitution.

⁵⁰³ De Vos *et al* (note 335 above) 372.

⁵⁰⁴ *Ibid* 373.

and administered safeguards offered a less restrictive means of reaching the government's objective.⁵⁰⁵

Although the notion of 'over-breadth' is often conceptually and practically combined with the question of the availability of less restrictive means, there is merit to maintaining a distinction between the two concepts. With reference to the 'over-breadth inquiry,' however, the Supreme Court of Canada held:

A law that is drawn broadly to target conduct that bears no relation to its purpose "in order to make enforcement more practical" may therefore be overbroad. The question is not whether Parliament has chosen the least restrictive means, but whether the chosen means infringe life, liberty or security of the person in a way that has no connection with the mischief contemplated by the legislature. The focus is not on broad social impacts, but on the impact of the measure on the individuals whose life, liberty or security of the person is trammelled. Applying this approach, we conclude that the prohibition on assisted dying is overbroad. The object of the law, as discussed, is to protect vulnerable persons from being induced to commit suicide at a moment of weakness. Canada conceded at trial that the law catches people outside this class: "It is recognized that not every person who wishes to commit suicide is vulnerable, and that there may be people with disabilities who have a considered, rational and persistent wish to end their own lives". The trial judge accepted that Ms. Taylor was such a person — competent, fully-informed, and free from coercion or duress. It follows that the limitation on their rights is in at least some cases not connected to the objective of protecting vulnerable persons. The blanket prohibition sweeps conduct into its ambit that is unrelated to the law's objective.⁵⁰⁶

In further analysis, the Supreme Court of Canada found that

The question in this case comes down to whether the absolute prohibition on physician-assisted dying, with its heavy impact on the claimants' s7 rights to life, liberty and security of the person, is the least drastic means of achieving the legislative objective. It was the task of the trial judge to determine whether a regime less restrictive of life, liberty and security of the person could address the risks associated with physician-assisted dying, or whether Canada was right to say that the risks could not adequately be addressed through the use of safeguards.⁵⁰⁷

⁵⁰⁵ *Carter* (note 10 above) para 31.

⁵⁰⁶ *Ibid* 85-86.

⁵⁰⁷ *Ibid* 103.

After reviewing the evidence, it was concluded by the trial judge that ‘a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error. While there are risks, to be sure, a carefully designed and managed system is capable of adequately addressing them.’⁵⁰⁸

By applying the Supreme Court of Canada’s judgment in a South African context, it is therefore possible to conclude that there are less restrictive, alternative means available to achieve the end of protecting the vulnerable in society. The Court, however, would not be able to take on the role of policy-maker, and the responsibility would thus fall on the legislature to ensure there is a secure legislative framework in place to allow for a permissive regime that protects the vulnerable in society.

3.3.4.4 Balancing and Proportionality

Once it has been determined that the purpose of the limiting measure is legitimate and that there is a rational connection between the limiting measure and the purpose that it seeks to achieve, and that there are no alternative, less-restrictive means, the enquiry leaves something worth balancing.⁵⁰⁹ What needs to be balanced at this point are the competing goods, namely the right and the limiting measure which has been deemed to serve a constitutionally acceptable purpose.

When balancing the right against the limiting measure, the right should be considered in terms of its relative importance under the scheme of rights and interests protected by the Constitution, and further consideration should be given to the whether the limiting measure strikes at the core or on the periphery of the right.

In looking at the rights to life and dignity in terms of their relative importance under the scheme of rights and interests protected by the Constitution, there is no doubt that the rights to life and dignity are of pre-eminent importance, despite the lack of a formal hierarchy of rights. The Constitutional Court highlighted this fact in the *Makwanyane* judgment when it was stated that

⁵⁰⁸ Ibid 105.

⁵⁰⁹ De Vos *et al* (note 335 above) 373.

‘the rights to life and dignity are the most important of all human rights.’⁵¹⁰ Moreover, as mentioned above, the prohibition on assisted dying erodes the dignity and quality of life of terminally ill patients to such an extent that it cannot be denied that the limiting measure strikes at the core of these rights.

Therefore, because the rights to life and dignity are of supreme importance and the limiting measure, the prohibition on assisted dying, strikes at the heart of the rights, the bar is set fairly high for the justification, as the greater the impact on the right, the greater the justification that is required.⁵¹¹ Because the limiting measure in this instance was not found to be rationally connected to a legitimate constitutional purpose and there were alternative, less restrictive means available to achieve said purpose, the final balancing process is rendered futile as the limiting measure did not meet the abovementioned internal thresholds.

There are two possible outcomes or conclusions that could be reached by the Court: first, it could be found that the limitation is justifiable because the limitation has a proportionate effect on the right. Alternatively, the Court could conclude that the limitation is not justifiable and that the right should prevail over the limitation. The reason for this conclusion may be that the ‘effect on the right is disproportionate to the good achieved by the measure’⁵¹² or that the means chosen were not well-tailored to the purpose of the limitation.⁵¹³

Should the first conclusion be reached by the Court (and it is found that the limitation on the right is justifiable and proportionate to the impact on the right and its importance) then balancing in its purest form has been achieved in the sense that one interest/value simply outweighs another right/interest/value. Should the second conclusion be reached, and the limiting measure is found to be unjustifiable, then the right shall prevail as the right was either too important and the effect thereon was too great or because the good achieved by the limiting measure did not hold enough merit.

⁵¹⁰ *S v Makwanyane* (note 199 above) 144.

⁵¹¹ *De Vos et al* (note 335 above) 375.

⁵¹² *Ibid* 376.

⁵¹³ *Ibid*.

As in the case of the prohibition on assisted dying, many cases see the limiting measure fail as a result of not being well-tailored to its purpose rather than as a result of failing the balancing test. There are more cases in which the limiting measure went ‘further than is necessary to ensure its end’⁵¹⁴ and in which it was found that the means were not reasonable because they were ‘overbroad’⁵¹⁵ than cases where the limiting measure failed the balancing test.

3.4 Conclusion of the Limitation Enquiry

Through an analysis of the limitation enquiry, it is therefore evident that the prohibition on assisted dying strikes at the core of the rights to life and dignity, two of the most important and fundamental rights guaranteed to all persons in South Africa. This limitation proves difficult to justify in terms of the requirements of the limitation clause, and should therefore not be considered a legitimate or justifiable limitation of the rights to life and dignity. This limitation of rights can be remedied through carefully drafted legislation which will perform a dual function to permit the practice of assisted dying for those who qualify in terms of the legislation, and have requested it, while simultaneously protecting those who may be vulnerable and require protection against unsolicited, involuntary or non-voluntary euthanasia.

It is therefore evident, through an analysis of case law and the limitation of rights pertaining to assisted dying, that should a permissive regime be implemented, a stringent legislative framework is required in order to regulate and control the practice of assisted dying in limited circumstances.

A proposed legislative framework shall be discussed below in order to evidence the proposition that the South African health care system will be able to adapt to the demands of a permissive regime that allows for assisted dying in limited circumstances while protecting the rights of all parties involved. The potential for abuse is naturally higher when assisted dying is legalised in a health care system in which people do not have equal access to resources, however, a stronger

⁵¹⁴ *South African National Defence Union v Minister of Defence* (note 363 above) 11.

⁵¹⁵ *Coetzee v Government of the Republic of South Africa; Matiso and Others v Commanding Officer Port Elizabeth Prison and Others* 1995 (4) SA 631 (CC) 13-14.

degree of prescriptive control will be possible through a legislative framework as opposed to regulating the practice of assisted dying ‘on a case-by-case basis through the common law.’⁵¹⁶

⁵¹⁶ V Hiley 'In Pursuit of a Good Death: Responding to Changing Sensibilities in the Context of the Right to Die Debate' (Thesis submitted for Doctor of Juridical Studies at the University of Sydney) (2008) 228.

CHAPTER 4: PROPOSED LEGISLATIVE FRAMEWORK

4.1 Introduction

Having found that the prohibition against assisted dying unjustifiably limits constitutionally protected rights, this chapter will consider the legislative framework that should be put in place to enable the practice of doctor-assisted dying for terminally ill, mentally competent adults. In doing so, it will critically examine the *Draft Bill on the End of Life Decisions Act*, in light of international best-practices from the American states of Oregon, Washington and California, taking into account contributions made by the United Kingdom. Although legislation has been operating effectively in other countries such as Belgium, Switzerland and the Netherlands, much research has already been compiled drawing comparisons between these legal systems and their similarities to South Africa.⁵¹⁷ The comprehensive nature of the American legislation and the courts' reliance thereon (evidenced in the most recent judicial decisions pertaining to assisted dying) indicates that South Africa can look to the American legislation for guidance when formulating legislation to be implemented for the purposes of regulating the practice of assisted dying thus, for the sake of simplicity, this study has been limited to an analysis of comparative American legislation.

After setting out the history of the *Draft Bill*, this chapter will consider the most important aspects of the bill in light of comparative legislation, namely: Definitions, Procedures, Safeguards and the constitution of a committee for deciding on requests for assisted deaths. These aspects of the legislation will be integral in ensuring the effective operation of the legislation and the efficient regulation of the practice of assisted dying for the terminally ill.

4.2 The Draft Bill: Background

The *Draft Bill of the End of Life Decisions Act* was proposed by the South African Law Commission in Project 86,⁵¹⁸ and has been subject to much debate since it was first put forward

⁵¹⁷ Project 86 (note 6 above) and Grove (note 5 above) 5.

⁵¹⁸ Project 86 (note 6 above).

in 1998. Some academics believe it provides a good starting point from which the legislature can formulate and promulgate relevant legislation,⁵¹⁹ however, others have disagreed and argued that, ‘from a constitutional perspective, the *Draft Bill* does not strike a proper balance between the state’s duty to protect life, and a person’s right (derived from the rights to physical and psychological integrity and to dignity) to end his or her life.’⁵²⁰

This *Draft Bill* will form the basis for discussion, using the Oregon *Death with Dignity Act*, the Washington *Death with Dignity Act*, the California *End of Life Option Act*, the English *Assisted Dying Bill* and the Canadian decision of *Carter v Canada (Attorney-General)* to make recommendations for amendments to the *Draft Bill*, in order to formulate legislation that can implement and regulate a permissive regime of assisted dying in South Africa.

The Oregon *Death with Dignity Act*⁵²¹ came into effect in 1997 and has, to date, seen 1327 prescriptions written for lethal medication in terms of the Act with only 859 deaths occurring as a result of the legislation.⁵²² The Washington *Death with Dignity Act* was passed in November 2008 and came into effect in March 2009 and, as of 16 March 2015, there have been 725 patients who participated under the Act.⁵²³ The California *End of Life Option Act*, based on the Oregon *Death with Dignity Act*,⁵²⁴ was approved by the California Assembly on a vote of 42 to 33 and by the California Senate on a 23 to 14 vote.⁵²⁵ The Bill was thus passed in both legislative chambers and the *End of Life Option Act* was signed into law by Governor Jerry Brown on 5 October 2015.

The *Assisted Dying Bill*, a Private Member’s Bill tabled by MP Rob Marris in the House of Commons in June 2015 was debated in September 2015 but was ultimately rejected by MPs in a

⁵¹⁹ LB Grove (note 5 above) 105 and 146.

⁵²⁰ I Currie & J de Waal *The Bill of Rights Handbook* 6th ed (2013) 289.

⁵²¹ This Act has been in force for eighteen years and has proved to have effective safeguards that regulate the practice of assisted dying and provide protection to vulnerable persons (such as the elderly and disabled) by excluding them from the ambit of the legislation and limiting the applicability of the legislation to terminally ill, mentally competent adults.

⁵²² Oregon Public Health Division Report 2014 page 2

⁵²³ Washington State Department of Health 2014 *Death with Dignity Act* Report Executive Summary.

⁵²⁴ Analysis 2015 California “*End of Life Option Act*” accessed at www.patientsrightscouncil.org/site/analysis-2015-california-end-of-life-option-act-sb-128/

⁵²⁵ George Eighmey, California Assembly and Senate Approve *End of Life Option Act*, 11 Sept 2015, accessed at: www.deathwithdignity.org/2015/09/11/california-assembly-and-senate-approve-end-of-life-option-act

vote of 330 to 118.⁵²⁶ Despite its rejection, the *Assisted Dying Bill*, hereafter referred to as the ‘English *Assisted Dying Bill*’,⁵²⁷ was well formulated and is worthy of analysis alongside the aforementioned American legislation.

To date, Canada has not yet enacted any legislation pertaining to assisted dying, but in the *Carter* judgment, the Supreme Court of Canada suspended its ruling for a period of twelve months in order to give the government time to amend its laws. Reference was made to enacting legislation in the *Carter* judgment and shall thus be referred to wherever applicable.

In essence, legislation that permits and regulates the practice of assisted dying affords peace of mind to terminally ill, mentally competent adults by offering them the right to choose an assisted death, should their suffering become unbearable in their final months or weeks of life. This eliminates the burden of having to end one's life oneself in a less dignified manner or seeking the illegal assistance of a doctor, friend or family member or incurring hefty travel expenses by travelling to regions where assisted dying is permitted, such as at Dignitas in Switzerland.

It is important for the proposed legislation to be clear and precise so that it can never be argued that the legislation will act as a slippery slope for an abuse of active euthanasia, or that the legislation will lead to vulnerable persons being euthanized without consent and the perpetrators evading liability in terms of the Act. Moreover, legislation should afford protection to vulnerable persons in society by limiting the scope of the legislation to be applicable only to terminally ill adults of sound mind and to ensure that the laws that make it a criminal offence to assist persons who do not qualify in terms of the legislation⁵²⁸ in ending their lives will remain unaltered.

The legislation should be drafted in such a manner that its provisions respect, protect, promote and uphold the rights and values of life, dignity, patient autonomy and bodily and psychological integrity. Moreover, the legislation should protect more than just the patient's interests, but should also protect the rights and interests medical practitioners who wish to assist terminally ill

⁵²⁶ James Gallagher & Philippa Roxby, MPs reject ‘right to die’ law, 11 September 2015, www.bbc.com/news/health-34208624

⁵²⁷ Although being referred to as the ‘English *Assisted Dying Bill*’, the Bill stipulates that it would have been applicable only to residents of England and Wales and the Act further provides that it would not have extended to Scotland or Northern Ireland.

⁵²⁸ This would include, but not be limited to, elderly and disabled persons who are not terminally ill.

patients in fulfilling their wishes for a dignified death. The legislation needs to strike a balance between competing constitutional rights and values, and this should be done through stringent procedures, strict safeguards and careful monitoring for compliance.

4.3 Definitions

In order for a piece of legislation on assisted dying to operate effectively, a clear definitions section is required. In the *Draft Bill on End of Life Decisions*, the definitions section made a clear distinction between ‘intractable and unbearable illness’⁵²⁹ and ‘terminal illness.’⁵³⁰

An ‘intractable and unbearable illness’ was defined as ‘an illness, injury or other physical or mental condition, excluding a terminal illness, that offers no reasonable prospect of being cured and causes severe physical or mental suffering of a nature and degree not reasonable to be endured.’⁵³¹ A ‘terminal illness’ was defined as ‘an illness, injury or other physical or mental condition that, in reasonable medical judgment, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering or causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.’⁵³² Some academics have argued that the definition of intractable and unbearable illness is too broad, and that the term ‘intractable and unbearable condition’ would have matched the above definition more accurately.⁵³³ Maintaining the distinction between an intractable and unbearable condition and a terminal illness will provide clarity when limiting the ambit of the legislation's applicability to ‘terminally ill’ patients.

In the *Carter* judgment, the phrase ‘grievous and irremediable medical condition’⁵³⁴ was used instead of ‘terminal illness.’ It was proposed that a grievous and irremediable medical condition includes ‘an illness, disease or disability that causes enduring suffering that is intolerable to the

⁵²⁹ Section 1 of the Draft Bill on End of Life Decisions Act.

⁵³⁰ Ibid.

⁵³¹ Section 1 of the Draft Bill on End of Life Decisions Act.

⁵³² Section 1 of the Draft Bill on End of Life Decisions Act.

⁵³³ LB Grove (note 5 above) 107.

⁵³⁴ *Carter v Canada (Attorney-General)* 2012 BCSC 886 24.

individual in the circumstances of his or her condition.⁵³⁵ Although legislation is yet to be enacted in Canada, this definition provided by the Supreme Court of Canada places emphasis on the importance of the individual patient in question by looking at how much suffering can be tolerated by that person in the circumstances of his or her condition, thereby respecting that individual's patient autonomy and dignity. This patient-centered approach differs greatly from the definitions found in foreign legislation that regulates assisted dying, as shall be discussed below.

The English *Assisted Dying Bill* defined a person as having a 'terminal illness' if they have been diagnosed by a registered medical practitioner as having an 'inevitably progressive condition which cannot be reversed by treatment'⁵³⁶ and, as a consequence of that terminal illness, that person is 'reasonably expected to die within six months.'⁵³⁷ The legislation stipulated that treatment which 'temporarily relieves the symptoms of an inevitably progressive condition cannot be regarded as treatment which reverses that condition.'⁵³⁸

The Oregon *Death with Dignity Act* provides that a 'terminal disease' is an 'incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.'⁵³⁹ Similarly, the Washington *Death with Dignity Act*⁵⁴⁰ and California *End of Life Option Act*⁵⁴¹ also incorporate the same wording into the definition of a terminal disease, stipulating that the disease will produce death within a period of six months.

It should be noted that the definition of a terminal illness/disease, as found in the English *Assisted Dying Bill*, Oregon *Death with Dignity Act*, Washington *Death with Dignity Act* and

⁵³⁵ *Carter v Canada (Attorney-General)* 2012 BCSC 886 24: They say that "grievously and irremediably ill" means the following: 1. A person is "grievously and irremediably ill" when he or she has a serious medical condition that has been diagnosed as such by a medical practitioner and which: a. is without remedy, as determined by reference to treatment options acceptable to the person; and b. causes the person enduring physical, psychological or psychosocial suffering that: i. is intolerable to that person; and ii. cannot be alleviated by any medical treatment acceptable to that person. 2. A "medical condition" means an illness, disease or disability, and includes a disability arising from traumatic injury

⁵³⁶ s2(1)(a) *Assisted Dying Bill*.

⁵³⁷ s2(1)(b) *Assisted Dying Bill*.

⁵³⁸ s2(2) *Assisted Dying Bill*.

⁵³⁹ Oregon *Death with Dignity Act* 127.800 s1.01 Definitions (12).

⁵⁴⁰ Initiative 1000 (I-1000) *Death with Dignity Act* (Chapter 70.245 RCW).

⁵⁴¹ California *End of Life Option Act* (Senate Bill no 128) 443.1 (q).

California *End of Life Option Act* differs from the definition provided in the South African *Draft Bill* and the *Carter* judgment in that specific reference is made to a six month life expectancy. This six month limitation functions as a safeguard to ensure that all patients who are diagnosed with terminal illnesses have to pursue other treatment options if their prognosis includes a life expectancy of more than six months, and thus cannot be pressured into seeking an assisted death prematurely and, in addition, doctors cannot resort to assisted dying as an alternative to palliation if the patient has more than six months to live.

By imposing this safeguard, however, it can be argued that the legislation would detract from the patient's autonomy, independence and bodily and psychological integrity by limiting the timeframe in which the person may seek an assisted death with no regard for the circumstances of his or her condition. If the purpose of the legislation is to promote and respect patient autonomy, dignity and bodily and psychological integrity by enabling a terminally ill person to take control of their own death, it is somewhat contradictory for the State to retain control over the timing of the patient's death by imposing such a specific time frame.

The definition of a grievous and irremediable medical condition, as formulated in the *Carter* judgment, respects the dignity and autonomy of a patient by determining the extent of suffering that can be tolerated by that person in the circumstances of his or her condition. This definition is preferable, as it does not impose a rigid timeframe within which a patient may request an assisted death with no regard for the circumstances of his or her condition. Therefore, for the purposes of legislation to regulate end of life decisions and assisted dying in South Africa, the definitions of 'terminal illness' and 'intractable and unbearable condition' should take into account the experience of the suffering patient, and should thus resemble the formulation of the Supreme Court of Canada's definition of a grievous and irremediable medical condition.

With regard to the definitions of euthanasia and assisted dying, no formal definitions are provided in the definition sections of any of the abovementioned Acts or Bills. It is, however, still possible to gain an understanding of what constitutes an assisted death through a careful reading of the relevant provisions in the legislation. It is therefore unnecessary to include formal, static definitions for the various forms of assisted dying in the legislation if there are provisions

to regulate procedural aspects of assisted dying that clearly stipulate forms of permissible and impermissible conduct. Thus, our understanding of the definition of assisted dying shall be gleaned from the procedures and safeguards established in the legislation and the forms of conduct that will be permitted in terms of the legislation, rather than from a rigid definition in the definitions section.

The *Draft Bill* includes a definition of death for the purposes of the legislation, yet there are no corresponding provisions in any of the other comparable pieces of foreign legislation. The *Draft Bill* provides in section 2(1) ‘(Conduct of a medical practitioner in the event of clinical death)’⁵⁴² that, for the purposes of the legislation, a person is considered dead when ‘two medical practitioners agree and confirm in writing that the person is clinically dead according to the following criteria for death: (a) the irreversible absence of spontaneous respiratory and circulatory functions; or (b) the persistent clinical absence of brain-stem function.’⁵⁴³ Should a person be considered dead according to the provisions of sub-section (1), the legislation stipulates that ‘the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of treatment.’⁵⁴⁴

It is necessary to include a provision in the legislation that clarifies when the precise moment of death occurs, as this bears significant legal implications.⁵⁴⁵ When the *Draft Bill* was first proposed, the National Health Act 61 of 2003 had not yet been enacted. Prior to the enactment of the National Health Act, the traditional moment of death was accepted as the irreversible absence of spontaneous respiratory and circulatory functions, ie when the heart and lungs stopped functioning on their own.⁵⁴⁶ Advances in medical technology, however, have enabled restoration of a heartbeat when it has ceased and resuscitation of respiration where it has failed.⁵⁴⁷ As such, section 1 of the National Health Act now defines death as brain death.⁵⁴⁸

⁵⁴² Section 2(1) of the *Draft Bill*.

⁵⁴³ Section 2(1) of the *Draft Bill*.

⁵⁴⁴ Section 2(2) of the *Draft Bill*.

⁵⁴⁵ The moment of death holds certain legal implications that are important for the purposes of succession, criminal liability, insurance claims and the harvesting of organs.

⁵⁴⁶ *S v Williams* 1986 (4) SA 1188 (A) 1194E-F.

⁵⁴⁷ J Milton *South African Criminal Law and Procedure: Common-law Crimes* 3 ed (1996) 347.

⁵⁴⁸ s1 National Health Act 61 of 2003. Refer to note 341 above.

Brain death/brainstem death can be defined as the ‘irreversible and irreparable cessation of all the brainstem functions, inclusive of complete cessation of the heartbeat, respiration, blood circulation and digestive functions.’⁵⁴⁹ Neocortical death, however, occurs when the patient is not brain dead and is biologically alive, but has suffered damage to the cortex of the brain and is thus left in a permanent vegetative state with no cognition or conation.⁵⁵⁰

The issue that arises in this context, however, is when a patient is not brain dead or in a permanent vegetative state, but is terminally ill and requests assistance in dying. An important question to be considered is whether the patient’s continued existence can be considered ‘life’ or ‘life worth living’. In *Good Life, Good Death: A Doctor’s case for Euthanasia and Suicide*, Dr Christiaan Barnard asserted that ‘the primary goal of medicine was to alleviate suffering and not merely to prolong life.’⁵⁵¹ Barnard further argued that advances in modern medical technology demand that we ‘evaluate our view of death and the handling of terminal illness’⁵⁵², as he felt that it was not the diagnosis of death that was a concern as much as a possible means of determining when the state of being alive ceases. Moreover, it was asserted that dying, in this context, could be defined as the irreversible deterioration in the quality of life which precedes the death of that particular individual.⁵⁵³

Although a definition of death that focus on quality of life is unsuitable for the purposes of promulgating legislation, a clinical definition of death, incorporating the precise moment of death, should be included in the legislation. In order for the death of a person to be established it is therefore prudent to ensure the person concerned is declared dead by at least two medical practitioners, one of whom must have been practicing as a medical practitioner for at least five years after the day on which she or he was registered as a medical practitioner.

⁵⁴⁹ *S v Williams* (note 573 above).

P Carstens *Legal Aspects Relating to Euthanasia and the Moment of Death in South African Medical Law: Some Reflections*.

⁵⁵⁰ *Clarke v Hurst NO and others* 1992 (4) SA 630 (D). P Carstens *Legal Aspects Relating to Euthanasia and the Moment of Death in South African Medical Law: Some Reflections*.

⁵⁵¹ Dr CN Barnard *Good Life, Good Death: A Doctor’s Case for Euthanasia and Suicide* 1 ed (1980).

⁵⁵² *Ibid*.

⁵⁵³ Dr C Barnard *Good Life, Good Death: A Doctor’s case for Euthanasia and Suicide* 1 ed (1980) 8.

The *Draft Bill* also fails to define other important key terms such as ‘palliative care’, ‘treatment’ and ‘care’. It has been argued that it is highly unlikely that the Commission intended for euthanasia to be included in the definition of ‘treatment’ or ‘care’ in the *Draft Bill*.⁵⁵⁴ However, a strong counterargument can be made for the inclusion of euthanasia under a definition of ‘treatment’ or ‘palliative care.’⁵⁵⁵ It is thus necessary to ensure that the definitions are well drafted to minimise the risk of ambiguity or legislative loopholes and, as such, important terms such as ‘palliative care’, ‘treatment’ and ‘care’ should be defined appropriately.⁵⁵⁶

For the sake of completeness and clarity, additional terms such as self-administer, aid-in-dying drug and lethal agent should be included in the definition section of the proposed legislation. The California *End of Life Option Act* defines self-administer as ‘a qualified individual’s affirmative, conscious and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death.’⁵⁵⁷ The Washington *Death with Dignity Act* defines self-administer as ‘a qualified patient’s act of ingesting medication to end his or her life in a humane and dignified manner.’⁵⁵⁸ The Oregon *Death with Dignity Act*, the English *Assisted Dying Bill* and the *Draft Bill*, however, all omit definitions for the terms self-administer and self-administration.

It is important to include a formal definition of ‘self-administration’ in the legislation, as the degree of involvement on the part of the medical professional will be essential in determining whether the patient died as a result of an act of active euthanasia or doctor-assisted suicide and, consequently, whether or not there was compliance with the legislation.

A hybrid formulation of the two definitions stated above should be considered as part of the proposed legislation in South Africa. Self-administration should thus be defined as a patient’s affirmative, conscious and physical act of administering and ingesting the lethal agent provided by the medical professional to end his or her own life in a humane and dignified manner thereby incorporating the most important elements of each definition.

⁵⁵⁴ Grove (note 5 above) 107.

⁵⁵⁵ Ibid.

⁵⁵⁶ Ibid.

⁵⁵⁷ California *End of Life Option Act* (Senate Bill no 128) s1(p).

⁵⁵⁸ The Washington *Death with Dignity Act* (Initiative Measure 1000) s1(12).

The proposed legislation also requires a clear definition for an ‘aid-in-dying drug’⁵⁵⁹ or lethal agent that is to be provided to the patient who has requested assistance in dying. There are several methods by which a person can bring about their own death in a humane and dignified manner, with the assistance of a medical professional, which include injecting, swallowing or inhaling measured amounts of the lethal substance. The legislature would have to consider the submissions and recommendations of medical professionals when formulating a definition for a lethal agent, as medical evidence is required in order to determine the most appropriate lethal agent to be specified in the legislation.

4.4 Procedures

When analysing legislation that regulates assisted dying, it becomes evident that many of the safeguards aimed at protecting the vulnerable are found in the procedures outlined in the legislation. It is important for these procedures to be clearly delineated in order to ensure that patients and medical professionals alike understand what is expected of them and what conduct is permissible in terms of the legislation.

There are substantial similarities between the abovementioned pieces of foreign legislation with regard to the procedures that are to be followed by patients and medical practitioners in instances where a patient has requested an assisted death.

The procedure with regard to the cessation of life in the *Draft Bill* is explained as follows: ‘if a medical practitioner is requested by a patient to put an end to that patient’s suffering, or to enable the patient to put an end to his or her own 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 the patient is suffering from a terminal or intractable and unbearable illness and that the patient is over the age of 18 years and mentally competent.’⁵⁶⁰ Furthermore, the patient must be ‘adequately informed of the illness from which he or she is suffering as well as the prognosis

⁵⁵⁹ California *End of Life Option Act* (Senate Bill no 128) s1(b).

⁵⁶⁰ There appears to be common ground between each of the abovementioned pieces of legislation with regard to the requirements for eligibility in terms of the Act. Each statute requires the person requesting an assisted death to be an adult, aged 18 years or older, mentally competent and diagnosed with a terminal illness. Some statutes have further requirements that need to be fulfilled before a person is eligible for an assisted death in terms of the legislation. This will be discussed further under the section for safeguards.

of his or her condition and of any treatment or care which is available.⁵⁶¹ The patient's request must be based on a 'free and considered decision.'⁵⁶² The request for an assisted death by the patient must be repeated by the patient 'without self-contradiction on two separate occasions at least seven days apart, the last of which must be no more than 72 hours before the medical practitioner gives effect to the request.'⁵⁶³

In addition, the patient must sign a 'completed certificate of request, asking the medical practitioner to assist the patient to end his or her life, the signing of which must be witnessed by the medical practitioner.'⁵⁶⁴ The *Draft Bill* does not include a template of the required form that the certificate of request should take, however, the English *Assisted Dying Bill*, the Washington *Death with Dignity Act*, the Oregon *Death with Dignity Act* and the California *End of Life Option Act* all include a template for a declaration of intent that must be completed before the request for an assisted death will be granted. These templates shall be discussed and analysed below as safeguards in the legislation.

The *Draft Bill* also provides that a patient may rescind their request for an assisted death 'at any time and in any manner without regard to his or her mental state.'⁵⁶⁵ Should the request be rescinded by a patient, the medical practitioner bears the responsibility of destroying the certificate of request as soon as practicable and this fact should be noted on the patient's medical record.

It is clearly stipulated in the *Draft Bill* that the medical practitioner shall only give effect to the patient's request if s/he is 'satisfied that ending a patient's life or assisting a patient to end his/her own life is the only way for the patient to be released from his or her suffering.'⁵⁶⁶ The *Draft Bill*, however, does not stipulate what constitutes 'suffering'. Suffering is subjective and to some, suffering could mean enduring physical pain, but to others, suffering could mean a loss of dignity and struggling to perform basic daily functions independently. If such a provision were to

⁵⁶¹ *Draft Bill* s5(1)(c).

⁵⁶² *Draft Bill* s5(1)(d).

⁵⁶³ *Draft Bill* s5(1)(e).

⁵⁶⁴ *Draft Bill* s5(1)(f).

⁵⁶⁵ *Draft Bill* s7(a).

⁵⁶⁶ *Draft Bill* s5(1)(i).

remain in the legislation, it would mean that the ultimate decision to end the patient's life could lie with the doctor rather than the patient, as a doctor may not be satisfied that all the legislative requirements have been met and may thus deny the patient's request for an assisted death if the patient has not explored alternative available remedies, such as hospice care, palliative care and palliative sedation. This provision should be deleted from the legislation as retaining such a provision would contradict the purpose of the legislation, as it disregards patient autonomy and detracts from the patient's power of choice and control over medical decisions. The legislation should make assisted dying available to terminally ill patients as an alternative option to other courses of treatment such as palliative care and hospice care. Should the legislation prevent a medical practitioner from giving effect to the patient's request for an assisted death on the basis that there are other ways for the patient to be relieved from his or her suffering, this would hinder the operation of the legislation and should thus be omitted.

It should be emphasised that the proposed legislation would make assisted dying available to terminally ill patients as an alternative course of treatment to relieve them from their suffering when treatment has become futile and death is imminent. There are currently four main options available to a patient: (i) palliation, (ii) withdrawal of treatment that has already been administered yet has subsequently become futile, (iii) withholding/refusal of treatment and (iv) assisted dying, however, a patient may only elect from the first three options as assisted dying remains unlawful.

For many patients, however, palliation and sedation are not treatment options they wish to pursue. Palliative care cannot necessarily provide relief from suffering in all cases,⁵⁶⁷ and the effects of opioid medication are not always guaranteed.⁵⁶⁸ Although it is usually possible to secure relief from pain and nausea and to suppress seizure activity,⁵⁶⁹ not all patients achieve the same level of pain relief and some require higher doses of medication in order to control their symptoms. Higher doses of medication can have severe effects on a person and loss of physical

⁵⁶⁷ *Seales v Attorney-General* (note 12 above) 38.

⁵⁶⁸ RG Twycross *Palliative Care Formulary* 2 ed (2002) 169.

⁵⁶⁹ In the context of palliative care, seizures can occur in approximately 13 per cent of cases. See G Tradounsky 'Seizures in Palliative Care' (2013) *Canadian Family Physician* 951.

and mental capacity, behavioral changes and psychological impacts can only be relieved to a minimal extent.⁵⁷⁰

Australian palliative care expert, Professor Michael Ashby, and Dr Rajesh Munglani, professional consultant in pain medicine, both described the limitations of palliative relief in affidavits that were considered by the court in the case of *Seales v Attorney-General*.⁵⁷¹ Numerous negative side effects such as a massive weight gain, impairment of sleep, behavioral and mood changes as well as a predisposition to stomach ulcers and bleeding are linked to the administration of steroids used in palliative treatment.⁵⁷² Should one stop or reduce the usage of steroids, one is likely to suffer from severe headaches which are difficult to control by morphine or other pain killers.⁵⁷³

In brief summation, should a patient, who has been fully informed of his or her treatment options, elect not to pursue palliation, but requests an assisted death instead, a medical practitioner would not be able to give effect to the patient's wishes if there is a provision in the legislation that requires the medical practitioner to be satisfied that assisted dying is the only way for the patient to be released from his or her suffering. Section 5(1)(i) should thus be removed from the *Draft Bill* and no similar provision should be enacted in future legislation to regulate assisted dying in South Africa, as there are other, more effective, safeguards that can be implemented.

The *Draft Bill* further provides that, once satisfied of the abovementioned legislative requirements, the medical practitioner who has received a request for an assisted death will have to 'consult and confer with an independent medical practitioner who is knowledgeable in respect of the terminal illness from which the patient is suffering.'⁵⁷⁴ This independent medical practitioner must have 'personally examined the patient and checked the patient's medical history, and must further confirm that the patient is a mentally competent adult, is suffering from a terminal or intractable and unbearable illness, and that an assisted death is the only way for the

⁵⁷⁰ Affidavit of Lecretia Seales' principal oncologist in *Seales v Attorney-General* (note 12 above) 39.

⁵⁷¹ *Seales v Attorney-General* (note 12 above).

⁵⁷² *Seales v Attorney-General* (note 12 above) 40-41.

⁵⁷³ *Ibid* 41.

⁵⁷⁴ Section 5(2) of the *Draft Bill*.

patient to be released from his or her suffering.⁵⁷⁵ This final requirement, however, should be omitted from the legislation as discussed above. The *Draft Bill* stipulates that both the primary medical practitioner and the independent consulting medical practitioner will be required to record in writing the findings with regard to the abovementioned facts pertaining to the patient and the circumstances of his or her illness.

The notion of consulting with an independent medical practitioner is reflected in the Oregon *Death with Dignity Act*, the Washington *Death with Dignity Act*, the California *End of Life Option Act* and the English *Draft Bill* on Assisted Dying which all make reference to an attending doctor/physician and a consulting physician or independent doctor. The duties and obligations of both the primary and the consulting medical practitioner are clearly stipulated in the relevant pieces of legislation, but the role of the consulting physician shall be discussed under safeguards below.

The procedures outlined in the *Draft Bill* further require that the patient's medical record be supplemented with the following documentation:

A note of the oral request made by the patient for an assisted death; the certificate of request; a record of the doctor's opinion that the patient has made the decision to end his or her own life freely, voluntarily and after due consideration; the report from the independent medical practitioner referred to above and a note by the medical practitioner indicating that all of the legislative requirements have been met, indicating the steps taken to carry out the request and a notation of the substance prescribed to the patient.⁵⁷⁶

A similar list of documents that are required to supplement the medical record of the patient can be found in the Oregon *Death with Dignity Act*, the Washington *Death with Dignity Act* and the California *End of Life Option Act*. These documents provide information that is necessary for the reporting requirement that will be discussed below under safeguards.

⁵⁷⁵ Ibid.

⁵⁷⁶ Section 5(8)(a)-(e) of the *Draft Bill*.

4.5 Decision making by panel or committee

The *Draft Bill* includes another model to facilitate assisted dying which differs greatly from the procedures found in the American and English legislation discussed above. The *Draft Bill* proposes that a panel or committee be established for the purpose of deciding on cases of assisted dying. Similar multi-disciplinary committees were instituted in the Netherlands, but the *Draft Bill* proposes that the committee should be approached before the request for an assisted death is granted, rather than forming part of a subsequent review process as in the Netherlands.⁵⁷⁷

The *Draft Bill* proposes that euthanasia⁵⁷⁸ may only be performed by a medical practitioner when the request for euthanasia has been approved by an ethics committee ‘constituted for that purpose, consisting of five persons including: two medical practitioners (other than the practitioner attending to the patient), one lawyer, one person who shares the same home language as the patient, one member from the multi-disciplinary team and one family member.’⁵⁷⁹

This committee, once constituted, would have to verify in writing, that in its opinion, the request made by the patient for euthanasia was a ‘free, considered and sustained request; the patient is suffering from a terminal or intractable and unbearable illness and that euthanasia is the only way for the patient to be released from his or her suffering.’⁵⁸⁰

The *Draft Bill* further stipulates that the ‘request for euthanasia must be heard within three weeks of being received by the committee.’⁵⁸¹ This, however, poses pragmatic issues because a terminally ill patient could experience a rapid deterioration of health within a period of three weeks which could change the circumstances of their request, and three weeks may be insufficient notice to constitute a committee of five members.

⁵⁷⁷ Grove (note 5 above) 103.

⁵⁷⁸ The term ‘euthanasia’ is used in this context in order to accurately reflect the provisions of the *Draft Bill*, however, a new piece of legislation formulated for implementing assisted dying in South Africa should use the term ‘assisted death’ or ‘assisted dying’ wherever applicable.

⁵⁷⁹ Section 5(1)(a)-(e) of the *Draft Bill*.

⁵⁸⁰ Section 5(2)(a)-(c) of the *Draft Bill*.

⁵⁸¹ Section 5(3) of the *Draft Bill*.

Once a committee has granted authority for euthanasia to be performed in terms of the legislation, the committee must ‘report confidentially to the Director-General of the Department of Health, by registered post, the granting of such authority.’⁵⁸² The report to the Director-General must set out ‘the personal particulars of the patient concerned, the place and date where the euthanasia was performed and the reasons therefor.’⁵⁸³ It must also include ‘the names and qualifications of members of the committee who issued the certificates in terms of the legislation and the name of the medical practitioner who performed the euthanasia.’⁵⁸⁴ The Director-General may call upon members of the committee or the medical practitioner who performed the euthanasia to make a report furnishing any additional information that may be required. Should an assisted death be granted by a committee in terms of the *Draft Bill*, the medical record of the patient should be supplemented by ‘the full particulars regarding the request made by the patient, a copy of the certificate issued by the committee authorising the euthanasia and a copy of the report’⁵⁸⁵ that is sent to the Director-General of Health, as referred to above.

Although the constitution of a multi-disciplinary committee for the purposes of determining whether or not to grant a terminally ill person the right to die has its merits,⁵⁸⁶ there are numerous pragmatic issues and shortfalls to this model. It would prove difficult to identify and define the legal criteria upon which the ethics panel/committee should make its decisions, and this allows for the potential influence of private moral views, which could unfairly discriminate against the patient who approached the committee to request an assisted death. A person who is suffering from a terminal illness in their final months of life may not have the strength and/or the ability to appear before a committee. Moreover, a person who is suffering intolerable pain should not have to wait three weeks after submitting a request for an assisted death for a panel to hear the request, after which it would take even more time for the panel to present its decision and either grant or deny a patient the right to an assisted death.

⁵⁸² Section 5(4)(a) of the *Draft Bill*.

⁵⁸³ Ibid

⁵⁸⁴ Ibid.

⁵⁸⁵ Section 5(5) of the *Draft Bill*.

⁵⁸⁶ By instituting an ethics committee to decide on whether or not a patient should be granted the right to an assisted death, each case will be decided independently on its merits and it would respect the multicultural society in South Africa. Instituting a panel would also ensure that patients are not influenced by doctors or relatives and would lower the risk of abuse, thereby satisfying those who feel that South Africa is not yet ready to allow assisted dying.

Through an analysis of the definitions and the procedures detailed above that should be incorporated into the proposed legislation for South Africa, it is evident that the term 'assisted dying' is more appropriate than 'euthanasia' as used in the *Draft Bill*. The term 'euthanasia' in the context of human death holds negative implications for many people as a result of historical widespread abuses of euthanasia, such as under the Nazi regime.⁵⁸⁷ Therefore, the proposed legislation for South Africa will not legalise the practice of human euthanasia that could be open to abuse, but will only permit assisted dying for those who qualify to participate under the legislation if they have requested an assisted death and are physically able to self-administer the lethal agent that is provided to them by a medical practitioner.

Although it is intended as a safeguard, the required ability to self-administer the lethal agent that is found in most of the abovementioned foreign legislation could constitute a form of indirect discrimination against those who are physically unable to do so. As a result of terminal illnesses, many patients are left paralysed or unable to perform basic bodily functions, such as swallowing, and rely on feeding tubes or the assistance of others in order to ingest food or medication. Patients in this condition, who are unable to independently self-administer a lethal agent, would be excluded from the operation of the legislation and any medical practitioner, friend or family member who actively participates in administering the lethal agent to the patient would not be afforded protection against criminal liability.

The strict requirement of self-administration that excludes certain patients from the operation of the legislation could be challenged as a form of indirect discrimination on the grounds of physical disability. Influential activists in the right to die movement, such as Dr Jack Kevorkian, argued that legislation such as the Oregon *Death with Dignity Act* is insufficient as it does not help those who cannot help themselves. In an interview with CNN's Anderson Cooper in April 2010, Dr Kevorkian argued that the legalised assisted dying in Oregon, Washington and Vermont is 'not done right' and does not constitute a medical service, because a doctor cannot be directly involved, as a doctor would be punished and have his or her license revoked by the American Medical Association.⁵⁸⁸

⁵⁸⁷ Project 86 (note 6 above) 128.

⁵⁸⁸ Anderson Cooper 360 CNN, Video Conversation with Dr Jack Kevorkian accessible at: <http://ac360.blogs.cnn.com/2010/04/16/video-conversation-with-dr-jack-kevorkian/>

It will prove exceptionally difficult for doctors and medical practitioners to provide assistance to terminally ill patients who have experienced such a severe decline in their physical well-being that they are paralysed or unable to ingest medication on their own. Although difficult, it would not be impossible. Doctors Jack Kevorkian and Philip Nitschke invented machines which could be set up by a doctor but subsequently operated by patients to bring their own lives to an end in a peaceful and dignified manner. By utilising such machines, the patients were able to control the timing of their own deaths by triggering the release of the lethal agent with a simple push of a button.⁵⁸⁹ These machines could be adapted to suit the needs of a patient who suffers from paralysis or an inability to swallow independently, and could provide assistance to those who would otherwise be excluded from the operation of the proposed legislation on the grounds of their disability.

In order to accommodate procedures for various forms of self-administration and to make provision for those who require additional assistance in self-administering a lethal agent, a provision similar to the following should be enacted with regard to the preparation of the medicine prescribed for a patient. The English *Assisted Dying Bill* stipulates that:

An assisting health professional may (a) prepare the medicine for self-administration by that person; (b) prepare a medical device which will enable that person to self-administer the medicine; and (c) assist that person to ingest or otherwise self-administer the medicine; but the decision to self-administer the medicine and the final act of doing so must be undertaken by the person for whom the medicine has been prescribed.⁵⁹⁰

The Bill further stipulates that this provision ‘does not authorise an assisting health professional to administer a medicine to another person with the intention of causing that person’s death.’⁵⁹¹ Such a provision will provide protection to the patient as well as the medical practitioner who must still refrain from performing the final act of ending the patient’s life. This will assist in

⁵⁸⁹ CE Anderson 'Suicide Doctor Wins Dismissal' (1991) 77 *ABA Journal* 22.

⁵⁹⁰ *Assisted Dying Bill* s4(5)(a)-(c).

⁵⁹¹ *Ibid* s4(5).

striking a balance between the protection of patient's rights as well as protection of the rights of the medical practitioner.

4.6 Safeguards

The Project 86 Report incorporates specific proposals with regard to safeguards that were suggested by various interested parties in submissions received by the South African Law Commission.⁵⁹² Parties both for and against assisted dying all emphasised the importance of preventing or containing any abuse of statutory law as effectively as possible by implementing procedural safeguards and tightening the safeguards already proposed by the Commission. These proposed safeguards, as well as the safeguards included in the relevant foreign legislation, shall be examined below for the purpose of recommending changes to the *Draft Bill*.

4.6.1 Attending and consulting physicians

As mentioned above, the recommended procedure for the proposed legislation in South Africa requires the participation of both a primary attending physician as well as an independent consulting physician who examines the patient, confirms the diagnosis and prognosis and signs the declaration of intent. It is important for a second, consulting medical practitioner to play an active role in the process of facilitating end-of-life decisions for terminally ill patients. Not only will a second medical practitioner ensure that the correct diagnosis and prognosis has been given, but the involvement of a second medical practitioner ensures there are certain checks and balances in place to guard against an abuse of the legislation, and to assist in preventing any undue influence, coercion or duress, essentially providing another layer of protection for potentially vulnerable patients.

4.6.2 Timeframes/Waiting periods

One of the proposals received by the Commission, in respect of legislative safeguards, concerned the lack of specificity in the *Draft Bill* with regard to the number of requests that need to be

⁵⁹² Project 86 (note 6 above) 134.

made by the patient requesting an assisted death in addition to the interval of time that is required between each request.⁵⁹³ It was suggested that a prolonged period of time between the initial request for an assisted death and all subsequent requests will give the patient more time to reflect on his or her decision, but ‘without becoming overbearing.’⁵⁹⁴ Proposals received by the Commission suggested that after an initial oral request for an assisted death has been made by the patient, a waiting period of seven days should follow before a written request is made by the patient. After the written request has been made by the patient, it was suggested that a second waiting period of 48 hours should follow before the patient is offered repeated, formalised opportunities to rescind the decision.⁵⁹⁵

The English *Assisted Dying Bill* also stipulates certain waiting periods and time frames within which no action may be taken. In accordance with the Bill, the lethal medication prescribed for the patient can only be delivered to the patient ‘after a period of no less than 14 days has elapsed since the day on which the patient’s written declaration of intent took effect.’⁵⁹⁶ If, however, both the attending and the independent doctor agree that the patient is ‘reasonably expected to die as a result of their terminal illness within one month from the day on which the written declaration took effect, the waiting period is reduced to six days.’⁵⁹⁷ The English Bill does not specify any other waiting periods between requests.

The Oregon *Death with Dignity Act*, Washington *Death with Dignity Act* and the California *End of Life Option Act* all specify a mandatory waiting period of 15 days to elapse after making an initial oral request to the medical practitioner, before the patient can make a second oral reiteration of the request.⁵⁹⁸ At the time the ‘second oral request [is made], the attending physician [must] offer the patient an opportunity to rescind the request.’⁵⁹⁹ In addition to the oral requests made by the patient, a written request⁶⁰⁰ must also be made, the requirements for which shall be discussed below. The legislation further stipulates that no less than 15 days shall elapse

⁵⁹³ Ibid 134-135.

⁵⁹⁴ Ibid 135.

⁵⁹⁵ Ibid 135.

⁵⁹⁶ *Assisted Dying Bill* s4(2)(a).

⁵⁹⁷ Ibid s4(3).

⁵⁹⁸ Section 3.06 of the Oregon *Death with Dignity Act* and Section 70.245.110 of the Washington *Death with Dignity Act*.

⁵⁹⁹ Oregon *Death with Dignity Act* 127.840 s.3.06 Written and oral requests. [1995 c.3 s.3.06].

⁶⁰⁰ Oregon *Death with Dignity Act* 127.840 s.3.06 Written and oral requests. [1995 c.3 s.3.06].

between the patient's initial oral request and the writing of the prescription for the lethal medication, and no less than 48 hours shall elapse between the written request and the writing of the prescription.

In looking at the *Draft Bill* and the abovementioned pieces of foreign legislation, it is therefore preferable for the legislation to stipulate specific time frames and intervals that should elapse between the requests made by a patient seeking an assisted death. The proposed legislation should thus incorporate a waiting period longer than seven days to bring the legislation in line with its international counterparts.

The proposed legislation for South Africa should stipulate that 'two oral requests need to be made to the attending physician on two separate occasions'⁶⁰¹ no less than 15 days apart. The second oral request should be made 'no more than 72 hours before the medical practitioner gives effect to the request.'⁶⁰² No less than 48 hours should elapse between the written request made by the patient and the writing of the prescription for the lethal medication. The option and ability to rescind the request should be made available to the patient at all times, but the medical practitioner should offer the patient an opportunity to rescind his or her request at the time the written declaration is signed, and again before the attending physician makes the lethal medication available to the patient for self-administration. These timeframes will act as a safeguard by providing a mandatory 'cooling off' period for a patient who has requested an assisted death without becoming cumbersome.

4.6.3 Written request: Declaration of Intent/Certificate of Request

As mentioned above under the legislative procedures, it is necessary for a 'patient, or a person acting on behalf of the patient, to sign a certificate of request,'⁶⁰³ 'witnessed by the medical practitioner,'⁶⁰⁴ asking the medical practitioner to 'assist the patient in ending his or her life'⁶⁰⁵ and this certificate forms part of the patient's medical record.

⁶⁰¹ *Draft Bill* s5(1)(e).

⁶⁰² *Ibid.*

⁶⁰³ *Draft Bill* s5(1)(f).

⁶⁰⁴ *Draft Bill* 5(1)(g).

⁶⁰⁵ *Draft Bill* s5(1)(f).

The certificate of request, along with the other documents listed above that form part of the patient's medical record, provide a safeguard against abuse of the legislation. The extensive list of documentation that needs to be completed by the patient, the primary medical practitioner as well as an independent consulting doctor protects vulnerable members of society against coercion and duress from any third party who may try pressure a vulnerable person into requesting an assisted death against their will.

Although the *Draft Bill* stipulates that a certificate of request must be completed,⁶⁰⁶ no template or suggested structure for such a certificate is provided in the *Draft Bill* to offer guidance as to the form of the request. The Oregon *Death with Dignity Act*, the Washington *Death with Dignity Act*, the California *End of Life Option Act* and the English *Assisted Dying Bill* all include a template for a declaration of intent that needs to be signed before a person may receive assistance in dying.

The Oregon *Death with Dignity Act* stipulates that a patient's 'request for medication to end their life should be made in substantially the following form.'⁶⁰⁷

‘REQUEST FOR MEDICATION
TO END MY LIFE IN A HUMANE
AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

⁶⁰⁶ Ibid.

⁶⁰⁷ Section 6.01 of the Oregon *Death with Dignity Act*.

INITIAL ONE:

___ I have informed my family of my decision and taken their opinions into consideration

___ I have decided not to inform my family of my decision

___ I have no family to inform of my decision

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed.

I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESS

We declare that the person signing this request:

- a. Is personally known to us or has provided proof of identity;
- b. Signed this request in our presence;
- c. Appears to be of sound mind and not under duress, fraud or undue influence;
- d. Is not a patient for whom either of us is attending physician

_____ Witness 1

_____ Witness 2

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a healthcare facility where the person is a patient or resident. If the patient is an inpatient at a healthcare facility, one of the witnesses shall be an individual designated by the facility.⁶⁰⁸

The Washington *Death with Dignity Act* includes a similar provision with a suggested certificate of request in substantially the same form. Where the Oregon Act states: 'I request that my attending physician prescribe medication that will end my life in a humane and dignified

⁶⁰⁸ 127.897 s6.01 of the Oregon *Death With Dignity Act*.

manner'⁶⁰⁹ the Washington Act states: 'I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and to contact any pharmacist to fill the prescription.'⁶¹⁰ Although this difference in wording is slight, the inclusion of the phrase 'that I may self-administer' has important consequences, as discussed above, with regard to the degree of participation by the medical practitioner and the ultimate act of self-administration by the patient which would render the death an assisted suicide rather than an act of voluntary active euthanasia.

The California *End of Life Option Act* also includes a similar formulation of the written request for an aid-in-dying drug to end one's life in a 'humane and dignified manner.'⁶¹¹ The only difference in the request form is that the California Act states: 'I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorise my attending physician to contact any pharmacist about my request.'⁶¹² This formulation of the request highlights the patient's right to remain in control and to retain the power of choice at all times. Up until the final moment of the patient's life, even after signing the written certificate of request, the patient still retains the ability to choose whether or not he or she wishes to take the aid-in-dying medication. This is an important safeguard to include in the legislation, as it is of the utmost importance to ensure that the terminally ill patient who has requested an assisted death has their autonomy respected and is allowed to retain the ability to choose and control aspects of their death.

A second difference between the California *End of Life Option Act* and the Oregon and Washington Acts is that the Californian legislation provides: 'My attending physician has counselled me about the possibility that my death may not be immediately upon the consumption of the drug. I make this request voluntarily, without reservation and without being coerced.'⁶¹³ This formulation of the request omits the phrase 'I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about

⁶⁰⁹ Ibid.

⁶¹⁰ 70.245.220 of the Washington *Death With Dignity Act*.

⁶¹¹ California *End of Life Option Act* 443.11.(a).

⁶¹² Ibid.

⁶¹³ 443.11 of the California *End of Life Option Act*.

this possibility'⁶¹⁴ as well as the phrase 'I accept full moral responsibility for my actions.'⁶¹⁵ It is prudent for the legislators to have broadened the scope of the provision and to couch the provision in general terms, rather than making specific reference to a timeframe of three hours. Moreover, it is wise to exclude the concluding phrase 'I accept full moral responsibility for my actions' because although there is a strong link between morality and the law, it is unnecessary to include a provision about moral responsibility in a legal declaration of intention for an assisted death. The moral responsibility of the patient has no legal consequences for the sake of an assisted death and should thus not be included in the legislation. The California legislature replaced this phrase with: 'and without being coerced' which is more appropriate for the sake of the legislation.

Despite its rejection by Parliament in 2015, the English *Assisted Dying Bill* also includes a schedule with a proposed form for the declaration to be made by a patient who requests an assisted death. Although less detailed than the abovementioned American formulations of a certificate of request, the proposed form for the Declaration is still worthy of analysis.

'Declaration: Assisted Dying Act 2016

Name of declarant:

Date of Birth:

Address:

I have [condition], a terminal condition from which I am expected to die within six months of the date of this declaration.

The Attending Doctor and Independent Doctor identified below have each fully informed me about the diagnosis and prognosis and the treatments available to me, including pain control and palliative care.

Having considered all this information, I have a clear and settled intention to end my own life and, in order to assist me to do so, I have asked my attending doctor to prescribe medicines for me for that purpose.

⁶¹⁴ 127.897 s6.01 of the Oregon *Death With Dignity Act*.

⁶¹⁵ Ibid.

I make this declaration voluntarily and in the full knowledge of its significance.

I understand that I may revoke this declaration at any time.

Signature:

Date:

Witness

Name of Witness:

Address:

This declaration was signed by [name of declarant] in my presence and signed by me in [his/her] presence.

Signature:

Date:

Countersignature: Attending Doctor

I confirm that [name], who at the date of the declaration is [age] years of age and has been ordinarily resident in England and Wales for [time]:

- (1) is terminally ill and that the diagnosis and prognosis set above is correct;
- (2) has the capacity to make the decision to end their own life; and
- (3) has a clear and settled intention to do so, which has been reached on an informed basis, without coercion or duress, and having been informed of the palliative, hospice and other care which is available to [him/her].

Signature:

Date:

Name and Address of Attending Doctor:

Countersignature: Independent Doctor

I confirm that [name], who at the date of this declaration is [age] years of age and has been ordinarily resident in England and Wales for [time]:

- (1) is terminally ill and that the diagnosis and prognosis set above is correct;

- (2) has the capacity to make the decision to end their own life; and
- (3) has a clear and settled intention to do so, which has been reached on an informed basis, without coercion or duress, and having been informed of the palliative, hospice and other care which is available to [him/her].

Signature: _____ Date: _____

Name and Address of Independent Doctor⁶¹⁶

One of the features that sets this suggested declaration of intent apart from the American certificates of request as discussed above, is the requirement that both the attending and the independent doctor sign the declaration. The American certificates of request require the signature of two witnesses, whereas the English declaration of intent requires the signature of one witness in addition to the signatures of both the attending doctor and the independent doctor.

This is an important safeguard to include in legislation pertaining to assisted dying, as it ensures the participation of both doctors who must confirm that the patient has the capacity to make the decision and that the decision was reached on an informed basis, without coercion and duress. This respects the notion of patient autonomy and ensures protection for the vulnerable members of society who could potentially fall victim to abuse of the legislation by third parties and be coerced into requesting an assisted death against their will.

Although this safeguard is important in ensuring that patient autonomy is respected and guarding against abuse of the legislation, the fact that the American formulation of a proposed certificate of request did not include the countersignature of both doctors does not necessarily threaten the integrity of the certificate of request. In accordance with the American legislation, the counselling physician/independent doctor will have to confirm, in writing, that ‘the attending physician’s diagnosis and prognosis is correct and verify that the patient is capable, is acting voluntarily and has made an informed decision.’⁶¹⁷

⁶¹⁶ Schedule to the English Assisted Dying Bill.

⁶¹⁷ Oregon *Death with Dignity Act* 127.820 s.3.02 Consulting physician confirmation.

Despite their different formulations, the abovementioned pieces of legislation have each included adequate safeguards to ensure that there is considered participation by both the attending and the independent/consulting doctor and that no person may receive assistance in dying until both doctors are satisfied that the conditions have been fulfilled.

4.6.4 *Counselling*

Each of the Acts or Bills discussed thus far include a provision stipulating that the attending and/or the independent doctor must refer the patient to counselling with an appropriate specialist if they have doubts as to the patient's mental capacity and competence, or if they feel the patient is suffering from a psychological disorder or depression that has impaired their judgment. In the suggestions put forward in the Project 86 Report, it was proposed that 'an assessment of the patient's mental competence'⁶¹⁸ (to determine whether they qualify as a patient in terms of the legislation) should include an 'assessment of whether the patient is suffering from depression which may impair decision making.'⁶¹⁹

With regard to the patient's mental capacity, the English *Assisted Dying Bill* provides:

If the attending doctor or independent doctor has doubt as to a person's capacity to make a decision under subsection 3(b) or (c), before deciding whether to countersign a declaration made by that person the doctor must (a) refer the person for assessment by an appropriate specialist; and (b) take account of any opinion provided by the appropriate specialist in respect of that person.⁶²⁰

The Oregon *Death with Dignity Act* and the Washington *Death with Dignity Act* both provide:

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counselling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counselling determines

⁶¹⁸ Project 86 Report (note 6 above) 135.

⁶¹⁹ Project 86 (note 6 above) 135 (b).

⁶²⁰ *Assisted Dying Bill* s5(a) and (b).

that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.⁶²¹

The California *End of Life Option Act*, however, deals with the mental health assessment of the patient differently. The legislation stipulates:

Before a qualified individual obtains an aid-in-dying drug from the attending physician, the consulting physician shall perform all of the following:

- a. Examine the individual and his or her relevant medical records.
- b. Confirm in writing the attending physician's diagnosis and prognosis.
- c. Determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made informed decisions.
- d. If there are indications of a mental disorder, the consulting physician shall refer the individual for a mental health specialist assessment.
- e. Fulfill the record documentation required under this part.

Upon referral from the attending or consulting physician pursuant to this part, the mental health specialist shall:

- a. Examine the qualified individual and his or her relevant medical records.
- b. Determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision.
- c. Determine that the individual is not suffering from impaired judgment due to a mental disorder.
- d. Fulfill the record documentation requirements of this part.⁶²²

The legislation further requires a 'report of the outcome and determinations made during a mental health specialist's assessment,'⁶²³ if performed, to be documented in the patient's medical records.

Ensuring patients have the requisite mental capacity to make a request for assistance in dying (and undergoing psychological evaluation should there be any doubt as to the patients' mental health) is an important safeguard to include in the legislation. The *Draft Bill*, however, makes no

⁶²¹ Oregon *Death with Dignity Act* 127.825 s.3.03. Counseling referral.

⁶²² California *End of Life Option Act* 443.8.

⁶²³ Ibid.

reference to any form of counselling or psychological evaluation should there be doubt as to the mental health of the patient. It is vital for this safeguard to be included in the proposed legislation, as many patients who are terminally ill suffer from depression and should have their mental health evaluated before their request for an assisted death is considered.

It is submitted that a psychological evaluation should not be left to the discretion of the attending and consulting doctors. Although the attending medical practitioner should be suitably qualified to assess the mental competence of a patient in order to make a determination as to whether their decision was made freely and voluntarily, without coercion or duress, all patients who request assistance in dying should be referred to mandatory or optional counselling before having their request fulfilled. By including this safeguard in the legislation, it offers another level of protection to patients who may be facing pressure from a third party or are suffering from depression and wish to end their lives prematurely as a result of these factors.

The attending and consulting medical practitioners play a vital role in explaining the diagnosis and prognosis to a patient and ensuring that the patient has been adequately informed of his or her treatment options. A psychologist or counsellor to whom the patient would be referred for a mental health evaluation or counselling would play a different role to that of the medical practitioner. The medical practitioner will be vital in ensuring the patient can understand and come to terms with their diagnosis and prognosis but a psychologist or counsellor would assist the patient in coming to terms with the consequences of their decision and dealing with the moral and emotional burden of deciding to end one's life to relieve suffering.

Although there are merits to referring a patient for mandatory counselling once they have requested an assisted death, there are numerous pragmatic issues involved with mandatory counselling referrals. The Choice on Termination of Pregnancy Act⁶²⁴ includes a provision that deals with counselling and stipulates that the state shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy.⁶²⁵ Such a provision, that encourages the provision of counselling, but does not make it compulsory unless it is at the discretion of the attending and/or consulting medical practitioner, should be included

⁶²⁴ Choice on Termination of Pregnancy Act 92 of 1996.

⁶²⁵ s4 Choice on Termination of Pregnancy Act 92 of 1996.

in the legislation regulating assisted dying. For pragmatic reasons, however, it is unwise for the legislation to impose mandatory counselling for every patient who requests assistance in dying in terms of the legislation.

4.6.5 Rescission of Request

The next major safeguard that is enshrined in the legislation is the patient's ability to rescind their request for an assisted death at any time and in any manner. The *Draft Bill* stipulates: '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.'⁶²⁶ Moreover, if a patient rescinds their request, the attending medical practitioner shall, 'as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record.'⁶²⁷ Similar provisions are included in each of the abovementioned pieces of legislation. The English *Assisted Dying Bill* stipulates: 'A person who has made a declaration under this section may revoke it at any time and revocation need not be in writing.'⁶²⁸ Moreover, in the proposed form of the declaration of intent found in the English *Assisted Dying Bill*, it is suggested that the patient include a clause which states that they understand they may revoke their request for an assisted death at any time.

The Oregon *Death with Dignity Act* also stipulates that the attending medical practitioner must 'inform the patient that he or she has an opportunity to rescind the request at any time and in any manner,'⁶²⁹ and that the patient must be offered an opportunity to rescind the request at the end of a mandatory 15 day waiting period between the initial oral request and the writing of the prescription.⁶³⁰ Moreover, a separate section of the legislation stipulates: 'A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request.'⁶³¹

⁶²⁶ s7(a) *Draft Bill on End of Life Decisions Act 1999*.

⁶²⁷ s7(b) *Ibid*.

⁶²⁸ s7 *Assisted Dying Bill*.

⁶²⁹ 127.815 s3.011(h) of the *Oregon Death with Dignity Act*.

⁶³⁰ 127.840 s.3.06 and 127.835 s3.05 of the *Oregon Death with Dignity Act*.

⁶³¹ *Oregon Death with Dignity Act* 127.845 s.3.07 Right to Rescind Request.

The Washington *Death with Dignity Act* also provides, under a section entitled 'Written and Oral Requests,'⁶³² that the attending physician must offer the patient an opportunity to rescind their request at the time of making a second oral request no less than 15 days after their initial oral request. The Act further provides, under a section entitled 'Right to Rescind Request'⁶³³ that a patient may 'rescind their request at any time and in any manner without regard to his or her mental state.'⁶³⁴ 'No prescription for medication to end the patient's life may be written without the attending physician offering the patient an opportunity to rescind their request.'⁶³⁵

The California *End of Life Option Act* includes a similar rescission clause which states: 'An individual may at any time withdraw or rescind his or her request for an aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual's mental state.'⁶³⁶ The Act goes further to stipulate that the attending physician's 'offer to the patient to withdraw or rescind his or her request at the time of the patient's second oral request'⁶³⁷ must be recorded and included in the patient's medical record.

It is therefore evident that affording a patient an opportunity to rescind their request at any time and in any manner is an important provision to include in the legislation to operate as a safeguard to protect patients against making decisions without a clear and settled intention. Moreover, it is important to ensure the legitimacy of the attending physician's offer to the patient to rescind his or her request by including the offer as a mandatory component of the patient's medical record.

4.6.6 Conscientious Objection

Another important safeguard to include in the legislation is a provision for conscientious objection that protects the moral interests and religious beliefs of the medical practitioner. The *Draft Bill* states: 'The provisions of this Act shall not be interpreted so as to oblige a medical

⁶³² 70.245.090 of the Washington *Death With Dignity Act*.

⁶³³ 70.245.110 of the Washington *Death with Dignity Act*.

⁶³⁴ Ibid.

⁶³⁵ Ibid.

⁶³⁶ 443.4 (a).

⁶³⁷ California End of Life Option Act 443.9 (f).

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.⁶³⁸

The English *Draft Bill* on Assisted Dying also includes a conscientious objection clause which states: 'A person shall not be under any duty (whether by contract or arising from any statutory or other legal requirement) to participate in anything authorised by this Act to which that person has a conscientious objection.'⁶³⁹

The Oregon *Death with Dignity Act* similarly provides: 'No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner.'⁶⁴⁰ Moreover, the Washington *Death with Dignity Act* also provides for conscientious objection by stipulating that only 'willing health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner.'⁶⁴¹

The California *End of Life Option Act* provides that 'participation in activities authorised pursuant to this part shall be voluntary. Notwithstanding s442 to 442.7, inclusive, a person or entity that elects, for reasons of conscience, morality or ethics, not to engage in activities authorised pursuant to this part is not required to take any action in support of an individual's decision under this part.'⁶⁴² Moreover, the legislation provides that a medical practitioner who refuses to participate under the Act will not be subject to any criminal or disciplinary liability.⁶⁴³

The conscientious objection clause is particularly relevant and important in a South African context, as equal respect must be given to the protection of the cultural, religious and moral beliefs of medical professionals. Without the conscientious objection clause, the legislation could be deemed unconstitutional as it would violate the constitutional rights of medical professionals to freedom of conscience, religion, thought, belief and opinion.⁶⁴⁴ In accordance with the Health

⁶³⁸ *Draft Bill* s10.

⁶³⁹ *Assisted Dying Bill* s5 Conscientious Objection

⁶⁴⁰ Oregon *Death with Dignity Act* s4(4).

⁶⁴¹ Washington *Death with Dignity Act* s19(1)(d).

⁶⁴² California *End of Life Option Act* s443.14 (e)(1).

⁶⁴³ *Ibid* (e)(2).

⁶⁴⁴ s15 of the Constitution.

Professions Council of South Africa Human Rights, Ethics and Professional Practice Committee's statement⁶⁴⁵ pertaining to ethical conflicts and dilemmas, that arose as a result of the Termination of Pregnancy Amendment Bill, a conscientious objection can be upheld if the objecting practitioner has made a proper referral to an appropriate doctor. Thus, should a medical professional object to fulfilling a terminally ill person's request for assistance in dying and refuse to countersign the person's declaration of intent or refuse to prescribe lethal medicine to that terminally ill person, that medical professional will be entitled to do so, provided he or she has made a proper referral to an appropriate doctor. There will be no obligation incumbent on a medical professional to fulfil a person's request if it goes against their cultural, religious or moral beliefs.

No doctors or medical professionals in South Africa should ever be placed under any obligation to assist a terminally ill person in fulfilling their wish to die. Following the *Stransham-Ford* judgment, Minister of Health, Dr Aaron Motsoaledi, argued that the legalisation of assisted dying would place an undue burden on doctors in South Africa. A conscientious objection clause in the legislation, however, would provide protection to all medical professionals who object to the practice of assisted dying on religious, cultural or moral grounds.

4.6.7 Role of a doctor/medical practitioner

The *Draft Bill* stipulates that the 'termination of a patient's life on his or her request to release him or her from suffering may not be effected by any person other than a medical practitioner.'⁶⁴⁶

In the closing argument made by Dr Jack Kevorkian in his 1999 trial,⁶⁴⁷ the doctor made a strong argument for the legalisation of assisted dying. Dr Kevorkian submitted that doctors are afforded a certain degree of protection against prosecution for acts which, when performed in the context of a medical procedure, are considered medically necessary and are surgical procedures but, if similar acts were performed by anyone other than a doctor, they would be held criminally liable.

⁶⁴⁵ Accessible at: http://www.hpcs.co.za/Uploads/editor/UserFiles/downloads/publications/annual_reports/hpcs-annual-report-2009-2010.pdf

⁶⁴⁶ *Draft Bill* s5(4).

⁶⁴⁷ F Charatan 'Dr Kevorkian Found Guilty of Second Degree Murder' (1999) 318 *British Medical Journal* 962

For example, as delineated above in the limitation of rights enquiry, if a patient is suffering from bone cancer and a doctor considers it medically necessary to amputate the patient's leg to relieve him or her from suffering, the doctor may perform such a procedure. If any other person who is not a doctor were to cut off another person's leg, they would face criminal charges. Similarly, should a doctor end a patient's life, at the patient's request, with the intention of relieving that patient of his or her suffering, it should be deemed a medically necessary procedure and not murder. As a result of this protection afforded to doctors, it is vital that assisted dying, as provided for in the proposed legislation, should only be facilitated by a qualified medical practitioner.

Although the Minister of Health Dr Aaron Motsoaledi argued against the involvement of a medical practitioner in assisted deaths, it is safer for a patient to have the assistance of a qualified medical practitioner with the experience and expertise to guarantee the patient a controlled and dignified death. It would be unwise for family members or friends to assist in bringing about the death of a loved one, as matters could go unregulated and many of the safeguards delineated in the legislation would become futile.

Many who oppose the participation of doctors in assisted dying argue that such involvement violates the doctor's oath to 'do no harm'⁶⁴⁸ however, extending the life of a terminally ill suffering individual against their will to live can be considered tantamount to a violation of the oath to do no harm.

The *Draft Bill* should therefore retain the requirement that only a qualified medical practitioner may assist a terminally ill patient in ending his or her own life. This would act as a safeguard for both the patient and the medical practitioner if assisted dying were legalised in South Africa and regulated through legislation.

⁶⁴⁸ 'End of Life Care: An Ethical Overview' (2005) Center for Bioethics University of Minnesota 42 accessed at http://www.ahc.umn.edu/img/assets/26104/End_of_Life.pdf

4.6.8 Reporting

Each of the abovementioned pieces of legislation, barring the *Draft Bill*, require annual reports to be compiled for the purpose of facilitating a statistical analysis of deaths which occurred as a result of assistance provided in accordance with the legislation.

The statistical reports compiled from data collected as a result of the Oregon and Washington *Death with Dignity Acts* have been essential in measuring the efficacy of the legislation and ensuring compliance with the law. In accordance with the Washington *Death with Dignity Act*, the attending physician of a patient who has died in terms of the Act must, within 30 days of the patient's death, file the Attending Physician Compliance Form, the Consulting Physician Compliance Form and the Written Request for Medication to End Life Form with the Department of Health.⁶⁴⁹ Such requirements, although procedural, are an integral component of the reporting process that is a legislative safeguard.

Statistical reports from 1998 to 2014 are publically available from the Oregon Department of Human Services and, similarly, the Washington Department of Health has made statistical reports from 2009 to 2014 publically available. The Washington Department of Health and the Oregon Public Health Division collect information submitted by healthcare providers (in the form of paperwork and death certificates), review the information to check for compliance with reporting requirements and, should the information be inadequate or incomplete, the health care providers are contacted.⁶⁵⁰ The information collected from the healthcare providers is not available as public record, but summarised data is released in the annual statistical report.⁶⁵¹

However, the reported statistics can be easily misrepresented. In order to gain a proper understanding of the impact of the legislation on the number of legal assisted deaths, it is necessary to perform a thorough analysis of the statistics.

⁶⁴⁹ Additionally, if a psychiatrist or psychologist performed a patient evaluation, the Psychiatric/Psychological Consultant Compliance Form must be submitted to the Department of Health within 30 days of writing the prescription.

⁶⁵⁰ Washington State Department of Health, *Death with Dignity Act*, accessed at: www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct

⁶⁵¹ Ibid.

Since its inception in 1997, a total of 1327 prescriptions have been written for lethal medication in accordance with the Oregon *Death with Dignity Act*, but only 859 patients have died from ingesting this medication. The Oregon Public Health Division released a public report of the key findings from 2014, based on paperwork and death certificates as of 2 February 2015.⁶⁵² The number of prescriptions written annually for patients in accordance with the legislation has increased from 24 prescriptions in 1998 to 155⁶⁵³ prescriptions in 2014. The total number of prescriptions, however, is not an accurate reflection of the number of patients who have died as a result of the legislation. Of the 24 patients who received prescriptions in terms of the *Death with Dignity Act* in 1998, only 16 died from ingesting the lethal medication. In 2014, only 105 of 155 patients died from ingesting the lethal medication prescribed to them. Of these 105 patients who died in 2014, 94 had their prescriptions written in 2014, but 11 patients had their prescriptions written during 2012 and 2013 and only elected to ingest the medication in 2014. The other patients who had prescriptions written in 2014 either rescinded their requests for an assisted death or they died of natural causes before they were able to ingest the medication. In 2014, the 105 terminally ill patients who died as a result of the medication prescribed to them in terms of the *Death with Dignity Act* corresponds to 31 assisted deaths per 10 000 total deaths in Oregon.⁶⁵⁴ Only three of the 105 patients who died in 2014 were referred for formal psychiatric or psychological evaluation.

Of the 105 *Death with Dignity Act* deaths in 2014, 67.6 per cent were aged 65 or older and the median age of patients was 72 years. Of these deaths, 47.7 per cent of patients were well educated individuals, holding at least a baccalaureate/bachelor's degree. The majority of terminally ill patients who requested assistance in terms of the Act were reported to have cancer, but the 68.6 per cent in 2014 was lower than the average of 79.4 per cent for all previous years. The number of patients with ALS, however, increased from 7.2 per cent in previous years to 16.2 per cent in 2014. 93 per cent of patients were enrolled in hospice care either at the time the lethal medication was prescribed to them or at the time of their death.

⁶⁵²

public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathWithDignityAct/Documents/year17.pdf

⁶⁵³ The 155 prescriptions written in 2014 were written by 83 different physicians, with each physician writing between 1-12 prescriptions.

⁶⁵⁴ The rate per 10 000 deaths of Oregon residents was calculated using the 2013 statistics which was the most recent year for which final death data was available.

Loss of autonomy was the main concern raised by 91.4 per cent of patients who requested assisted deaths in 2014. 86.7 per cent of patients stated that a decreasing ability to participate in activities that made life enjoyable was a reason for seeking an assisted death and 71.4 per cent of patients cited a loss of dignity.

In accordance with the Washington *Death with Dignity Act*, the Washington State Department of Health released a public report summarising the data and statistics pertaining to deaths that took place in 2014.⁶⁵⁵ The report includes data from documentation received by the Department of Health as of March 2015.

In accordance with the Washington *Death with Dignity Act*, 176 patients received prescriptions for lethal medication in 2014.⁶⁵⁶ These prescriptions were written by 109 different medical practitioners and the medication was dispensed by 57 different pharmacists.⁶⁵⁷ Of the 176 patients who received prescriptions in 2014, only 170 are known to have died.⁶⁵⁸ No documentation was received by the State Health Department to indicate that death had occurred for the remaining 6 patients who received prescriptions in terms of the Act.⁶⁵⁹ Of the 170 patients who died in 2014, 126 died after ingesting the medication, 17 died without having ingested the medication and for the remaining 27 patients, ingestion status was unknown.⁶⁶⁰

The average age of participants under the Act ranged from 21 to 101 years of age.⁶⁶¹ Of the 170 participants who died in 2014, 73 per cent of the patients had cancer and 13 per cent of the patients had a neurodegenerative disease such as ALS, statistics which bear a striking similarity to the numbers recorded in terms of the Oregon *Death with Dignity Act* in 2014. Moreover, 76 per cent of the participants under the Act were well educated with at least some college education.

⁶⁵⁵ Washington State Department of Health 2014 *Death with Dignity Act* Report Executive Summary www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2014.pdf

⁶⁵⁶ When the Washington *Death with Dignity Act* was first enacted, only 65 patients had prescriptions written for them in 2009 in terms of the Act. Of these patients, however, only 36 were known to have ingested the medication and died as a result thereof.

⁶⁵⁷ Washington State Department of Health 2014 *Death With Dignity Act* Report Executive Summary 1.

⁶⁵⁸ Ibid 2.

⁶⁵⁹ Ibid 2.

⁶⁶⁰ Ibid.

⁶⁶¹ Ibid 1.

The three main reasons cited by patients for requesting an assisted death in terms of the Act included a loss of autonomy (89 per cent), a loss of the ability to participate in activities that make life enjoyable (94 per cent) and a loss of dignity (74 per cent). This reflects a similar result to the statistics gleaned from the Oregon *Death with Dignity Act*.

A higher percentage of patients in Washington were at home at the time of their death, with 92 per cent of patients dying at home, whereas in Oregon 89.5 per cent of patients were at home at the time of their death. These statistics are still remarkably high and reflect the large number of patients who elect to die in the comfort of their own homes rather than in a hospice, hospital or other care facility.

It is therefore evident that the reporting requirement enables the collection of important information which assists with the monitoring and regulation of the practice of assisted dying. It is essential to include a mandatory reporting requirement in the proposed legislation for South Africa, as this serves a dual function by guarding against procedural abuse of the legislation and also providing an indicator to monitor the efficacy of the legislation.

In conclusion, the legislation envisaged for South Africa to implement a permissive regime for assisted dying requires greater clarity than what is provided in the *Draft Bill*. The definitions section of the *Draft Bill* should be revised in accordance with the suggestions outlined above, moreover, clear procedures, outlining the responsibilities of the patient and the doctors involved, are required as an integral part of the legislation. Procedures should be as succinct and unambiguous as possible, delineating exactly what is required in order for an assisted death to be compliant with the legislation. Stringent safeguards, as proposed above, should be incorporated into the proposed legislation to adequately combat the concerns raised by parties opposed to the implementation of legalised assisted dying in South Africa.

Once such a legislative framework is implemented in South Africa, those who qualify in terms of the legislation and require the assistance of a doctor in order to protect their autonomy, dignity and the right to a life with dignity, will be afforded the right to choose an assisted death if they so

wish. Just as the Choice on Termination of Pregnancy Act allows pregnant women the option of a safe, lawful abortion while protecting the medical practitioner's right to conscientious objection, legislation regulating assisted dying will afford a safe, dignified death to those terminally ill adults who seek relief from unbearable and intolerable pain and suffering while protecting the rights and interests of the medical practitioners involved.

It is acknowledged that the limitation on the scope of the proposed legislation will have the effect of excluding certain groups of persons from the operation of the legislation and omits to address advance healthcare directives. These issues, however, are significantly more complex and require a greater level of judicial analysis and legislative focus. The proposed legislation outlined above deals with the core issues surrounding assisted dying and end-of-life care and provides an adequate foundation upon which the rights of those who seek a dignified death can be respected and protected.

CHAPTER 5: CONCLUSION

The right to live a dignified life is a right that no person should be deprived of. In the context of South Africa's constitutional democracy, doctor-assisted dying for the terminally ill is an issue that needs to be addressed in a meaningful and substantial way.

Recent judicial decisions in South Africa, Canada and New Zealand confirmed that the prohibition on assisted dying results in a substantial infringement of certain fundamental rights. The cases of *Carter*, *Stranham-Ford* and *Seales* have highlighted the need for legal reform in jurisdictions where assisted dying is prohibited, such as South Africa, and gave context to the rights-based arguments in favour of abolishing the prohibition on assisted dying. These cases, however, also confirmed that the issue of regulating the practice of assisted dying needs to be dealt with by the legislature and cannot be handled on a case-by-case basis by the courts.

The abovementioned cases each dealt with the voluntary request for a doctor-assisted death by a terminally ill, mentally competent adult. A person in this position should not be denied the right to die a dignified death as a result of the private moral views of other individuals in power. The State should respect an individual's choice to end his or her own life in a dignified manner, with the assistance of a willing doctor, when he or she chooses not to pursue alternative treatment options such as palliative care or palliative sedation when the pain and suffering caused by a terminal illness becomes too much to bear.

The global trend toward approaching the issue of assisted dying from a rights-based perspective is particularly relevant in a South African context with our extensive rights-based jurisprudence that has emerged through the transition into a constitutional democracy. Thus, although the issue of assisted dying has been debated for centuries around the world, the approach toward doctor-assisted dying is changing in light of the increased focus on rights globally and South Africa cannot, and based on previous cases, will not, immunize itself from these developments. Significant legal developments have already occurred in South Africa to remedy the unjustifiable infringements of rights that occurred as a result of other limiting measures such as the prohibitions on abortions and same-sex marriages. Despite conflicting cultural and religious

beliefs, legislation was promulgated in order to remedy the unjustifiable limitation of rights that occurred as a result of these prohibitions. Similarly, the issue of doctor-assisted dying needs to be addressed in order to protect the rights of those who are suffering as a result of the severe limitation of the rights to life, dignity and autonomy.

As evidenced above through an analysis of the limitation of rights enquiry, the prohibition on assisted dying constitutes a limiting measure that substantially infringes on certain fundamental rights, namely the rights to life, dignity and autonomy. The prohibition on assisted dying became entrenched in the jurisprudence of South Africa through the development of the criminal law, which has seen perpetrators facing criminal charges for merciful acts of compassion in assisting their loved ones to be released from their suffering. Despite lenient sentencing, the prohibition on assisted dying and the criminal charges that arise therefrom place tremendous strain on the family of a terminally ill patient who wishes to end their life with dignity, but requires assistance in doing so. Moreover, the prohibition on assisted dying severely limits the options that are available to a terminally ill person who wishes to end their life with dignity, as persons in this position are often faced with the decision of ending their own life prematurely (while still physically able to do so) or losing any form of control they would have over the manner and timing of their death at a later stage in the progression of their illness.

The prohibition on assisted dying thus strikes at the core of the rights to life, dignity and autonomy, and does not merely infringe on the periphery of the aforementioned rights. This limitation of rights is not considered constitutionally justifiable in that it cannot be justified in accordance with s36 of the 1996 Constitution. Although the prohibition on assisted dying is sourced in the law of general application, it cannot be said that the purpose of the limiting measure is ‘reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.’⁶⁶² Moreover, there are alternative, less-restrictive means available to achieve the same purpose as the prohibition on assisted dying that will not constitute such a severe impairment of constitutionally protected rights. These measures can be effectively implemented and enforced through prescriptive legislation.

⁶⁶² Section 36 of the Constitution.

Although there are strong arguments to be made in opposition to the legalised practice of doctor-assisted dying, compelling statistical evidence from permissive jurisdictions indicates that a strict, prescriptive legislative framework can operate to protect the vulnerable in society and can also protect the rights and interests of medical practitioners while simultaneously respecting the right of terminally ill patients to choose an assisted death if they no longer wish to endure intolerable pain and suffering. This evidence is derived from reports compiled from the data collected in accordance with the Oregon *Death with Dignity Act* and the Washington *Death with Dignity Act*. Moreover, these findings rebut the notion that permitting assisted dying will result in a slippery slope that may lead to the unregulated practice of involuntary euthanasia.

Once it is established that an unjustifiable limitation of constitutionally protected rights arises as a result of the prohibition on assisted dying, legislative intervention is required. Foreign legislation provides meaningful guidance in establishing a legislative framework that can be implemented in South Africa to regulate the practice of doctor-assisted dying, by building on the *Draft Bill on End of Life Decisions Act*, as proposed by the South African Law Commission. By establishing clear definitions, procedures and safeguards, the legislation can effectively operate to balance the rights of those who seek medical assistance in dying and the rights of those who object to the practice thereof based on moral or religious beliefs. Only terminally ill, mentally competent adults who have requested a doctor-assisted death on repeated occasions and have completed a written certificate of request will be able to access the doctor-assisted dying envisaged by the legislation.

As a result of unequal access to resources within the South African health care system and competing cultural and religious beliefs in South Africa, care needs to be taken to ensure that the legislation operates effectively to protect the rights of all parties involved. Just as the Choice on Termination of Pregnancy Act has operated effectively within the confines of the South African health care system to protect the rights of women who choose to have an abortion, the assisted dying legislation should similarly function in a way that protects the rights of terminally ill patients who choose a doctor-assisted death.

When signing the *End of Life Option Act* into law, Governor of California, Jerry Brown, summed up the need to have legislation that regulates the practice of assisted dying in this powerful concluding statement in a letter to members of the California State Assembly:

In the end, I was left to reflect on what I would want in the face of my own death. I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others.⁶⁶³

Although there has been reluctance to engage with the discourse on assisted dying in South Africa, the recent judicial decisions have sparked a movement toward change which cannot be ignored. The rights to life, dignity and autonomy that form the foundation of the limitation of rights enquiry are not merely hypothetical rights, but are the rights of real patients who are suffering as a result of the current prohibitory regime.

Death is an integral part of life and should result in the completion of a dignified life rather than the negation thereof. A permissive regime for assisted dying is thus required in South Africa and, although it will prove challenging to implement, a strict legislative framework can regulate and control the practice of assisted dying in order to relieve terminally ill, mentally competent adults of the suffering that strips them of their constitutional right to a dignified life.

We should always debate ideas that appear to strike at the centre of our humanity. Ideas and proposals should be tested. I believe that consensual "assisted death" for those that ask for it is quite hard to oppose, especially by those that have some compassion. But we do need in this world people to remind us that we are all human and humanity is precious.⁶⁶⁴

⁶⁶³ Letter Signed by Governor Edmund G Brown Jr, 5 October 2015 accessed at:
https://www.gov.ca.gov/docs/ABX2_15_Signing_Message.pdf

⁶⁶⁴ Sir Terry Pratchett "Shaking Hands with Death" (2010) delivered as the Richard Dimpleby Lecture, published by Corgi Books 2015.

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Annexure A: Lecretia Seales' first affidavit in the proceedings

Palliative care and pain medication is not guaranteed to address all pain - if pain relief is required in high doses, Ms Seales was concerned that it would impact on her awareness of herself and her loved ones. Concerned that death would be slow, unpleasant, painful and undignified and the person may be forced to experience a death that is no way consistent with the person they are and the way they have lived their life.

I know that if I take my own life, I will need to do so alone and in secret to avoid the possibility of my loved ones being implicated. I hate the thought of going through that alone, with my loved ones having to find me and not being able to say goodbye to them properly. If I wait too long to make this decision, I could become physically unable to take my own life other than by refusing food and water. I do not want to die that way but dying that way may still be more bearable than having to suffer through to the bitter end without choice.

It seems incomprehensible to me that I can exercise a choice to end my life when I am able, and still have quality of life, but can't get any help to do so at a later point when my life no longer has any quality left for me. I want to live as long as I can but I want to have a voice in my death and be able to say "enough."

I want to be able to die with a sense of who I am and with a dignity and independence that represents the way I have always lived my life. I desperately want to be respected in my wish not to have to suffer unnecessarily at the end. I really want to be able to say goodbye well.



09 March 2016

Ms Kirsty Lee Frances (211517741)
School of Law
Howard College Campus

Protocol reference number: HSS/0236/016M

Project title: Implementing a permissive regime for assisted dying in South Africa: A rights-based analysis

Full Approval – No Risk / Exempt Application

In response to your application received on 11 December 2015, 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

.....
Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Mr Christopher Gevers and Dr Shannon Bosch
Cc Deputy Academic Leader Research: Suhayf Bhamjee
Cc School Administrator: Ms Robynne Louwe

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

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



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