

The “Murder or Mercy” debate surrounding Euthanasia in South Africa: A discussion on the current South African legal position in light of case law, a comparative study to foreign jurisdictions and recommendations made by the South African Law Reform Committee.

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*Specially dedicated to the memory of my grandfather, an inspiration all on its own.*

*People do not die from suicide, they die from sadness*

*- Anonymous*

DECLARATION:

This research has not been previously accepted for any degree and is not being currently considered for any degree at any other university.

I declare that this Dissertation is an original piece of work except where specifically acknowledged and is made available for photocopying and for inter-library use.

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A handwritten signature in black ink, appearing to be 'A. Alli', written in a cursive style.

Signed: A. Alli

Dated: 02 December 2016

## ABSTRACT

Dying with dignity is an age old debate in South Africa and unlike many foreign jurisdictions; South Africa has been slow, if not unwilling to address the prevailing issue of the “murder or mercy killing” debate. Despite report submissions by the Law Reform Commission advancing development of the common law by enacting the End of Life Decisions Bill, the common law position regarding mercy killing remains rudimentary. Recent case law on its application of section 39 and examination of various Constitutional rights situated within the Constitution advance for change based on the interpretation of an individual’s constitutional right to freedom, dignity, and free will. These rights are examined objectively in light of patients prevailing circumstances, capacity, competence, the evolving legal position, foreign law and recommendations in so far as voluntary active euthanasia and physician-assisted suicide is concerned. This research will focus on examining individuals’ Constitutional rights, safeguards which can be implemented, methods adopted to euthanize individuals and the implementation of legislation and regulations that regulate euthanasia in foreign jurisdictions sharing similar legal systems to South Africa such as Canada and the Netherlands. In addition, this research aims to highlight that there is a need for the implementation of the End of Life Decisions Bill and that dilatory tactics by the legislature in not giving the Bill adequate or any attention are detrimental in that the position is now left unclear to society following current case law developments.

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## CHAPTER 1: INTRODUCTION

### 1.1 *Motivation and Current Problems*

The need to survive is shared amongst all biological beings. It is an instinct inherent amongst all humans. Just as humans are programmed with the drive to overcome all obstacles to maintain survival, so too are they programmed and conditioned to believe that to kill or take one's life is immoral, and later on as they grow older, they learn that it is not only legally wrong to take a life but also morally reprehensible. Human beings however, are easily conditioned in that their perspectives are able to evolve and adapt to change. For example when we are told that killing another human is wrong and punishable, we accept it. Likewise when we are told that the killing of another human may be justified in the instance when we are able to supply a valid private defence in law, we accept it. Our acceptance is premised on reasoning and justifications advanced by the law, our evolving society and evolving public policies.

It is understandable that the condoned and justified killing of an individual, irrespective of the medical context within which a killing may be framed, would raise legitimate fears that allowing for such termination of life would open the door to all sorts of abuse. The concern that a deluge of misuse is likely to follow, is not entirely without substance.<sup>1</sup> In fact allowing of any form of killing within society is arguably a risky move onto uncharted terrain. It is, however, a move which we do not seem to hesitate to make when it comes to the killing of our enemies in war (personally unknown and often indiscriminate as when we bomb cities), executing criminals or killing in self-defence.<sup>2</sup>

The issue of the legalization of euthanasia in South Africa has become a contemporary phenomenon since the recent Northern Gauteng High Court decision<sup>3</sup> that granted an order in favour of permitting a competent applicant suffering from a terminal illness to be euthanized. Whilst I will be discussing this case in greater detail in chapter two, this case is important to

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<sup>1</sup> E H Loewy and R S Loewy *The Ethics of Terminal Care, Orchestrating the End of Life* (2000) 108

<sup>2</sup>Ibid (see fn 1 above) 108

<sup>3</sup>*Stransham-Ford v Minister of Justice and Correctional Service and Others* 2015 (4) SA 50 (GP) (hereafter "Stransham-Ford")

my research in that it signifies a movement away from the current conceptual framework in South Africa in the absence of implementing legislation.

Previous to the *Stransham-Ford v Minister of Justice and Correctional Service* case, the practice of euthanasia was heavily guarded against by the common law.<sup>4</sup> The traditional common-law approach is that consent to bodily harm will not operate as a legitimate defence.<sup>5</sup>

My research will indicate what the implications of such a judgment are for the current position insofar as the prohibition on euthanasia in South Africa is concerned. I will argue that the judgment is significant in that it directly relates to and assists my argument for the legalization of euthanasia. Currently, there remains no provision in our law to regulate the practice of euthanasia and as there is no implementing legislation to regulate euthanasia, the danger in the absence of legislation may very well result in abuse or misinterpretation of what the judgment means in general.

The motivation for conducting this research derives from the danger of the abuse that may potentially ensue as a result of not implementing legislation to regulate this area of law aside from a historic ban on the practice found in common law. This danger of abuse is heightened by the judgment of the *Stransham-Ford* case which may very well have led to confusion and uncertainty in the public domain in causing the public to formulate the incorrect impression that the practice of euthanasia has become legal. Currently our law is in a state of conflict.<sup>6</sup> Euthanasia or assisted suicide is arguably now, both legal and illegal in South Africa.<sup>7</sup> Despite the recent decision in the case of *Stransham-Ford*, no one can claim to know whether euthanasia or assisted suicide is lawful or not, thus leaving those who are suffering from a terminal illness, and who want to die as a result of the suffering they face, and their families and the doctors who are in a position to assist and want to help, in a state of uncertainty that can only cause more suffering.<sup>8</sup>

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<sup>4</sup>J M Burchell *Principles of Criminal Law* 4 ed (2005) 52 states that “a person cannot validly consent to be killed because the state has an interest in the requesters preservation of life”

<sup>5</sup>*Ibid* (see fn 4) 207. Additionally, Burchell uses an example to explain the traditional common law approach whereby “Y’s consent to being killed by X cannot purge the homicide of its unlawfulness”.

<sup>6</sup>J Grant ‘Is Euthanasia now Legal in South Africa?’ (2015) available at <https://criminallawza.net/2015/05/02/is-euthanasia-now-legal-in-south-africa-2/> accessed on 24 May 2016

<sup>7</sup> *Ibid* (see fn 6)

<sup>8</sup> *Ibid* (see fn 6)

Ultimately and to a large extent, we once obtained guidance as to the lawfulness of euthanasia and assisted suicide from judgments and the SALC reports, however these decision were to a large extent fact-bound, not law-bound.<sup>9</sup>

Despite the need for legislation to regulate euthanasia and submissions made by the Law Reform Commission,<sup>10</sup> it still remains illegal until the law changes explicitly. However, whilst the illegality is maintained, the High Court judgment seems to say otherwise by delivering a judgment that has the effect of usurping the common-law position. Additionally, insofar as the applicant is concerned, the judgment remains exclusive in its applicability to the applicant. Which leads us to question as to (a) whether such a specific judgment can usurp the common-law position and (b) whether the law has become subjective in its application to certain individuals? Whilst that may be an interesting observation, the focus of my research is not premised on subjectivity of the law in its application but rather on implementing legislation to regulate euthanasia and in this instance a comparative study to Canada will be done with a brief overview of the practice in Netherlands.

## 1.2 *Summary of thesis, Aims, Objectives and Research Goals*

In this research I will provide an introduction of the current legal status of euthanasia in South Africa and discuss the constitutional clauses that would be directly affected by the practice. My study will adopt a comparative analysis, focusing on the particular conditions in Canada and Netherlands that have led to euthanasia becoming legal. Based on the law reform submissions, the most recent case<sup>11</sup> and a consideration of comparative study, my research will argue that euthanasia can work in South Africa with the guidance and assistance of a legal framework.

My study will focus primarily on the concept and practice of voluntary active euthanasia and physician-aided suicide. The primary aim of this research is to examine the current South African stance taken in respect of euthanasia and further, to examine euthanasia from a common-law, constitutional law and case law perspective in conjunction with the SALC law reform report (project 86) on euthanasia.

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<sup>9</sup> J Burchell (see fn 4)

<sup>10</sup> I Mahomed *Commission of inquiry into Euthanasia and the Artificial Preservation of Life in South Africa: Project 86* (1998)

<sup>11</sup> *Supra Stansham-Ford v Minister of Justice* (See fn 3)

The reasons for focusing on active euthanasia and physician-assisted suicide particularly, is owing to the fact that at the time of the request being made, the patient is mentally competent to make such a request. Additionally, the only defining characteristic that sets these two apart is the execution of the final act, i.e. physicians only assist the patient in executing the final act, they are not responsible or held accountable for the death of the patient, whilst voluntary active euthanasia entails physicians executing the final act, which directly causes the death of the patient.<sup>12</sup> Although, this should not be misconstrued to imply that practitioners will not be held liable. The liability of practitioners will be discussed in greater detail in chapter four.

In simplification, an analogy can be used to best describe the distinction between the two. For a case of physician-assisted suicide a physician must have provided the means to assist the patient in executing the final act leading to his death. By doing this the physician would have to supply a lethal dose or prescribe one that would result in death upon intake by the patient. On the other hand, voluntary active euthanasia simply requires the physician to physically administer a lethal dose into the patient, summarily leading to death of the patient. It is argued that in the context of causation the voluntary act of the patient in ingesting the lethal dose breaks the chain of causation. I will expand on the definitions of the different distinctions of euthanasia later on in this chapter.

The underlying purpose of my research is aimed at arguing that when a patient is mentally competent and suffering from a terminal illness which will ultimately lead to his/her death, that person should be able to exercise his/her right to autonomy in requesting to be euthanatized. In these circumstances a physician ought to be legally able to assist provided that the procedure is legally regulated. These proposed regulations will be discussed further in Chapter four of this research, which seeks to provide for a way forward.

### *1.3. Research Methodology*

This research adopts a qualitative and desktop approach. The resources I will be relying primarily on will be textbooks, journal articles, law reports, reported articles from the media and legislation. My research will refer to the Constitution, as a variety of fundamental rights that stem from the Constitution are material to the discussion of euthanasia. These rights will be discussed further in Chapter two. More importantly and in comparison to any other law, the

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<sup>12</sup>*Ibid* (See fn 1) p4.

Constitution is the highest law of the land. Law or conduct inconsistent with the Constitution is invalid.<sup>13</sup>

In addition to the Constitution, I will be referring to common law, case law and statutory laws in respect of conflicting positions and current debates surrounding the topic of euthanasia. International legal principles, cases and statutes will be considered in order to evaluate the position that other jurisdictions have taken in adopting the practice of euthanasia.

#### 1.4. Terminology and Definition

For the purpose of this research it is firstly important to clarify the terminology that will be referred to. The following terminology will be made reference to and for all intents and purposes, the terminology referred to shall be understood to be defined by the definition following it. This terminology has been employed by the writer and will be employed throughout the research dissertation.

##### 1.4.1. Euthanasia

‘Euthanasia’ can be broadly defined as any conduct that brings about an easy or painless death for a patient suffering from an incurable or painless illness or disease or condition.<sup>14</sup> Although strict conditions are applied when it is practised, ‘mercy killing’, as it is sometimes termed, is legally allowed in a few countries.<sup>15</sup>

Euthanasia encompasses multiple distinctions and characteristics, i.e. ‘voluntary active euthanasia’, ‘passive euthanasia’, ‘non-voluntary euthanasia’, ‘involuntary euthanasia’ and ‘physician-assisted suicide’. In most of the aforementioned cases it refers to instances in which the physician or doctor of a patient suffering from a terminally ill disease performs the last causal step leading to the death of the patient, and thus can be said to kill the patient.<sup>16</sup>

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<sup>13</sup> Section 2 of the Constitution of the Republic of South Africa, 108 of 1996

<sup>14</sup> DJJ Mukartet *al* ‘Palliative Care: Definition of Euthanasia’ (2014) 104 *SAMJ* 259

<sup>15</sup> J Meuwissen, ‘Is Dying a Choice?’ available at <http://www.capechameleon.co.za/printed-issue/issue-18/health/> accessed on 24 April 2016

<sup>16</sup> G Dworkin ‘The Nature of Medicine’ in G Dworkin & R G Frey (ed) *Euthanasia and Physician Assisted Suicide* (1998) 3

#### *1.4.2. Euthanasia Tourism*

‘Euthanasia tourism’, as the definition suggests, involves residents belonging to a country that condemns the practice of euthanasia travelling to a country that condones the practice of euthanasia and requesting to be euthanized, provided that the law in the latter country does not prohibit doctors from administering euthanasia to non-residents.<sup>17</sup>

#### *1.4.3. Voluntary Active Euthanasia*

‘Voluntary Active Euthanasia’ is sometimes referred to as ‘Active Euthanasia’ and is defined as the intentional killing of a person suffering from an incurable illness or disease, and fulfils the legal criteria for murder in South Africa.<sup>18</sup> The request to be euthanized is made at the request of the terminally ill, mentally competent and well-informed patient who is able to communicate his request. This includes cases where terminally ill patients that are faced with the inevitable fatality of their condition either seek assistance in executing their deaths (i.e. physician-assisted suicide), or refuse to undergo burdensome medical treatment designed to treat their condition and choose to self-administer medication that will ultimately result in their death (i.e. voluntary euthanasia). Additional cases of refusal include assistance from any medical machinery such as life support machines, as well as a refusal to consume any meals and simply resigning themselves to death in the process.<sup>19</sup> Voluntary Active Euthanasia differs from Passive Euthanasia in that a patient requests is competent to make a decision regarding euthanasia, i.e. a decision to self-administer a lethal injection or refusal of medical treatment which will result in imminent death. Voluntary Active Euthanasia is therefore not only confined to a positive act by definition. Voluntary Active Euthanasia may also be a request made by a mentally competent patient, suffering from a terminal illness to intentionally and

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<sup>17</sup>‘Hollands Euthanasia Law’ available at <http://www.patientsrightscouncil.org/site/hollands-euthanasia-law/> accessed on 27 April 2016

<sup>18</sup> DJJ Mukart *et al* (fn 11 above) 259

<sup>19</sup> Voluntary and Involuntary Euthanasia accessed at <http://www.bbc.co.uk/ethics/euthanasia/overview/volinvol.shtml> accessed on 14 June 2016

wilfully omit to ingest medication or nutrients that will sustain his/her medical condition and prolong their life.

#### *1.4.4. Passive Euthanasia*

‘Passive Euthanasia’ is defined as the withholding of extreme medical measures or alternatively, removing a patient from life support when a situation where there is little or no success in a beneficial treatment available to assist or improve the patient’s condition.<sup>20</sup> Passive Euthanasia remains a contentiously practiced form of euthanasia in South Africa with South African court’s ruling that it is a permissible practice in certain instances.<sup>21</sup> Instances that label the practice of passive euthanasia as legal in South African courts are held to be based on a consideration of factors such as; reasonableness, fairness and justice before decisions to withhold or discontinue the medical treatment of a patient are taken.<sup>22</sup> It has been held further, a patient’s death as a result of the discontinuance of medical treatment, would not in law be the cause of the patient’s death if he were to die as a result of the discontinuance.<sup>23</sup> It is argued that the underlying medical condition causes the death of the patient and that doctors are not liable for a crime of murder because the element of ‘intention’ in the killing a person is absent.<sup>24</sup>

#### *1.4.5. Involuntary Euthanasia*

‘Involuntary Euthanasia’ herein refers to the practice of euthanasia on a terminally ill patient who is informed, maintains mental capacity and refuses to be euthanized. However, despite his objection, he is euthanized. In other words, the person wants to live but is killed anyway.<sup>25</sup> This type of euthanasia will fall within the ambit of the definition of murder as it involves the unlawful killing of another human being.<sup>26</sup>

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<sup>20</sup> Ibid (see fn 19)

<sup>21</sup> *Clarke v Hurst NO* (1992) 4 SA 360 (D) 631E-F

<sup>22</sup> *Supra Clarke v Hurst NO* p632

<sup>23</sup> *Supra Clark v Hurst NO* p632

<sup>24</sup> DJ McQuiod-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

<sup>25</sup> *Ibid* (See fn 17)

<sup>26</sup> *Ibid* (See fn 17)



#### 1.4.6. *Non-Voluntary Euthanasia*

‘Non-Voluntary Euthanasia’ is distinguishable from any other form of euthanasia such as voluntary or involuntary euthanasia, and occurs in instances when the wishes of a patient are unknown or unascertainable.<sup>27</sup> Thus, these instances involve situations where the patient’s condition is such that his decision-making capacity is encumbered. Examples of these encumbrances would be a person in a coma; a person too young, such as a baby; a person lacking mental capacity or even a person suffering from severe brain damage.<sup>28</sup>

#### 1.4.7. *Physician-Assisted Suicide*

‘Physician-Assisted Suicide’ or ‘Physician-Aided Suicide’ is the ‘facilitation of suicide’<sup>29</sup> by a physician. It involves medical assistance by a medically-trained health care practitioner who uses his medical knowledge or medical technologies available to him by virtue of his vocation, to assist a person in committing suicide.<sup>30</sup> Therefore, the defining element of physician-assisted suicide requires that there be some degree of assistance by a trained health care practitioner.

#### 1.4.8. *Assisted Dying*

Any person assisting another person in the act of suicide.<sup>31</sup>

#### 1.4.9. *Patient Autonomy*

The concept of ‘Patient Autonomy’ was first introduced into South African law in 1976 in the case of *Richter and another v Estate Hammann*<sup>32</sup> and almost two decades later, in the case of

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<sup>27</sup>LB Grove (2008) *Framework for the Implementation of Euthanasia in South Africa* (LLM Thesis) Retrieved from the University of Pretoria UPSpace Institutional Repository. p9.

<sup>28</sup>*Ibid* (See fn 17)

<sup>29</sup>*Ibid* (See fn 15) p3

<sup>30</sup>*Ibid* (See fn 24) p9

<sup>31</sup> G van der Walt and EK du Plessis “I don’t know how I want to go but I do know that I want to be the one who decides” – The right to die - The High Court of South Africa Rules in *Stransham-Ford and Minister of Justice an Correctional Services: The Minister of Health Professional Council of South Africa and the National Director of Public Prosecution* (3 June 2015) (2015) 36.3 *Obiter* 801’ (also accessible from: <http://www.derebus.org.za/recent-articles-research-7-2/>) accessed during April 2016.

<sup>32</sup>1976 (3) SA 226 (C)

*Castell v De Greef*<sup>33</sup> it became ingrained in South African medical and health jurisprudence.<sup>34</sup> It can be defined as a patient's right to be well-informed of the consequences of any medical condition and the medical treatments that are available following his/her condition prior to health practitioners obtaining the necessary consent required. Therefore, the concept of patient autonomy is directly related to self-determination, the right to bodily integrity and autonomous moral agency, all of which have been accepted as fundamental rights afforded to patients<sup>35</sup> and have been subsequently codified under section 6, 7 and 8 of the National Health Act<sup>36</sup>.

Apart from the fact that these rights are important in advancing the argument for euthanasia, they are considered as fundamental rights because they originate from the section 12 of the Constitution, i.e.; the right to bodily and psychological integrity which affords one with the right to security and control over oneself.

It is suggested that the principle of patient autonomy is directly linked to the doctrine of informed consent.<sup>37</sup> This suggestion has been derived from *Castell v Greef*, where the court held that in principle, it was unreasonable for the medical profession to disregard a patient's attitude towards a particular medical treatment after advising her accordingly of all the risks attached to a medical treatment or operation, as her right to bodily integrity, and autonomy entitle her to reject and refuse medical treatment irrespective of a dissimilar view that may be maintained by the patient's medical practitioner or the entire medical profession.<sup>38</sup>

#### 1.4.10. Palliative Care

'Palliative Care' is defined by the World Health Organization as:-

An approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness through the prevention and relief

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<sup>33</sup> 1994 (4) SA 408 (C)

<sup>34</sup> R Britz and A le Roux-Kemp 'Voluntary informed consent and good clinical practice for clinical research in South Africa: ethical and legal perspectives' (2012) 102 *SAMJ* 9

<sup>35</sup> *Supra* (See *Castell v Greef*) at 420I, 421C and D-E

<sup>36</sup> Act 61 of 2003

<sup>37</sup> *Ibid* (See fn 31)

<sup>38</sup> *Supra* (See *Castell v Greef*) at 421D

of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.<sup>39</sup>

In addition, it is defined as medical care or treatment afforded to a patient suffering from a terminally ill disease or condition with the object of relieving physical, emotional and psychosocial suffering and of maintaining personal hygiene.<sup>40</sup> Thus, palliative care aims to maintain a patient's stable mental and physical condition whilst alleviating any discomfort the patient would be experiencing as a result of his sustained and fatal illness or disease.

#### *1.4.11. Terminally ill patient*

'Terminal Illness' means an illness, injury or other physical or mental condition that –

- a. In reasonable medical judgment, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering; or
- b. Causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.<sup>41</sup>

Therefore, a 'terminally ill patient' involves any person afflicted by a terminal illness as defined by the South African Law Report on Euthanasia and the Artificial Preservation of Life.

### *1.5. Conceptual Framework*

South Africa is a constitutionally governed country, with all laws and regulations subject to the Constitution's application and ambit. Thus, it is the highest law of the land and any law or conduct that is inconsistent with it is invalid.<sup>42</sup> Chapter two of the Constitution consists of fundamental rights of South African citizens, affirming values such as freedom, equality and dignity. Essentially, chapter two of the Constitution is the cornerstone of democracy in South Africa. Alongside these clauses that will be discussed in more detail in chapter two, is section 39; i.e. the interpretation of the Bill of Rights. This section empowers the court to develop the

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<sup>39</sup> L Gwyther, 'Withholding and withdrawing treatment: Practical applications of ethical principles in end-of-life care' (2008) 1 *SAJBL*

<sup>40</sup>*Stranham –Ford case and Clarke case* supra (see fn 3 and fn 6 at p13)

<sup>41</sup>*Stranham-Ford case and Clarke case* supra (see fn 3 and fn 6 at p13)

<sup>42</sup>Section 2 of the Constitution of the Republic of South Africa 1996.

common law in order to give effect to the Constitution and promote the objectives of the Constitution.<sup>43</sup>

Euthanasia remains a common law crime in South Africa, thus making the practice presently unlawful.<sup>44</sup> Cases such as *Castell v Greef* and *Clarke v Hurst* are amongst the few cases that have discussed passive euthanasia and the importance of obtaining informed consent from a patient before conducting any medical treatment. This is to ensure that doctors will not incur liability for any risks or complications which may flow from medical treatments. Whilst the South African Law Commission has compiled a report on the issue of Euthanasia, there has been no resulting legislation or consideration given to legislation being implemented over the past few years.

The Law Commission Report makes no specific recommendations regarding voluntary active euthanasia, but rather provides three options available for consideration.<sup>45</sup> These options will be discussed further in the next chapter.

Canada's decision to allow for the practice of euthanasia came into effect after a response to cases brought by the families of two British Columbian women, Gloria Taylor and Kay Cater.<sup>46</sup> Both women like Robert Stransham-Ford, did not have the benefit of the judgment as they died prior to the ruling. The Canadian Court ruled that it was an infringement on one's security of person to leave one to endure intolerable suffering.<sup>47</sup> Whilst this ruling allows patients to be euthanized, the Canadian law sets out the categories that must be met before one becomes eligible or qualifies to be assisted. The criteria will be discussed in greater detail in chapter three.

On the other hand, the current statutory law regulating euthanasia in Netherlands is the 'Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001'. Space constraints permit only the relevant sections of the Dutch legislation and its applicability to be discussed. This is done in order to have the benefit of both the Canadian and Dutch systems.

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<sup>43</sup>*Ibid* the Constitution (See Section 39)

<sup>44</sup>*Stransham-Ford v Minister of Justice and Correctional Service and Others* (Supra Fn 3) p56F

<sup>45</sup>*Ibid* (fn 4) 208

<sup>46</sup> Canada Legalizes Euthanasia, As High Court passes Assisted Suicide Law, accessed at <http://www.medicaldaily.com/canada-legalizes-euthanasia-high-court-passes-assisted-suicide-law-321394> on 27 April 2016

<sup>47</sup>*Charter v Canada (Attorney-General)* 2012 BSCS 1322

### 1.6. *The Current Legal Position in South Africa*

It is unquestionable that our legal framework is ever-evolving. Such change is necessitated in order to give effect to the Constitution in developing the common law, adapt to societal change or community sentiments,<sup>48</sup> changing public policies and international considerations. What remains questionable is whether our legal framework is evolving fast enough to rise to the debate circulating around the issue of euthanasia. Under our current law, physician-assisted suicide or active voluntary euthanasia remains unlawful.<sup>49</sup> However, a move for a changed position has been under construction with the introduction of the report on a draft bill for euthanasia supplied by the Law Reform Commission in 1998. Despite this, many years have passed since the draft bill on *Euthanasia and the Artificial Preservation of Life* was last tabled at parliament. The bill remained an issue comfortably shelved by the Health Professionals Council of South Africa (cited as third respondents in the *Stransham-Ford* case), sheltered from any public debate it may generate. Currently, the decision in the *Stransham-Ford* judgment sparks much confusion about the legal position and has revived the debate.

### 1.7. *Rationale for Research – A ‘Changing Climate for Reform’*

Presently there is a need for re-considering the issue of euthanasia. Nel, suggests that there is a need for reconsideration, partly because frequently invoked legal principles that were formulated centuries ago may have become ‘outdated’ and may be inappropriate to deal with modern issues.<sup>50</sup> It is for this reason that legal principles need to be revisited, because old laws and regulations cannot cope with contemporary issues.

In some instances the South African criminal justice system may be described as progressive in its ability to evolve to social reformation and technological and societal invention.<sup>51</sup> In a way, the criminal justice system is not conventional and rigid. We are constantly confronted with a variety of challenges brought on by changes and changed perspectives. Our law is constantly applied and developed in order to cope with these challenges and changes.

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<sup>48</sup> Also termed as ‘legal convictions of society’

<sup>49</sup>*Stransham-Ford* p56-F

<sup>50</sup>Nel “Regsvrae random die genes kundigebehandeling van ernstiggestremdepasgeborenes” 1998 *Tydeskryf vir die Hedendaagse Romans-Hollandse Reg* p73 also cited in Grove (see fn 27) p4

<sup>51</sup>C R Snyman, *Criminal Law* (2014) 6ed 20

Technology develops every day and with it, the law develops to accommodate it. Likewise, there are advancements in the medical profession, in medical treatment and medical technologies. These advancements provide advantages and disadvantages which we knew little to nothing about 30 years ago. One example of these challenges and changes is abortion, which was initially illegal until the Choice on Termination of Pregnancy Act<sup>52</sup>. The Act secured and protected a person's right to make decisions concerning their reproduction and control over their bodies.

As already mentioned, the world is changing significantly and South Africa, to no lesser degree remains unchanged.<sup>53</sup> Some thirty years ago, homosexuality, abortion and mixed marriages and even euthanasia were considered illegal in various jurisdictions. Whilst these changes are accepted in some jurisdictions, many places still remain firm in their laws against homosexuality, abortion, euthanasia, etc. Labuschagne, as cited in Grove, argues that the law has become outdated with suicide pacts and similar phenomena becoming increasingly common.<sup>54</sup> Therefore, it is apparent that society has changed drastically from the first time that the legal position on euthanasia was decided.

It is for the aforementioned reasons that I have embarked on a research to evaluate the South African position, placed in conflict after the *Stransham-Ford* decision.

### 1.8. *Choice of Legal System*

Canada is used as a chosen legal system in advocating for the practice of euthanasia because of its similarities to our legal structure. These similarities are evident in the Canadian Charter for human rights that are central and fundamental to Canada. Likewise, South Africa shares a similar rights-centred approach. These rights mirror our Constitutional rights. In addition, Netherlands is also used as a comparative study to South Africa because the Dutch and South African principles share a common heritage and similar legal principles.

Netherlands is used as a comparative study for two reasons; (a) the common law of South Africa is Roman-Dutch law.<sup>55</sup> Roman-Dutch law is a system of law that initially originated in

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<sup>52</sup>Act 92 of 1996

<sup>53</sup> Grove (See fn 27) p4

<sup>54</sup> Grove (See fn 27) p4

<sup>55</sup> C R Snyman, *Criminal Law*, 6ed (2014) 6

Rome and was later received in Netherlands;<sup>56</sup> and (b) Dutch law contains extensive developments of regulations on euthanasia.

It is for the aforementioned reasons that this research will briefly observe a reflective position of the developments of euthanasia in Netherlands. Having initially shared a common stance with South Africa against the practice of euthanasia, it is now a practice regulated by legislation for a substantial period of time and has adopted a developed rule of law in respect of euthanasia.

### *1.9. Chapter Overview and Research Design*

This research is divided into five chapters. Whilst the content of the first chapter has already been noted, the next chapter two (2) considers the constitutional debate and evolving South African position. Further, chapter two considers implementation of the legal framework suggested by the Law Reform Commission and focusing on the options available in the End of Life Decisions Bill.

Chapter three (3) will explore international legal developments such as the Canadian Criminal Code, as well as other legislation and relevant cases. Additionally, this chapter will briefly look at regulations governing euthanasia in Netherlands.

Chapter four (4) is dedicated to suggested changes and recommendations, drawing on the strength of the practices in Canada and Netherlands as well as considering the safeguards and mechanisms that can be adopted to prevent abuse, this is then followed by a short discussion of the Minimum Sentencing Legislation and its application on criminals that practice euthanasia illegally. The Minimum Sentencing Legislation secures a degree of liability for unauthorised criminals practising euthanasia to be penalised. A recommendation is accordingly made for introduction of legislation to govern the practice of euthanasia.

The final chapter concludes that notwithstanding fundamental rights and analysis of euthanasia and physician-assisted suicide in other jurisdictions, namely Canada and Netherlands, South Africa has not adopted legislation to regulate euthanasia and assisted suicide. Such legislation is necessary in a developing jurisdiction such as South Africa that has adopted many of its legal principles from Canada and Netherlands.

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<sup>56</sup> Ibid Snyman (see fn 55) 6

### 1.10. Conclusion

It is without a doubt that there is much debate surrounding the issue of euthanasia and its legalization in South Africa. Amidst this growing debate is the question of whether or not, it has become legal in light of the Gauteng High Court ruling. Legislation can resolve this uncertainty as there is currently tremendous pressure on South Africa to reach a decision that will reflect on the equality<sup>57</sup> of the law in its application. It is further submitted that there is great potential for South Africa to give effect to the Constitution by carrying out its obligation in developing the common law and determining what the right to life means in context.

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<sup>57</sup>Section 9 of the Constitution (1996) states that the law must be applied equally amongst all individuals whilst the ruling in the *Stransham-Ford* case limits its applicability to the applicant.



## CHAPTER 2: THE CONSTITUTIONAL DEBATE AND EVOLVING POSITION

### 2.1. Introduction

Control over our own lives is one of the most important goods we enjoy. In health, we exercise control daily over how we shall live, making decisions that shape our lives and affect their quality. We take the making of these decisions for granted: it is our life, and how we live it and what we make of it is up to us. We take for granted as well our ability to see that our decisions in this regard are put into practice: in health, we act in ways that reflect our decisions about how we want to live. When serious illness overtakes us, however, it becomes harder to control the course of our lives; other people become involved in our care, and we can lose the ability to see that the decisions we make with respect to our lives are implemented.

Today, the media is filled with stories of terminally ill patients who seek a dignified release from the lives they are presently living and who turn to their doctors for assistance in dying. In a perfectly straightforward sense, such patients seek to continue to exercise control over their lives, now in the form of bringing about their deaths. They no longer want to live the life to which illness has condemned them. They seek an exit. Quite naturally, they turn to their doctor for help.

As the ‘death with dignity’ movement links arms with the ‘patient autonomy’ and ‘control over one’s life’ movements, and as tragic cases involving all these slogans play themselves out in the media, the need for help [in respect of the legality of these burdens] becomes more pressing.<sup>58</sup>

### 2.2 Background

Fundamental values such as the right to life, dignity, autonomy and freedom of choice underpin the Constitution of South Africa. These values are not just writings on a piece of paper, put together to look fancy. They are values that are the cause of argument, they stimulate arguments for the advancement of regulations, are causes of contention, and they help formulate discourse in various aspects of the law. All of these values are encompassed under Chapter two of the Bill of Rights.<sup>59</sup>

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<sup>58</sup>R G Frey ‘Distinctions in Death’ in R G Frey *Euthanasia and Physician-assisted Suicide* (1998) pages 17-18

<sup>59</sup> Constitution of the Republic of South Africa, section 7-8:

“(1) *This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in*

The Bill of Rights is a liberating text aimed at facilitating a smooth social and economic transition in South Africa, whilst simultaneously protecting the human dignity of all.<sup>60</sup>

### 2.3 *The Constitutional Debate Surrounding Euthanasia in South Africa*

#### *A General Overview*

The present South African legal system entails a combination of Roman-Dutch, English, German and unique South African elements of law, all of which must be tested against the values of the Bill of Rights.<sup>61</sup>

The rights to equality, human dignity, life, as well as freedom and security of person, are rights firmly entrenched within the Constitution. These rights are categorised as ‘subjective rights’.<sup>62</sup> Additionally, they are not only fundamental to our democracy but also play an active and significant role in South Africa’s transition from a history riddled with injustice and unfair discrimination towards an open and democratic society, free of arbitrariness and inequality. The criminalization of euthanasia infringes on these fundamental rights encompassed within the Constitution as it directly impairs an individual’s ability to regulate his life in accordance to his wishes. However, whilst these rights guarantee a degree of entitlement and are important in affirming individuality and independence in the decisions one makes, they are also subjected to limitations. These limitations are regulated under section 36 of the Constitution, a section saddled with the responsibility of ensuring that no harm occurs as a result of a right being enforced, alternatively that there is a substantially fair and justified limitation of a right being invoked.

In *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*<sup>63</sup> the Constitutional Court granted an order declaring the common-law offence of

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*our country and affirms the democratic values of human dignity, equality and freedom.*

(2) *The state must respect, protect, promote and fulfil the rights in the Bill of Rights. . . .*

*Section 8:*

*‘(3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court —*

*(a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common-law to the extent that legislation does not give effect to that right; . . . .’*

<sup>60</sup> P De Vos *et al*, *South African Constitutional Law*, (2014) 317

<sup>61</sup> J Burchell, *Principles of Criminal Law*, 4 ed (2013) p8

<sup>62</sup> *Carmichele v Minister of Safety and Security and Another* 2001 (4) SA 938 (CC) at para 54

<sup>63</sup> *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1999 (1) SA 6 CC

sodomy to be unconstitutional and invalid on the premises that it unfairly discriminated against a class of individuals based on their sexual preference. An important advancement in this landmark judgment was provided when the fundamental right to dignity triumphed over a common-law crime that had once been firmly ensconced within South African law. The court analysed the elements that defined sodomy as a common-law crime and defined it as an instance of the criminalisation of private conduct by capable and consenting adults which resulted in no harm being caused to others.<sup>64</sup> Thus, on the analysis of the court it can be argued that the common-law crime of sodomy and the common-law crime of euthanasia are elementally similar in that both common-law crimes can be defined as crimes that encompass elements of a private nature by consenting and capable adults. Therefore, if the reasoning and analysis of the common-law crime of sodomy in the *National Coalition v Minister of Justice* were to be applied to the common-law crime of euthanasia, the reasoning of the judgment would lead one to the conclusion that a request to be euthanized is a private act communicated by a capable and consenting adult, albeit suffering from a terminal illness, causing no harm to anyone else. Although arguments may be advanced that euthanasia is a purely paternalistic act on the part of a state to want to protect individuals, it is submitted that when decisions to be euthanized is made by competent and informed individuals, interference or ‘protection’ by the state is no longer necessary. Whilst many other rights played a role in the *National Coalition* case, space constraints for this research permits the writer to the relevant portions of the judgment.

Whilst the focus on *National Coalition v Minister of Justice* was on the common-law crime of sodomy, it is submitted that the court’s finding and reasoning must be pursued in advancing for the decriminalization of the common-law crime of euthanasia. In invalidating the common-law crime of sodomy, the court reasoned that certain common-law crimes fulfil no legal benefit other than to criminalise conduct which fails to conform with moral or religious views maintained by fragmented portions of society having been introduced into law within a pre-constitutional dispensation. Similarly, and in application of the court’s reasoning, euthanasia was part of the common-law dating back a long time within a pre-constitutional dispensation, a crime situated in an era that condemned any form of suicide, whereas the post-constitutional regime requires developments to the law in order to give effect to the people’s rights.<sup>65</sup>

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<sup>64</sup>Supra *National Coalition for Gays and Lesbians* at page 27, para 26 and 27F – 28A-B

<sup>65</sup>*Stransham-Ford v Minister of Safety and Security* 2015 (4) SA p60I-A

Understandably, there are a number of (common-law) criminal laws for drugs, traffic offences and sex offences where the state still criminalises these harmful forms of conduct even if they are consensual, these laws remain constitutional. This is because ‘there is no legitimate purpose to validate the “impugned” law and the absence of legitimate purpose means that there is nothing to access as the lack of legitimate purpose renders, at the outset, the limitation unjustifiable’.<sup>66</sup> Euthanasia is different from common-law crimes because there is no justifiable and legitimate purpose to validate it as a common-law crime. Therefore, it is not per se a common law crime. Although the right to life will always factor as a strong argument against any decision that results in death, the right to freedom and security, self-autonomy, choice are also strong arguments for advancing euthanasia. This will be discussed in greater detail below.

It is submitted that the exclusive legality afforded to passive euthanasia in practice, to the extent that voluntary euthanasia and physician-assisted suicide is excluded is an unjustified limitation on an individual’s right to dignity and equality. The limitation on euthanasia serves no valid purpose when consideration is given to the fact that passive euthanasia is practiced. Passive euthanasia, as previously discussed falls under the general umbrella of euthanasia as a concept. In fact, courts have often held that medical practitioners who cause the death of a patient to be hastened, at the advanced directive or consent of the patient’s family, will not be held criminally liable for murder.<sup>67</sup>

Under the Constitutional dispensation, a fully capable and consenting requestor in full control of his cognitive functions, suffering from a terminal illness should be entitled to exercise and invoke his private right to dignity and equality in submitting his request to be euthanized. The limitation of this right in so far as its applicability is limited to passive euthanasia serves no valid purpose under our Constitutional regime. To some extent, common-law limitations present a reflection of archaic, traditional religious thinking formulated under a pre-constitutional era with laws primarily regulated by an enforcement of traditional moral views of a portion of society.<sup>68</sup> Likewise, it is submitted that the common-law limitation on euthanasia presents out-dated thinking which has no place in a modern and technologically advanced constitutional dispensation. Whilst palliative care may prove to be an option, it is not an option that many terminally ill patients are satisfied with. In some instances patients request an end to their suffering, even if it means ending their lives, they are willing to explore this option which

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<sup>66</sup>*Van der Merwe v Road Accident Fund & Others* 2006 4 SA 230 CC 63

<sup>67</sup>Burchell (ibid see fn 61) 567

<sup>68</sup>*Supra National Coalition for Gays and Lesbians* para 37 at 31G-H/I

is only available by means of euthanasia. Palliative care, does not offer an end to their suffering, it merely provides a temporary relief whilst prolonging the illness. Thus, the common-law position criminalizing the practice of voluntary euthanasia and physician-assisted suicide should be reappraised.<sup>69</sup> These submissions will appear clearer through a discussion of the relevant human rights the approach taken in the *Stransham-Ford* judgment below.

### 2.3.1 Section 9 – The Right to Equality;

For a long period of time South African law has maintained a blanket criminal ban on the practice of any form of euthanasia. However, developments within the field of medicine have led to a change in the legal position and consequently, passive euthanasia became an area of practice ostensibly safe from legal liability.<sup>70</sup> When it comes to euthanasia, both the legal and medical fraternities acknowledge the existence of a slippery slope between passive and active euthanasia.<sup>71</sup> From a philosophical perspective, there is no distinction between physician-assisted suicide by ‘providing the sufferer with a lethal agent or by switching off a life-support device’<sup>72</sup>, or the injecting of a strong dose of morphine with the intent to relieve pain’ with the knowledge that the respiratory system will close down resulting in death.<sup>73</sup> Therefore, it would appear that there is no logical ethical difference that can be presented to substantiate a ‘distinction between the withdrawing of treatment to allow a ‘natural process of death’ and physician-assisted suicide’.<sup>74</sup>

Accordingly, maintaining the declaration that the common-law manifestation of homicide i.e. euthanasia in our present Constitutional dispensation remains a crime is a position that is inconsistent with the Constitutional right to equality as it allows one category of patients’

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<sup>69</sup> Harms JA in *Carmichele v Minister of Safety and Security 2004 (3) SA at p330A-C*:

*“Although the transition to the new dispensation kept the general body of South African law and the machinery of State intact, the advent of the Bill of Rights exposed all existing legal provisions, whether statutory or derived from the common-law, to reappraisal in the light of the new constitutional norms heralded by that transition. The retention of the existing legal and administrative structures facilitated a reasonably smooth transition from the old order to the new. But the transition did have an effect on the country’s criminal justice system. People who had acquired specialised knowledge of the system, and had become skilled and sure-footed in its practice, were confronted with a new environment and lost their confidence...”*

<sup>70</sup> Obiter from *Clarke v Hurst 1992 (4) SA 630 D* allows the practice of passive euthanasia

<sup>71</sup> N J Finkel *et al* “Right to Die, Euthanasia and Community Sentiment” (1993) Vol.17 No.5 *Law and Human Behaviour* 488

<sup>72</sup> On an application of the findings in *Clarke v Hurst* (Supra see fn 70)

<sup>73</sup> *Stransham-Ford v Minister of Correction Services* @p59-60 para 21

<sup>74</sup> *Stransham-Ford* (Supra see fn 73 above)

access to assisted dying and denies another category. Whilst there is much written on this aspect, all of which cannot be accommodated in this research, it is narrowed to a few arguments against euthanasia that is discussed later on in this chapter.<sup>75</sup>

In confining this argument to the legal debate and ‘in determining legal liability for terminating a patient's life, there is no justification for drawing a distinction between an omission to institute artificial life-sustaining procedures and the discontinuance of such procedures once they have been instituted’<sup>76</sup>. On a liberal and somewhat bold interpretation this would mean that there is no distinction between:-

- a. A medical practitioner omitting to keep a patient alive, with such an omission formulating as a result of the request of a fully cognisant patient in a pre-artificial life-sustenance stage communicating a request, either verbally or through the use of a living will, requesting that a medical practitioner omit any attempt to keep him alive and/or;
- b. Actively stopping treatment of not treating a patient that is being sustained through artificial means or procedures once they have been instituted.

On a practical note, it would appear that there is more logic in adhering to the will of a competent patient who requests to be euthanized, or alternatively should he be unable to self-administer a lethal drug due to the severity of the illness, then to adhere to his request for assistance on the administration of a lethal agent.

### 2.3.2 *Section 10 – The Right to Human Dignity;*

We live our entire life demanding that we be treated in a dignified manner, we proclaim that it is a fundamental right and we maintain a strong sense of entitlement to be affiliated with such a right. After all, why shouldn't we? It is a right fought for, a right that many were not afforded under the apartheid regime. Therefore, it is no surprise for a claim of impaired dignity to be brought to court when an individual feels that his or her right to dignity has been infringed. After all, section 10 of the Constitution secures that individual's right to dignity.

What makes one individual who has a clean bill of health more entitled to enforce his constitutional right to dignity than another individual who is terminally ill? The Constitution is

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<sup>75</sup> See above 2.4. and 2.5. for this discussion

<sup>76</sup> *Clarke v Hurst* p630H-I

premised on equality<sup>77</sup>. In snatching away the dignity of a person's death, are we not creating distinctions in death? Are we not creating controversy when we condone removing a person of life support but condemn acts of euthanasia for a person in similar circumstances and is not on life support? If the circumstance of one's death is inhuman, degrading and demeaning are we then to just sit back and allow nature to take its course when assistance to that person can enforce that person's dignity?

It is submitted that for a long period of time euthanizing animals severely injured or diseased has been recognised as humane treatment.<sup>78</sup> Accordingly, it is universally accepted that to permit an injured or diseased animal to suffer is not only cruel, inhumane and merciless, but also a crime.<sup>79</sup> From the onset it is understandable that animals are not bearers of rights and that the comparison to humans cannot be direct, however there is no reason why the same dignity and humane treatment should not be advanced to humans. Are humans, as rights bearers then not entitled to dignity in dying, especially when a patient is mentally able and competent to communicate such a request?

The right to dignity is encompassed under section 10 of the Constitution which reads that 'everyone has inherent dignity and the right to have their dignity respected and protected'<sup>80</sup>. In advancing this right, the Constitutional Court has adopted a purposive approach to the interpretation of the Constitution and the rights that are situated within it.<sup>81</sup> In supporting this approach, the Constitutional Court has stated that human dignity is a right that must not be construed in isolation but rather, it is a right that must be understood in context so that due consideration is afforded to the history and the background of the Constitution.<sup>82</sup> When contextualizing the right to dignity, other rights also need to be considered.<sup>83</sup> 'The right to dignity must also be construed in a way which secures for "individuals the full measure of its protection".'<sup>84</sup> Whilst the purposive approach plays a significant role in interpreting section 10 as it unleashes and secures full protection of the right, it is also important to take cognisance of the fact that there are instances when a narrow approach as opposed to a generous purposive

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<sup>77</sup> The Constitution (see fn 13) ss1-3

<sup>78</sup> Section 2(1), 5(1), 8(1)(d) of the Animal Protection Act 71 of 1962

<sup>79</sup> *Stransham-Ford* at para 27

<sup>80</sup> Section 10 of the Constitution

<sup>81</sup> *Dawood and Another v Minister of Home Affairs and Others* 2000 (1) SA 997 (C) @ p1036B-C

<sup>82</sup> *Dawood v Minister of Home Affairs* (Supra fn 81) 1036C-D

<sup>83</sup> *Dawood v Minister of Home Affairs* Supra; *S v Makwanyane* 1995 (3) SA 391 CCat para 10; *Ferreira v Levin NO and Others* at para 171-172 and 255; *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC)899 at para 16

<sup>84</sup> *National Coalition for Gays and Lesbians* (Supra see note 64)

approach is required and taken.<sup>85</sup> This reasoning is based on the understanding that a generous or purposive approach may sometimes ‘overshoot’ the interpretation of the right and result in behaviour that falls outside the ambit of the Constitution.<sup>86</sup>

Does the refusal to legalise voluntary active euthanasia and physician-assisted suicide in respect of patients who are mentally competent and have the capacity to request or consent to assistance, infringe on the requester’s right to dignity? In my view, this question must be answered in the affirmative as patients who lack the capacity to consent may be passively euthanized.

The right to dignity occupies a central role within our constitutional dispensation; it occupies a significant and fundamental role that is repeatedly emphasized by our Constitutional Court.<sup>87</sup> Thus, its repetition in various Constitutional Court judgments serves to highlight its importance to our constitutional development and in order to be limited under section 36 of the Constitution, there would have to be substantially compelling reasons advanced in advocating for a justified limitation.<sup>88</sup>

### 2.3.3 Section 11 – The Right to Life;

What is the right to life? Is it the right not to die? And if it is, then are we not defining the right to life as the right to live? If the right to life is the right to live then it follows that dying is a part of living.<sup>89</sup> Whilst there is not much that has been said in the Constitution in guiding one to an answer as to what the right to life encompasses, the Constitutional Court has interpreted the right to life as one that involves a quality of life that is worth living.<sup>90</sup> Additionally, it has

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<sup>85</sup>*Soobramoney v Minister of Health* (Supra see fn 83) at para 17

<sup>86</sup>*Dawood and Another* (Supra see fn 81) at p1036G-H

<sup>87</sup>*Dawood and Another* (Supra see fn 81) at p1043B-D

<sup>88</sup>*Dawood and Another* (Supra see fn 81) at p1043D-E

<sup>89</sup>*Stransham-Ford v Minister of Safety and Security* 2015 (4) SA p61 para 23E-F

<sup>90</sup>*Stransham-Ford v Minister of Safety and Security* Supra para 326-327: “The right to life is, in one sense, antecedent to all the other rights in the Constitution. Without life, in the sense of existence, it would not be possible to exercise rights or to be the bearer of them. But the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as [a] 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 rights to human dignity and life are entwined. The right to life is more than existence— it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity.”



been stated that the right to life is entwined with the right to dignity, involving more than a person's existence.<sup>91</sup> It is submitted that in reality, the right to life has been interpreted by society as the right of a person to not have his life ended by another as opposed to the quality of one's life. The reason for this is for the obvious and fundamental reason that no one should be empowered with the decision to determine whether someone lives or dies. Any decision involving the decision of the life or death of another person can be defined as nothing short of arbitrary and unconstitutional especially and more particularly when such a decision does not factor in the opinion of the person whose life is being determined.

At this point, it is worthwhile to note the court's analysis in advancing for passive euthanasia in *Clarke v Hurst*<sup>92</sup> where it has been stated that 'as a matter of policy, taking into account factors such as reasonableness, fairness and justice, the discontinuance of the artificial feeding regime would not in law be the cause of the patient's death if he were to die as a result of such discontinuance.'<sup>93</sup> On application of the court's reasoning and with the use of a hypothetical situation it is manifestly evident that should X, a patient suffering from a terminal illness with only a week to live request that he be provided with the necessary prescription to terminate his life, or alternatively request assistance by a physician either through a request for a discontinuance of medication or administration of a lethal dose, the result of X's death would be not in law be the discontinuance of medication, assistance or prescription but rather as a result of the terminal illness.

The finding that the sacredness of the quality of life should be accentuated, as opposed to the sacredness of life per se is perhaps the most progressive argument and evolving argument advanced by Fabricius J in the right to life debate.<sup>94</sup>

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<sup>91</sup>*S v Makwanyane* (see fn 83) at para 326-327

<sup>92</sup>*Clarke v Hurst* (Supra see fn 21) at p632A-B

<sup>93</sup>*Clarke v Hurst* at p632A-B

<sup>94</sup>*Stransham-Ford* at p61 at para 25I-J

#### 2.3.4. Section 12 – Freedom and Security of Person ;

##### *The Right not to be subjected to Torture, Cruel or Inhumane treatment*

‘Section 12 combines the right to freedom and security of person with the right to bodily and psychological integrity’.<sup>95</sup> The right not to be subjected to torture, cruel or inhumane treatment is secured within the ambit of the Constitution and enveloped under the right to freedom and security of person. It is a liberating provision to be viewed not ‘negatively or selfishly as a mere absence of restraint, but positively and socially as an adjustment to the end of freedom of opportunity’.<sup>96</sup> The purpose of discussing this right particularly, is to focus on the direct result which would stem from a refusal to grant euthanasia or physician-assisted suicide to patients who are suffering from terminal illnesses.

Section 12 encompasses a right that encourages autonomy and creates a sphere of self-determination. The aim of this right is to ensure the protection of individuals from unwarranted intrusions made by the state.<sup>97</sup> Whilst the ambit of this provision affords protection against cruel and inhumane torture, the Constitutional imperative of the right to freedom and security of the person permits individuals to exercise their decisions in a liberal sphere, i.e. entitling one to occupy a sphere of autonomy, and make fundamental decisions in practice of their right to self-determination without being subjected to the control of the state.<sup>98</sup> This is the essence of our Constitution: to establish a society based on fundamental human rights and lay the foundations of a democratic society based on the free will of society, as well as ensuring equal protection.<sup>99</sup> Therefore, legislation and the common-law should give effect to these rights, including the right to freedom and security of person in order to ensure that the objectives of the Constitution are executed.

A recent and significant High Court case has added to the euthanasia debate, its judgment tipping the scale in favour of decriminalizing euthanasia. In the *Stransham-Ford v Minister of Justice and Correctional Services*<sup>100</sup> the court granted an order in favour of physician assisted suicide.

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<sup>95</sup> I Currie & J de Waal, *The Bill of Rights Handbook* 1998 (5ed) 292

<sup>96</sup> *National Coalition for Gays and Lesbians Equality v Minister of Justice* at p61 para 116

<sup>97</sup> Currie and de Waal (ibid see fn 95) 293

<sup>98</sup> In *Ferreira v Levin NO* 1996 (1) SA 984 (CC) at para 54; Ackermann J proposed a “broad and generous” reading of the subsection by defining the right as “the right to individuals not to have ‘obstacles to possible choices and activities’ placed in their way by the State.”

<sup>99</sup> The Constitution, 108 of 1996 @ ss1-3

<sup>100</sup> 2015 (4) SA 50 (GP)

It is submitted that there remains no common-law justification for maintaining the common-law crime of euthanasia. This submission is premised on the basis that with the coming into effect of the Constitution, a variety of rights were created and enclosed within the sanctity of the Bill of Rights. Whilst these rights, in certain circumstances may be justifiably limited within the realm of section 36 of the Constitution, it is difficult to find an argument that successfully favours the common-law position. For one, refusing to consider voluntary euthanasia and physician-assisted suicide as rights that vest solely upon a mentally capable patient goes against the spirit, purport and objects of the Bill of Right in that the principle of democracy and constitutionality is premised on the right to exercise one's right over one's life and to regulate ones affairs in manner that is harmless to others, without being subjected to any arbitrary authority or ruling.

The principle of democracy originates from the preamble to the Constitution which states that government must be 'based on the will of the people'.<sup>101</sup> This principle resonates in a number of provisions within the Constitution.<sup>102</sup> Therefore, if it is the will of the people to be euthanized because the act of keeping them alive would amount to torture from the effects of an illness or disease, then it follows that there is an unjustified impairment to their right to freedom and security of person and the right not to be subjected to cruel and inhuman torture. Although this is an argument that can only be developed with time.

Perhaps the most important and relevant argument in favour of euthanasia and the right to freedom is the qualifying threshold of section 12: 'what kind of protection does section 12 provide when someone is deprived of his or her freedom?' 'The Constitutional Court has guaranteed both substantive and procedural protection'.<sup>103</sup> These two components have been confirmed in *De Lange v Smuts NO*<sup>104</sup> and described in *S v Coetzee* as follows:-

[there are] two different aspects of freedom: first is concerned particularly with the reasons for which the state may deprive someone of freedom [substantive component]; and the second is concerned with the manner whereby a person is deprived of freedom [procedural component]. . .[O]ur Constitution recognises that both aspects are important in a democracy: the state may not deprive its citizens of liberty for reasons that are not acceptable, nor when it deprives its citizens of

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<sup>101</sup> I Currie & J de Waal, *The Bill of Rights Handbook* 1998 (5ed) 15

<sup>102</sup> *Ibid* *The Bill of Rights Handbook* and see the preamble of the Constitution at ss1, 7, 36, 57, 59, 61, 70, 72, 116, 118, 152, 160, 195, 234, 236, and Chapter nine

<sup>103</sup> *Ibid* Currie and de Waal, *The Bill of Rights Handbook* (5ed) 293

<sup>104</sup> *De Lange v Smuts NO* 1998 (3) SA 785 (CC) para 18

freedom for acceptable reasons, may it do so in a manner which is procedurally unfair.<sup>105</sup>

### 2.3.5. *The 'Right' to Autonomy;*

Although autonomy is not prima facie recognised as a right within our Constitution, it has been submitted that autonomy represents an underlying value of the Constitution, the 'value' of which can be defined as the ability to 'independently form opinions and act on them'.<sup>106</sup> In addition to being a constitutional value, it underlies an open and democratic society based on human dignity, equality and freedom.<sup>107</sup>

Whilst autonomy may not be a self-standing right situated within the Constitution such as the those rights encompassed within the Bill of Rights, it is evident through the wording of the right to dignity, equality, and freedom as well as the manner in which judgments are contextualized that every individual has the right to take charge of themselves - i.e. autonomy.

Although, autonomy may not be an express right, it is tacitly incorporated within the Bill of Rights falling within the ambit of the Constitution. It is afforded protection under the umbrella of rights in the Bill of Rights. The right to autonomy is not exclusively protected or limited in its protection solely through the right to dignity, freedom and security of person, life and equality. It is also evident in the right to religious, belief and opinion.<sup>108</sup>

Originally introduced into South African law in *Richter and Another v Estate Harmmann*<sup>109</sup> and later established in *Castell v De Greef*<sup>110</sup> the court held that it is the prerogative of the patient, in exercising his fundamental right to self-determination in deciding whether he wishes to undergo a medical operation and in principle it is irrelevant that the patient's perspective may be unreasonable to a medical practitioner as 'as the patient's right to bodily integrity and autonomous moral agency entitles him or her to refuse medical treatment'.<sup>111</sup>

On an application of the court's reasoning, it would appear to support voluntary active as the court indicates the irrelevance of the patient's perspective and unreasonableness in so far as

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<sup>105</sup>*Ibid* and *S v Coetzee* 1997 (3) SA 527 para 159

<sup>106</sup>*AB and Another v Minister of Social Development* 2016 (2) SA at p47 para 66-67

<sup>107</sup>*AB and Another v Minister of Social Development* Supra(see fn 106)

<sup>108</sup> Section 15 of the Constitution

<sup>109</sup> 1967 (3) SA 226 C

<sup>110</sup> 1994 (4) SA 408 (C)

<sup>111</sup>*Castell v De Greef* Supra (see fn 110) 409

their decisions regarding medical care and treatment are concerned. This means that a patient's request to be euthanized should be considered as the patient is exercising his fundamental right to self-determination.

In summation, the notion of autonomy is a recognised fundamental right, unambiguously accepted.<sup>112</sup> It has been emphasized that patient's need not be terminally ill to refuse 'life-saving medical intervention', such an emphasis outlines an 'explicit rejection of medical paternalism and an endorsement of patient autonomy as a fundamental right'.<sup>113</sup>

#### 2.3.6. *Section 36 – The Limitation Clause;*

Section 36 of the Constitution provides a safeguard within which all other rights stipulated within the Bill of Rights may be measured against. The purpose of this clause is to establish whether a right that is being claimed by a party is justifiably limited in accordance to this clause. That is, whether a person claiming entitlement to a right in the Bill of Rights is entitled to the protection by the right that s/he is claiming. Whilst the Bill of Rights affords protection to everyone, there are instances within which rights may be validly and legally restricted.<sup>114</sup> Courts need to establish whether a right has been infringed and if there is an infringement, determine whether it is justifiable.

#### 2.4. *Understanding the 'Threshold Test': Is the Prohibition on Voluntary Active Euthanasia a justified Limitation on the Right to Life, Dignity, Torture, Cruel and Inhuman Treatment?*

Section 36 entrenches certain criteria, which tests the constitutional justification of a right. A right is justifiably limited when it is said to be 'reasonable and justifiable in an open and democratic society based on equality, freedom and human dignity'<sup>115</sup> In this regard section 36(1)(b) and 36(1)(d) provides a guiding threshold test in measuring whether there is

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<sup>112</sup> South African Law Commission Report on Euthanasia and the Artificial Preservation of Life, "Project 86" (1998) 23 and 43

<sup>113</sup> Project 86 *ibid* (see fn 113) 43

<sup>114</sup> J Burchell, *Principles of Criminal Law*, 4 ed (2013) *Ibid* (See Fn 61) 320

<sup>115</sup> J Sarkin-Hughes *et al Resolving the Tension between Crime and Human Rights: An Evaluation of European and South African Issues* (2001) 318

reasonable and justifiable balance of competing rights.<sup>116</sup> It is important to note that the purpose of these sections facilitate and not dictate a strict standard of application. Their application operates to (1) determine whether there is a legitimate purpose in restricting a practice and (2) determine whether there a rational connection between the limiting measure and its stated purpose.<sup>117</sup>

In *Seales v Attorney General*<sup>118</sup> it was argued that an individual's vulnerability contributes against the argument for euthanasia, however very little to no evidence has been led to prove the authenticity of these allegations in euthanasia-practicing jurisdictions.<sup>119</sup>

The Minister of Health has submitted much motivation in so far as the argument against euthanasia is concerned. Some of these arguments have been supported by various authors and are addressed in greater detail below. They include the slippery slope argument, death as a natural process, cultural differences and beliefs, private moral views and the importance of societal perspectives in viewing doctors as being health workers and not people who kill.<sup>120</sup> Whilst these arguments provide valid grounds for concern, they lack constitutional substance in so far as the limitation on euthanasia is concerned as they do not indicate a constitutional argument for a limitation of constitutional rights. Additionally, legislation can be implemented to safeguard and address these concerns.

## 2.5. *The 'Rational Connection' Requirement*<sup>121</sup>

The rational connection requirement requires that there is a connection between the limiting measure and the purpose that is being sought. Accordingly, the limit needs to be proportional to the purpose that is sought. It has been held that a blanket ban on a practice is not 'rationally connected to the constitutionally legitimate objective of maintaining a particular discipline'.<sup>122</sup> Similarly, it would follow that a blanket ban on the euthanasia to protect vulnerable groups is irrational and disproportional to the measure and purpose sought.

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<sup>116</sup> P de Vos & W Freedman *South African Constitutional Law in Context* 1 ed (2014) 361

<sup>117</sup> *Ibid* *South African Constitutional Law in Context* (see fn 116 above)

<sup>118</sup> [2015] NZHC 1239

<sup>119</sup> *Seales v Attorney General* supra (fn 118) 62 and 66-67

<sup>120</sup> Judge Davis "Judge for Yourself: Discussing the Right to Die" at [https:// www.enca.com/media/video/judge-yourself-discussing-right-die-part-2](https://www.enca.com/media/video/judge-yourself-discussing-right-die-part-2) [Accessed 27 April 2016]

<sup>121</sup> P de Vos & W Freedman *South African Constitutional Law in Context* 1 ed (2014) 361 *ibid* (fn 116) 371

<sup>122</sup> *South African National Defence Union v Minister of Defence* 1999 (4) SA 469 (CC) at 35

## 2.6. *Less Restrictive Means to achieve the purpose*

Without going into much detail, the limitation on euthanasia can be addressed by enacting legislation. Any limitation will not pass constitutional muster when there are alternative means that can be employed to achieve the same end that will either not restrict rights at all, or will not restrict them to the same extent.<sup>123</sup> Therefore, if the concern in legalising euthanasia is that there will be abuse of vulnerable groups and the elderly will be taken advantage of then a less restrictive but equally effective and alternative method should be implemented to achieve the objective of the limitation without having a blanket provision in place banning euthanasia completely.

## 2.7. *The Development of the Common-law – Section 39*

In *S v Makwanyane*<sup>124</sup> the Constitutional Court in referring to section 35 of the interim Constitution, a predecessor of section 39 of the Constitution, stated that binding and non-binding international law may be used as tools of interpretation.<sup>125</sup> It is an imposing section compelling courts to develop the common law.<sup>126</sup> Thus, this section obliges courts to refer to not only national but international developments in understanding and interpreting laws and regulation. This right is addressed in greater detail and in context of the *Stransham-Ford* judgment below.

## 2.8. *Moving towards Reformation – The Case Law in Point:*

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

### 2.8.1. *Facts*

The applicant, Robin Stransham-Ford was an unmarried and practising advocate of the High Court of South Africa who brought an urgent application requesting the High Court to grant his application to be euthanized on the basis that he was suffering from a form of cancer, an illness in its stage four terminal phase, which caused him to endure severe pain and suffering.

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<sup>123</sup> I Currie & J de Waal, *The Bill of Rights Handbook* 1998 (5ed) *Ibid* (see fn 101) 184-5

<sup>124</sup> *S v Makwanyane* 1995 (3) SA 391 CC (hereafter “*S v Makwanyane*”)

<sup>125</sup> *Supra S v Makwanyane* (see fn 124) 392-3

<sup>126</sup> *Carmichele v Minister of Safety and Security and Another* 2001 (4) SA 938 (CC) 319

Essentially, the relief sought by the applicant was threefold in that: firstly, he wanted to be assisted in dying by a willing medical practitioner registered under the Health Professions Act<sup>127</sup> alternatively, to be enabled to self-administer a lethal agent supplied by such a medical practitioner.<sup>128</sup> Secondly, he did not want the medical practitioner to be subjected any civil, criminal or disciplinary liability or any other liability that may arise out of assisting or supplying him with the lethal agent.<sup>129</sup> Thirdly, he requested that the common-law position criminalizing euthanasia be developed to be made lawful and constitutional in the circumstances of his matter.<sup>130</sup> At the time of bringing the application Stransham-Ford was a mentally competent individual with no cognitive impairments and suffering from stage four terminal cancer that left him with a mere few weeks to live. Whilst the applicant died shortly before the outcome of the judgment was handed down in his favour, the judgment serves as the opening into a portal of progressive thinking and is a small victory for pro-euthanasia academics and organizations in South Africa that advocate for the recognition of euthanasia as a legal right in a transitioned society.

### 2.8.2. *Application of the law – Court Analysis*

The court analysed the applicant's request to be euthanized by means of a juxtaposition between the applicant's fundamental rights and important questions that were raised by the applicant which outlined the debate surrounding the end-of-life decisions and the applicant's wish to be euthanized. These questions were:-

- i. Is it conceivable that the health of a person may deteriorate to a level where he (the sufferer) would be justified in wishing to take his own life?
- ii. Ought the sufferer be permitted to take his own life?
- iii. Should another person (the Samaritan) be allowed to assist the sufferer to end his life?
- iv. May this person be a medical practitioner?
- v. Which safeguards need to be in place?<sup>131</sup>

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<sup>127</sup> Health Professions Act 56 of 1974

<sup>128</sup> *Stransham-Ford* (see fn 3) para 3A-E

<sup>129</sup> *Supra Stransham-Ford* para 3A-E

<sup>130</sup> *Supra Stransham-Ford* para 3A-E

<sup>131</sup> *Supra Stransham-Ford* para 3E-G



### A. Applicant's Health

These questions directed the court in focusing their judgment on the most pertinent and applicable areas of law pertaining to the applicant's request. The court began its judgment by considering the applicant's state of health as being one which caused the applicant to experience severe pain and suffering. Not long after setting out the severity of the applicant's condition did the court consider a report by Dr RAG de Muelenaere, a medical practitioner who had submitted a report based solely on the court application papers, without having conducted a private examination of the applicant himself or affirming the veracity of the contents of the report by oath.<sup>132</sup> The comments made by Dr RAG de Muelenaere appears verbatim from the judgment itself:-

“There are palliative 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 a 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 per cent of patients will die in pain, regardless of kidney function (doses can be titrated to patient needs and side effects). 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 and all I consider this request for assisted suicide to be against the current medical practice.”<sup>133</sup>

The applicant responded to Dr de Muelenaere by contending that palliative care had proven unsuccessful and unsatisfactory as it failed to address his need and right to death with dignity. In addition, the applicant contended that palliative care forced him to experience consistent and excruciating pain whilst being conscious of death. Arguments opposing palliative care are not uncommon and it has been suggested that a loss of consciousness amounts to an impairment of

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<sup>132</sup>Supra *Stransham-Ford* para 4

<sup>133</sup>Supra *Stransham-Ford* at p54 para 4J-D

one's right to dignity and patient autonomy.<sup>134</sup> This is because palliative care does not treat a patient's condition *per se*; it merely offers a diversion from the pain the patient experiences by rendering him/her unconscious for a small period of time. Palliative care is often resorted to as a means of 'tranquilize the pain away' for a short period by allowing the patient to slip into unconsciousness. Therefore, the pain and suffering that is endured by the patient is not remedied but temporarily halted before being resumed once again when the patient resumes consciousness.

### *B. Applicant's Quality of Life and Treatment*

Subsequent to the discussion of the applicant's poor health conditions, Fabricius J directed his attention to the applicant's deteriorating quality of life and the recurring symptoms of the applicant's illness. Specific note was taken of the fact that the applicant endured regular nausea, vomiting, constant frailty, bouts of weaknesses, waves of stomach cramps and diarrhoea essentially, the applicant was reliant on medication to sustain stability and ease the symptoms of discomfort borne from the terminal illness.<sup>135</sup> The conditions sustained by the applicant were supported by the applicant's medical practitioners who had examined him and confirmed the prognosis and diagnosis of the applicant's condition.<sup>136</sup>

Whilst the applicant continued to undergo palliative care and various treatments performed with the hope of easing his pain, there remained no successful prospects of survival or maintaining any semblance of a dignified or healthy life. The applicant had exhausted all the remedies that were available; Chinese medication, Vedic medication, cannabis and surgery.<sup>137</sup>

### *C. Required Development of the Law and Basis of the Applicant's Relief*

The applicant sought to inform the court through his submissions that he was no longer afraid of imminent death, but rather it was a prospect that he welcomed as his condition worsened and the illness progressed, he succumbed further to the increased frailty of his condition.<sup>138</sup>

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<sup>134</sup> D Benatar 'A Legal Right to Die: Responding to Slippery Slopes and Abuse arguments' (2011) 18 *Current Oncology* 206. Cited in K L Francis, *Implementing a Permissive Regime for assisted dying in South Africa-A Rights Based Analysis*

<sup>135</sup> *Stransham-Ford* at p54 para 4

<sup>136</sup> *Stransham-Ford* at p55 para 5-6

<sup>137</sup> *Stransham-Ford* at p55 para 7

<sup>138</sup> *Stransham-Ford* at p56 para 8-13

Whilst the fear of dying had long since dissipated the applicant's fear of suffering remained with him and led him to place in motion the application which was before the court, premising the application on the development of the common-law and relying on the court's inherent jurisdiction and duty to grant his application.<sup>139</sup>

### 2.8.3. *Decision of the Court - A Decision to Develop the common-law*

Superior courts are tasked with the responsibility of ensuring that common-law principles comply with the spirit, purport and objects of the Bill of Rights.<sup>140</sup> Therefore, common-law principles that deviate from the objectives of the Bill of Rights must be removed or revised.<sup>141</sup> This is what Fabricius J sought to do when he examined the prohibition on voluntary active euthanasia and assisted suicide alongside section 39 of the Constitution.<sup>142</sup>

As already mentioned, the applicant based his argument on section 39 of the Constitution which he also sought to correlate with section 8(3) of the Constitution.<sup>143</sup> Section 8(3) reads that:-

When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court;

(a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common-law to the extent that legislation does not give effect to that right; and

(b) may develop rules of the common-law to limit the right, provided the limitation is in accordance with section 36(1).

This provision was considered by Fabricius J in conjunction with *Bel Porto School Governing Body v Premier, Western Cape*<sup>144</sup> where it was stated that there were several provisions within the Constitution which had to be borne in mind when considering remedies, one of them being section 39.<sup>145</sup> If courts find that there is a Constitutional defect due to a common-law incapacity, the Court as a matter of constitutional imperative must declare it unconstitutional and render an appropriate remedy that is open-ended and flexible.<sup>146</sup> Section 8(3) requires that

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<sup>139</sup>*Stransham-Ford* para at p56 para 13-14

<sup>140</sup>*Carmichele v Minister of Safety and Security*2004 (3) SA 319J-320A

<sup>141</sup>Supra (see fn 140 above)

<sup>142</sup>*Stransham-Ford* at p56 para 13-14

<sup>143</sup>*Stransham-Ford* p56 para 14

<sup>144</sup> 2002 (3) SA 265 CC at para 180-181 (hereafter "*Bel Porto v Premier*")

<sup>145</sup>Supra (see fn 144) *Bel Porto v Premier*

<sup>146</sup>Supra (see fn144) *Bel Porto v Premier*

the court develop a suitable remedy within the context of the problem. Formulations of these developments and remedies are not amassed from personal inclinations or discretions.<sup>147</sup>

The applicant's argument contained references to multiple provisions arising from the Bill of Rights which he sought to evoke in advancing his application.<sup>148</sup> These provisions entailed the right to dignity, life and health, as well as freedom and security.<sup>149</sup> The majority of these rights have been analysed above.<sup>150</sup> Central to the argument invoked by the applicant was the right to his dignity which the court found that a reasonable reader or physician would conclude to have been impaired.<sup>151</sup> It becomes clear that dignity is a right that is inherent, encompassing distinct values and wide meanings.<sup>152</sup> 'It is the source of a person's innate rights to freedom and to physical integrity, from which a number of other rights — such as the right to bodily integrity — flow'.<sup>153</sup>

The court concurred with the applicant's submission that since current legal position had been premised within a pre-constitutional dispensation as such, the law requires development in order to give effect to the applicant's constitutional rights.<sup>154</sup> Following a discussion of the South African Law Commission<sup>155</sup> report and its proposal on implementing a legislative framework for euthanasia, Fabricius J quotes from Carsten & Pearmain:-

The present writers finally submit that the underlying values, spirit and purport of the applicable sections in the Constitution seem to be supportive of the introduction of voluntary active euthanasia in South Africa. Such a dispensation, along the lines of the recommendation of the South African Law Commission, should be strictly regulated and monitored to ensure the autonomy of competent terminally ill patients while guarding against any possible abuse of the system.<sup>156</sup>

The court took cognisance of the arguments advanced against euthanasia and weighed these arguments against the constitutional imperative to remedy constitutional defects and common-law principles. Thus, it is submitted that Fabricius J correctly aligned his reasoning within the regimes of 'patient autonomy and individual choice', finding that the Constitution supports the

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<sup>147</sup>Supra (see fn144) *Bel Porto v Premier*

<sup>148</sup>*Stransham-Ford* para 14-16

<sup>149</sup>*Stransham-Ford* Supra(see fn 143)

<sup>150</sup> See 2.3 above for the Constitutional Debate surrounding Euthanasia

<sup>151</sup>*Stransham-Ford* para 17I-J

<sup>152</sup>*Stransham-Ford* para 18

<sup>153</sup>*Stransham-Ford* para 20

<sup>154</sup>Supra *Stransham-Ford* para 22

<sup>155</sup> Hereafter 'SALRC'

<sup>156</sup>*Foundational Principles of Medical Law* (Lexis Nexus 2007) at 200 and *Stransham-Ford* para 23C-D

applicant's right to be euthanized.<sup>157</sup> To substantiate his finding, Fabricius J referred to the US case of *Cruzan v Director, Missouri Department of Health et al*<sup>158</sup> which sought to establish that the right to life (as situated within the ambit of the Constitution) also embraced dying as a part of life.<sup>159</sup> In addition, to fore-going life-sustaining ventilators, the Supreme Court held that 'the timing of death - once solely a matter of fate - is now increasingly becoming a matter of human choice'.<sup>160</sup>

In conclusion to his finding, Fabricius J applied the reasoning of the Supreme Court of Canada in *Charter v Canada*<sup>161</sup> and the *Rodriquez* case, which held that leaving terminally ill individuals in constant agony to either terminate their own life, often violently, or alternatively condemning them to a life of suffering until death, was a cruel sanction.<sup>162</sup> Thus, even the application of section 36 was held to be overly broad in its application as the South African Framework for the Implementation of Euthanasia made allowance for safeguards and the implementation of various options available before a decision to euthanize is taken.<sup>163</sup> Whilst the report will be discussed in greater detail below, it is submitted that in principle the Department of Health had not objected to the implementation of the proposed legislative framework but rather agreed to legalising euthanasia.<sup>164</sup>

In light of the arguments in *Stransham-Ford* and the reasoning adopted by the court, Fabricius J concluded that the common-law manifestation of homicide i.e. euthanasia insofar as its application related to the applicant, was stringent and unlawful, having regard to the unjustifiable impairment it caused to the applicant's right to dignity, life, health, privacy, freedom and patient autonomy. Accordingly, the court acceded to the applicant's request to be either assisted by a physician or alternatively, supplied the lethal agent by a medical practitioner to self-administer it i.e. voluntary active euthanasia. This means that in either one of these instances, the medical practitioner would not be held accountable for murder.

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<sup>157</sup>*Stransham-Ford* para 23D-E

<sup>158</sup> 297 US 261 (1990) 343

<sup>159</sup>*Stransham-Ford* para 24

<sup>160</sup>*Cruzen v Director, Missouri Department of Health et al* Supra(see fn 158) 343

<sup>161</sup> [2015] SCC 5

<sup>162</sup>Supra *Carter v Canada* (see fn 161 above) 5 and *Rodriquez* (see fn 233 below) p519 and Section 12 of the Canadian Charter on Human Rights

<sup>163</sup>*Stransham-Ford* para 29-32

<sup>164</sup>*Stransham-Ford* para 34B-C

## 2.9. *The Debate – Arguments and Concerns Advanced by many who advocate against Physician-assisted Suicide and Voluntary Active Euthanasia:*

### 2.9.1. *A dangerous ‘Slippery Slope’ leading to abuse*

It is not disputed that many significant academics have lent their time and dedicated articles, journals and books to join in the debate arguing against the legalization of euthanasia, however due to the ‘limited scope of this dissertation’, only a few arguments can be mentioned.<sup>165</sup>

Slippery Slopes have been a longstanding philosophical and rhetorical technique consistently used to address concerns, arguments and questions regarding the permissibility of acts such as abortion and euthanasia<sup>166</sup>. Whilst many may not accept slippery slope arguments, it is nonetheless still used as a mechanism. Arguments against the legalization of euthanasia often present themselves in the negative with questions such as ‘what if’s’ being introduced into the debate; ‘what if there is an abuse?’, ‘what if the patient has not been properly informed?’, ‘what if some physicians go on a ‘euthanasia-spree?’’. Frey<sup>167</sup> titles the perceived perilous concern against euthanasia as The Fear of the Slippery Slope.

The Slippery Slope operates in the following way:-

Take step A, and we shall be led to take steps B and C. Step A takes us out onto the slope; steps B and C take us down it. In this form, a slippery slope argument is consequentialist in character: The consequences of taking step A are that we shall take step B and C. This matter is one of probability, however so that we need to believe it likely or probable that we shall take steps B and C. For if this probability is low and remote, then fear of steps B and C may recede and step A may be taken; if, however, this probability is high, then the fear of steps B and C may well prevent us from granting the permissibility of steps A.<sup>168</sup>

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<sup>165</sup>LB Grove (2008) *Framework for the Implementation of Euthanasia in South Africa* (LLM Thesis) Retrieved from the University of Pretoria UPSpace Institutional Repository Grove 84 (see fn 27)(hereafter “LB Grove”)

<sup>166</sup>R G Frey, ‘The Fear of the Slippery Slope’ in R G Frey (1ed) *Euthanasia and Physician-assisted Suicide* 1998 page 43 (hereafter “The Fear of the Slippery Slope”)

<sup>167</sup>Ibid *The Fear of the Slippery Slope* 46

<sup>168</sup>Ibid *The Fear of the Slippery Slope* 44

Frey then elects to use a relatable and tangible analogy to provide an example of the consequential nature and pessimism of the use of the slippery slope feature, and in doing so highlights its inability to work:

If someone says, ‘Take a glass of wine, and you are well on your way to becoming an alcoholic,’ we need some reason for thinking such a thing. What is true is that if we never take a glass of wine, we cannot become an alcoholic. But not to take a glass of wine is to pass up one of the glories of France and one of the great pleasures of life. And for what? We need an account of the mechanism that insures that, once we venture out onto the slope of drinking alcohol, we shall slide down it. No one believed that having a glass of orange juice for breakfast ensures that one will have orange juice for breakfast the rest of one’s life.<sup>169</sup>

Similarly, and in justification for the legalization of voluntary active euthanasia and physician-assisted suicide, there is no merit to one arguing that the legalization of these practices will undoubtedly lead to the abuse of the practice. What remains, is merely a possibility of the occurrence of abuse, albeit the remoteness of that possibility arising in instances when the patient is competent, informed and would have repeated his/her request over a lengthy period of time. Therefore, it is sufficient to say that the risks of abuse and any concerns of the danger of the practice of voluntary active euthanasia and physician-assisted suicide will and can easily be cabined by a regulatory framework, structured in a manner that is dedicated to curb against abuse of the practices.

The likelihood of abuse is perhaps one of the strongest and current arguments presented. However, this argument can be easily addressed by implementing legislation. Again, in instances where the patient’s request has been expressed on a continuous basis and the voluntariness of such a request is consistent over a lengthy period of time, there is very little that can be presented in argument against the legalization or practice due to the apprehension of abuse. Any apprehension of abuse will be secured against by the implementation of legislation that will provide safeguards to monitor the system and requests made by patients who are competent and well informed. It is after all, not beyond human ingenuity to formulate and thereafter dedicate a set of well thought out guidelines to regulate voluntary active euthanasia and physician-assisted suicide.

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<sup>169</sup>Ibid *The fear of the Slippery Slope* 46

Our Constitutional Court is not unfamiliar with evolving perspectives and has ruled on a number of contemporary post-constitutional issues which have earned the position as landmark cases because of their ability to change pre-constitutional perspectives which still reigned in a post constitutional dispensation. Abortion<sup>170</sup> and the legalization of same-sex relationships<sup>171</sup> are exemplary instances of society's evolution into a constitutional state. Laws have increasingly begun to favour freedom of choice, 'resulting in court challenging proponents of strong government intervention to protect life'.<sup>172</sup>

Abortion was initially regulated under the Sterilization Act<sup>173</sup> which was later repealed by the Choice on Termination of Pregnancy Act<sup>174</sup>. Although abortion is now legal, it was initially a controversial dispute with many individuals maintaining a strong moral compass and belief that abortion qualifies as an act worthy of criminal sanction.<sup>175</sup> Regardless of the controversy, the Choice on Termination of Pregnancy Act was promulgated and its advent led to the introduction of a new era of abortion, leading to the termination of the elaborate bureaucratic and administrative barriers that impeded a woman's right to obtain a lawful abortion.<sup>176</sup>

Similarly, the Constitutional Court has implemented the values of the Constitution in *National Coalition for Gay and Lesbian Equality v Minister of Justice*.<sup>177</sup> The common-law crime of sodomy was declared unconstitutional as it infringed the fundamental rights to dignity, privacy and freedom.

The line of reasoning sought to be advanced can perhaps be better explained with the use of an analogy; there are instances within which the murder of an individual may be excused, these excuses present itself in the form of private defence or punitive private defence in criminal law. It is not uncommon for society to have their doubts when news of a murder breaks through society, making headlines in the media. There are various instances when an accused raises a private defence or putative private defence as an excuse for the crime of murder. Whether s/he is guilty remains to be proven along with the truthfulness of the

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<sup>170</sup> Choice on Termination of Pregnancy Act 92 of 1996; *Christian Lawyers Association of South Africa v Minister of Health* (1998) 4 SA 1113 (T)

<sup>171</sup> Civil Unions Act 17 of 2006; *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC); *Fourie v Minister of Home Affairs* 2005 (3) BCLR 241 (SCA)

<sup>172</sup> I Currie and J De Waal, *The Bill of Rights Handbook* 1998 (see fn 44) 288

<sup>173</sup> Act 2 of 1975

<sup>174</sup> Act 92 of 1996

<sup>175</sup> J Burchell, *Principles of Criminal Law* (2013) 6ed 557

<sup>176</sup> J Burchell, *Principles of Criminal Law* (2013) 6ed 558

<sup>177</sup> 1999 (1) SA 6 (CC)



accused's defence. In these instances, society demands a justification for the murder and the courts are obligated to make a determination in respect of the defence that is being raised.

Similarly, a request to be euthanized will be surpassed by a guided process, set out by legislation. This guideline will ensure against abuse as it will involve a step-by-step process highlighting the procedure that a physician will execute in dutifully carrying out a patient's request. The justification that society demands will be evident from the process that is followed. The process in respect of physician-assisted suicide is referred to under point four below, whilst voluntary active euthanasia is referred to under chapter three. The proposed guidelines for voluntary active euthanasia and physician-assisted suicide are provided for in this chapter and the next, i.e. chapter three. The reason for this is none other than the fact that whilst the law reform report includes a provision for physician-assisted suicide, it remains silent on voluntary active euthanasia and does not provide any legislative text for it. It is therefore more appropriate to discuss the proposed guidelines and practice for voluntary active euthanasia in chapter three as chapter three will be looking at international legal developments in other jurisdictions.

Addressing abuse of any newly introduced aspect of law is not uncommon. The Legislature is tasked with the duty to ensure that the provisions of a particular bill or law makes provision for penalties and sanctions that are to be encountered in the event of abuse. Likewise, health administrators that are in direct contact with patients are aware that they need to execute their duties in accordance with their doctor-patient mandate and accordingly warn patients of any danger that may arise from a medical procedure.<sup>178</sup> This requirement is embellished within the National Health Act<sup>179</sup>, which makes it obligatory on health practitioners to administer doses of medication and/or execute operations only upon receipt of a patient's informed consent.

### 2.9.2. *From 'Assisting' to 'Executing', The right to Self-determination or a gradual decline into a State of Anarchy?*

The twin driving forces of patient autonomy and relief of pain force us down the slope of killing from physician-assisted suicide through voluntary active euthanasia to non-voluntary/involuntary active euthanasia. Put summarily, the claim is that if we permit doctors to assist patients who want to die, soon they will be "assisting"

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<sup>178</sup>*Obiter* from *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C)

<sup>179</sup>*National Health Act* 61 of 2003

patients (or, in more dramatic terms, executing) those who do not want to die, and this truly is to approach the Nazi camps. We can all agree that to assist those who want to die is one thing, to kill those who do not want to die is quite another; and if legalizing a policy of physician-assisted truly meant that, say the elderly who did not want to die were killed off anyway, then we ought not to legalize physician-assisted suicide.<sup>180</sup>

The argument that is being submitted here is that if we are to permit medical practitioners to assist patients to be euthanized or provide them with the resources to enable euthanasia, the danger of non-consensual termination of the lives of the sick and the old is inevitable. It is doubtful whether there is any merit in this contention; that a requester's request to be euthanized or a patient's request for assistance in being euthanized will ultimately lead to mere executions, irrespective of a patient's right to self-determination.

The very existence of this argument is oblivious in totality to the implementation of safeguards that the law reform report addresses as well as safeguards that international jurisdictions implement in order to ensure against the execution being practised under the guise of assistance. If we demand that there be criteria for assisted dying and active euthanasia in order to regulate these practices and that regulation demands that a patient must be competent and well informed of their decision with the request having been made repeatedly over a period of time, how would we get to killing of elderly people or people who do not want to be euthanized? If the criteria stipulate that as a pre-requisite, the person must be competent to give consent and mentally able to request euthanasia or physician-assisted suicide then the likelihood of execution is unlikely.

Another argument advanced against euthanasia is the view maintained by some academics that 'from a constitutional perspective, the Law Commission's proposal does not seem to 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'<sup>181</sup>. Nevertheless, the argument against euthanasia premised on the 'no proper balance' cannot be said to extinguish the euthanasia debate or be exhausted by such a statement. This is because euthanasia is an on-going debate that needs addressing. If the argument is that the right to life outweighs the right to integrity and dignity or vice versa then support would need to be advanced as to how one right has more preference than another. Such arguments

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<sup>180</sup>Ibid *The Fear of the Slippery Slope* 59

<sup>181</sup>I Currie and J de Waal *The Bill of Rights Handbook* (5ed) 289

will indicate the logic and reason as to why euthanasia should or should not be considered. In fact, some academics are not disillusioned by this statement and maintain that the Draft Bill provides a good foundation for implementing legislation.<sup>182</sup>

## 2.10 A Brief Analysis of the Proposed Legislative Framework in South Africa:

### 2.10.1. Introduction;

In November 1998 the South African Law Commission<sup>183</sup> compiled a report entitled *Euthanasia and the Artificial Preservation of Life*, which became known as ‘Project 86’; a report that was subsequently submitted to the then Minister of Health for determination.<sup>184</sup> Unfortunately, the project which stipulated various options for euthanasia was shelved and was afforded little to no attention, at least until the recent *Stransham-Ford* judgment, where it has once again gained momentum. The reason advanced by the legislature and Ministry for the Department of Health for the 18-year lapse was that there had been other more pressing matters such as the Aids epidemic, which required their immediate attention.<sup>185</sup>

This segment of the research will focus on the framework that has been proposed by the SALC (now referred to as the SALRC) and consider the pertinent suggestions and criteria’s formulated in the draft Bill for *The End of Life Decisions Act*, specifically; definitions, regulatory provisions and procedures, decisions-making processes, and safeguards. Although the legislative framework does not make provision for voluntary active euthanasia, it does to some extent address the issue of voluntary active euthanasia as it did form part of the research investigation albeit unintentionally.<sup>186</sup>

It is an established observation [in common-law] that the merciful killing of a suffering patient is unlawful.<sup>187</sup> The SALC report is important as it aims to remove the element of

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<sup>182</sup> LB Grove (2008) *Framework for the Implementation of Euthanasia in South Africa* (LLM Thesis) Retrieved from the University of Pretoria UPSpace Institutional Repository (see fn 27 above) (hereafter “LB Grove”) p105 and 146

<sup>183</sup> Hereafter “SALRC”

<sup>184</sup> *Stransham-Ford* para 1C-D

<sup>185</sup> *Stransham-Ford* para 1C-E

<sup>186</sup> Voluntary Active Euthanasia was included within the enquiry into Euthanasia as a result of written submissions made by the public

<sup>187</sup> *Hartmann* 1975 3 SA 532 (C); *Nkwanyane* 2003 1 SACR 67 (W) 72d-f

unlawfulness through effective regulations. The objective of the proposed regulations aim to enable one to test the reliability and efficiency of the operation of life-terminating regulations and the subsequent decisions made by terminally ill patients requesting end-of-life assistance from physicians.

### 2.10.2. Background:

As already mentioned, the Draft Bill on *The End of Life Decisions Act* was initially submitted to Parliament in the year 1998. It was an initiative that was initially conceived through a submission made to the SALC by ‘SAVES’<sup>188</sup> in 1991 requesting consideration for the implementation of legislature to regulate Living Wills. Having approved the research, SALC thereafter conducted an investigation limited to passive euthanasia and cessation of treatment. However, what followed from the process of the investigation and the subsequent responses generated included a response to voluntary active euthanasia. This led to the commission expanding the scope of their investigation to address the queries in so far as they related to voluntary euthanasia. These queries formed part of the ‘First Draft Bill’.

Since the submission of the first Draft Bill was brought before Parliament in the year 2000 there has been no development to advance euthanasia in South Africa. The Bill was created in order to ‘stabilize’ uncertainty on the topic of euthanasia, following advances made within the medical profession, namely life sustaining mechanisms being utilized. It was submitted that the legislation would ‘remove legal uncertainty for doctors, patients and family’.<sup>189</sup> For some patients the advances made in medical technology signify a welcome sense of a prolonged meaningful life, whilst others see it as a protracted poor quality of life.<sup>190</sup> These advances admit worldwide recognition of patient autonomy and the need to consider a mentally competent patient’s right to refuse medical treatment.<sup>191</sup> In an attempt to illuminate the mounting uncertainty surrounding the legality of euthanasia within society, the SALC submitted recommendations to regulate euthanasia.

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<sup>188</sup> South African Voluntary Euthanasia Society, now known as SAVES The Living Will Society

<sup>189</sup> *Euthanasia and the Artificial Preservation of Life*, (Project 86) (see fn 11) 55 (hereafter referred to as “Project 86”)

<sup>190</sup> Project 86 at page 39

<sup>191</sup> *Ibid* Project 86 (see fn 189) at page 39

### 2.10.3.1. Definitions;

In an attempt to discuss the most salient factors proposed in the Draft Bill, it is expected that the Draft Bill will continuously receive much criticism from academics primarily because of the inadequate definition section which does little to inform the public of the definition of euthanasia and its distinctions.

Presently, the definitions appearing within the Draft Bill are limited to ‘competent witness’, ‘court’, ‘life-sustaining medical treatment’, ‘medical practitioner’, ‘palliative care’, and ‘terminal illness’. It is submitted that euthanasia could very well be considered within the ambit of the ‘palliative care’<sup>192</sup>, although it is presumable that the SALC did not intend to define euthanasia as a term that would be secured within the definition of ‘palliative care’.

Most pertinent to the debate is the criteria that must be set to determine what the qualifying factor or benchmark should be to enable one to access the process of euthanasia. It is without a doubt that the definition of ‘terminal illness’ will form part of the deciding factor as to whether a patient may request to be euthanized. Therefore, it is imperative that the definition of ‘terminal illness’ correctly defines the patient’s medical condition and simultaneously give effect to his right to patient autonomy.

‘Terminal illness’ is defined in the Draft Bill as ‘an illness, injury or other physical or mental condition which will inevitably result in the death of the patient concerned within a relatively short time and which is causing the patient extreme suffering; or is causing the patient to be in a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient’<sup>193</sup>. Juxtaposing the South African terminology against the Canadian one utilized in *Charter v Canada* whereby the court made reference to the applicant’s condition as a ‘grievous and irremediably medical condition’,<sup>194</sup> it is proposed that South Africa incorporate some aspects of this definition which infuses the right to patient autonomy more effectively within its ambit. Additionally, ‘grievous and irremediably medical condition’ is not limited in the scope of its application as it also infuses

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<sup>192</sup> LB Grove 107

<sup>193</sup> S1 of the Draft Bill on the End of Life Decisions Act

<sup>194</sup> 2012 BCSC 886 24: “A person is ‘grievously and irremediably ill’ when he 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.”

‘disease or disability arising from traumatic injury’<sup>195</sup> which is also situated within the ambit of an ‘illness’.

#### 2.10.4. *Regulatory Provisions and Available Options;*

There are three options available within the Final Draft Bill. Whilst none of these options make explicit reference to voluntary euthanasia, both voluntary active euthanasia and physician-assisted suicide are discussed in the Bill. The options are expressed in the Bill as follows:-

(i) Option 1 – Confirmation of the Present Legal Position;

Option 1 affirms the rudimentary position taken in *S v Hartmann*<sup>196</sup>. If a patient is terminally ill, a medical practitioner that hastens the death of the patient will be held criminally liable even if euthanasia is at the request of the patient. Essentially this option acknowledges that there may be instances within which a pro-euthanasia approach would have to be taken, however the view that is maintained within this option is that arguments advancing the practice of euthanasia is insufficient to weaken society’s resolve against the practice.

(ii) Option 2 – Decision making by the medical practitioner;

Option 2 represents the position taken in *Stransham-Ford v Minister of Correctional Services*. Ideally, this position enables a mentally competent adult suffering from a terminal or intractable and unbearable illness to request physician-assisted suicide. The patient’s request is based on an understanding of his illness and the decision to be assisted is premised on his free and considered decision.

(iii) Option 3 – Decision making by a panel or committee.

Option 3 gives empowers an independent committee with the decision-making capacity. A request to be euthanatized must be considered by the committee based on a set criteria. Such a committee consist of five categories of people, namely; two medical practitioners (one of whom must be the patient’s treating medical practitioner and the other an independent practitioner), an attorney, an interpreter sharing the same home language of the patient

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<sup>195</sup>Supra *Carter v Canada*(see fn 194 above)

<sup>196</sup> 1975 (3) SA 532 (C)

(presumably an expert), a member from the multi-disciplinary team, and one family member.

The committee must be satisfied that the request to be euthanized is made freely and voluntarily by the patient and that such a request is maintained longer than a week. Additionally, the committee must be satisfied that such a request must be considered in relation to the patient's terminal illness. The regulatory committee in this instance bears similarity to the committee formulated in Netherlands. However, the committee in Netherlands is formulated to *review* a decision that has already been made to euthanize a patient, whilst the South African objective to formulate a committee is to *ensure* the decision to euthanize is made within three weeks of a request being submitted.

#### *2.10.5. Safeguard Mechanisms for the Procedures*

The SALC Framework for the implementation of euthanasia is an important step taken in the move to empower and enforce people's rights to dignity, life, freedom and give effect to patient autonomy. Additionally, the framework advocates for important progressive developments and an acceptance of these developments made in the advancement of law and medical science. These proposed implementations within the area of euthanasia would receive little support from society without a successful system in place to educate society and medical practitioners on safeguard mechanisms available for the protection of patients and family member's. These proposed safeguards are examined below:-

##### *i. Advanced Directive / Power of Attorney / Living Will*

Section 6 of the Final Draft Bill introduces three options for the cessation of life of an incompetent person i.e. 'Advanced Directive/Living Will', alternatively a 'Power of Attorney'. Section 6(1) indicates that a competent person, upon reaching the age of majority, may make a directive (living will) to cede any medical treatment should he be diagnosed with terminal illness and rendered incompetent.

Section 6(2) does its best to destroy the possibility of abuse by empowering a competent person to act as an agent in respect of any medical decision that may need to be taken should the subject stated within the power of attorney become diagnosed with a terminal illness and become incompetent to make any medical decisions. Essentially, the power of attorney

operates in the same manner as an ordinary standard power of attorney, to be witnessed by two individuals signing in presence of each other. From the Final Draft Bill it would appear that the power of attorney would be created at a time when the patient is competent and come into effect at a time when the patient does not have legal capacity. The power of attorney would authorise an agent to undertake medical decisions on behalf of the patient, who is unable to make or communicate any decisions concerning his healthcare, ostensibly acting as a *bona fide* curator.

A concerning aspect regarding the power of attorney is that unless the patient's wishes are explicitly and specifically worded, the agent's decisions may not correctly reflect that of the principal. For this reason, it is more advantageous for a living will to be drafted by the patient to secure his interests at a later stage. It is recommended that the effect of a living will be the same as an ordinary will and that duplicate originals of the living will be held by the patient's family medical and legal practitioner, alternatively endorsed on the patient's medical records. It would be beneficial if the living will would be afforded the same protection and formalities as an ordinary will in that the patient must be able to communicate his living wishes and should they change over time, he should be able to attend to amendments to his living will in the form of codicils.

Additionally, section 6(4) permits a guardian or appointed curator to determine the medical decision which should be taken regarding the terminally ill patient's condition should such a patient fail to leave instructions either by means of an advance directive or power of attorney whilst simultaneously lacking decision-making capacity. Such a guardianship would be acting in the same manner as an agent authorised in a power of attorney, likewise a curator would function in the same manner as an ordinary present-day curator; i.e. ensuring that medical decisions are made with the patient's interest kept in mind.

## ii. Court Orders

In so far as the options available in the law reform report, the court may not make any decisions regarding the cessation of a patient's life unless a close family member is consulted with. Whilst this may operate as a safeguard, the Act is not clear as to what the position would be should the patient have no family so what weight can be attached to the family member's opinion. Additionally, there is uncertainty as to what would happen should more than one family member be heard by court and maintain different opinions regarding



the cessation of the patient's life and which member's opinion should have more or, if any, weight attached to it.

Option two of the law reform allows an interested party, upon application to the court to make an order regarding the cessation of a terminally ill patient who has not deposed to a living will or made a directive. The court's determination however, will be based on the evidence provided by two medical practitioners. None of the options subject the medical practitioners to civil or criminal sanctions.

### iii. Attending and Consulting Physicians

When a patient's request to be euthanized by means of a lethal injection is submitted to the treating physician, the treating physician must be satisfied that the patient:-

- a. is suffering from a terminal illness;
- b. is subject to extreme suffering;
- c. is over the age of 18 years and mentally competent;
- d. has been fully advised of the medical condition and the medical treatment, cure or options available to him;
- e. has made an informed and well-considered decision;
- f. persists in his request; and
- g. euthanasia is the only alternative available to release the patient's suffering.<sup>197</sup>

This section requires an independent medical practitioner, knowledgeable of the terminal illness to examine the patient and his medical history before confirming the facts of the treating medical practitioner. Therefore, this section does afford some form of safeguard by use of an independent physician.

### iv. Consultation Process

In terms of section 7(3), the consulting medical practitioner is required to engage with the patient's family, should the patient have a living will/advanced directive in place. This consultation is an interesting development in the field of law and medical practice as the National Health Act<sup>198</sup> specifically enunciates doctor-patient confidentiality as a privilege that is shared between the treating doctor and his patient. Section 14 operates as a non-

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<sup>197</sup> Section 6 of the Final Draft Bill as sourced from Project 86 (SALRC Report on Euthanasia and the Artificial Preservation of Life)

<sup>198</sup> Act 61 of 2003

disclosure clause whereby medical practitioners may not disclose their patient's health status or any information pertaining to it.<sup>199</sup> Should the medical practitioner not be satisfied with the authenticity of the directive/will he must treat the patient as if there was no directive/will in place and in the instance of the patient later becoming incompetent and mentally incapacitated, the treating medical practitioner must have his findings supported by an independent medical practitioner.<sup>200</sup>

In a way, section 8 creates a safety net against abuse, whereby a treating medical practitioner questioning the veracity of a directive/will may conduct an independent assessment and only once it is supported by the findings of an independent medical practitioner, having concluded his analysis may there be a cessation of further life-sustaining medical treatment. This means that the treating medical practitioner will not be unduly empowered with decision-making capacity.

The applicability of section 8, however, extends so far as cessation of life and continuation of palliative care. It does not encompass voluntary euthanasia as this section operates solely on the condition of incompetent, terminally ill patients.

Also a very interesting suggestion provided in the Draft Bill is the creation and development of a multicultural committee comprising of different individuals brought together to assess requests made by applicants. This is interesting because their role as a committee can be classified as a normal tribunal.

#### v. Time Periods

The consistency of a patient's request is the prevailing factor throughout the Draft Bill. Section 5(1) (e) of option two on the cessation of life requires that the request of a mentally competent person requesting cessation of life, submit his request on two separate occasions with each occasion being at least seven days apart, without any contradiction and with the latter request being not more than 72 hours before the medical practitioner gives effect to such request.<sup>201</sup> This is a convincing method that could be used to ensure that the patient is giving effect to a well-thought-out request regarding the cessation of his life.

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<sup>199</sup>Supra. The exceptions to section 14 are: court orders, patient consent to disclose information or public harm would result if the non-disclosure clause operated.

<sup>200</sup> Section 7(4) and section 8 of the Final Draft Bill sourced from Project 86

<sup>201</sup> Section 5(1)(e) of the Law Report on the Final Draft Bill sourced from Project 86

vi. Certificate of Request

According to the Draft Bill, treating medical practitioners are required to record the requests of a competent person requesting cessation of life by endorsing it on a medical certificate. This creates a sense of accountability on the part of practitioners should there be any form of abuse. Practitioners may destroy the certificate should the patient decide not to terminate their life. However, such a request must be endorsed on the patient's medical record.

*2.11. Conclusion*

There are a number of competing rights situated within the Constitution and relevant to the euthanasia debate. Most determinative and important is the 'inalienable right to life' entrenched within the Constitution. It has no substance unless it concedes that we own our lives and may make decisions about them to the extent that the exercise of our right is not to the detriment of others.<sup>202</sup> Amidst the right to life is the limitation test, assigned with determining whether there is a justification for limiting rights.

There are a number of security measures available within the Draft Bill. These security measures cater for the cultural diversity within South Africa whilst simultaneously creating a sense of institutional, professional and personal certainty amongst society. The implementation of these safeguards creates a sense of caution and eliminates any fear of professional or institutional abuse. According to the Bill, it is of primary importance for a physician to obtain permission from the patient, family member, court order or independent physician before attending to administer a drug that is lethal on a patient. Therefore, it is evident from these safeguards that there is a lack of the intention on part of the physician to kill a patient, especially one with mental capacity, requesting assistance or the prescription of a lethal agent. Whilst consent, at present does not operate as a defence to murder, the act of euthanasia should operate as a defence and be implemented within legislation.

There is a need for regulating legislation as the absence of legislation not only creates a sense of uncertainty but also makes the limitation of the right to patient autonomy difficult to explain and enforce.

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<sup>202</sup> Alfred Allen and the submissions of the Society of Advocates of Natal

It would appear that the primary concern dominating and central to the debate is the fear that there will be a mass murder situation resulting from the implementation and legalization of euthanasia. Whilst it is important to consider the merits of the arguments against euthanasia, it is fundamental to our democracy to give effect to the spirit and purport of the Constitution. Our democracy is premised on values that advocate for the right to life, freedom and security, privacy and self-determination. These rights provide a foundation for which euthanasia may be relied on.

## CHAPTER 3: INTERNATIONAL LEGAL DEVELOPMENTS

### 3.1. *Political Conventions and International Instruments*

#### 3.1.1. Introduction

Until recently, the issue of euthanasia, in particular voluntary active euthanasia received minimal attention on an international level.<sup>203</sup> However, recent times indicate that there have been significant developments pertaining to preliminary considerations of voluntary active euthanasia by a committee of the European Council.<sup>204</sup> These attempts extend to introducing legislation that will advocate for voluntary active euthanasia in the European Parliament.<sup>205</sup> The object of this chapter is to consider international instruments and examine the law and practice of physician-assisted suicide and voluntary active euthanasia in Canada and Netherlands, respectively.

There is no doubt that equality; human dignity and freedom are recognised as foundational values of our society. They are fundamental rights situated within the founding provisions of our Constitution.<sup>206</sup> They are rights that are given fundamental consideration not only on a national level through the implementation of legislation, but also on an international level through the implementation of conventions. In this instance, Section 39 of the Constitution<sup>207</sup> places an obligation on courts to consider international and foreign law when interpreting the Bill of Rights. Thus, courts may consider all the sources of international law recognised by Article 38(1) of the Statute of the International Court of Justice, i.e.:

- (a) international conventions, whether general or particular, establishing rules expressly recognised by the contesting States;
- (b) international custom, as evidence of a general practice accepted as law;
- (c) the general principles of law recognised by civilised nations;

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<sup>203</sup> M Otlowski, *Voluntary Euthanasia and the Common-law* (1997) 387 (hereafter “*Voluntary Euthanasia and the Common-law*”)

<sup>204</sup> *Ibid* *Voluntary Euthanasia and the Common-law* (fn 204 above)

<sup>205</sup> *Ibid* *Voluntary Euthanasia and the Common-law* (fn 204 above)

<sup>206</sup> Section 1(a) of the Constitution and *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 CC

<sup>207</sup> Constitution of the Republic of South Africa, Act 108 of 1996

(d) . . . Judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law.<sup>208</sup>

Many international conventions have been instrumental in facilitating our Constitutional Court's understanding and interpretation of the Bill of Rights. It has been stated that a ' cursory consideration of the international conventions and foreign jurisprudence makes it clear that the prohibition of discrimination is an important goal of both [foreign] national governments and the international community'<sup>209</sup> In this regard, article 1 of the UDHR<sup>210</sup> declares that '[a]ll human beings are born free and equal in dignity and rights'. In addition article 2<sup>211</sup> creates a sense of entitlement to these rights. This may be directly interpreted to mean that all patients must be treated equally and with dignity. Therefore, if patient consent is a pre-requisite to medical procedures<sup>212</sup> and treatment then similarly, a patient suffering from a terminal illness, with decision-making capacity, should be entitled to refuse treatment and such a decision should be obliged and respected by practitioners. Similarly, a patient's decision to request to be euthanized should also be respected.

It has been submitted that a doctor's inability to continue patient treatment except with the patient's consent, shall not render the doctor criminally liable for assisting suicide, especially in instances where he simply respected the patient's wishes to withhold or withdraw treatment.<sup>213</sup> Thus, if consent is a pre-requisite by law then it cannot as a matter of both law and logic be unlawful to do that which is legally required to do.<sup>214</sup> In this regard, it would appear that those arguing against euthanasia place reliance and support of their view against euthanasia on the justification that a doctor's decision to continue administering life-sustaining treatment against a patient's wishes would not be appropriate.<sup>215</sup> However, on an international and national level, this 'blanket authority' which doctors have over patients cannot be justified

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<sup>208</sup> J Dugard, *International Law and the Final Constitution* (1995) SAJHR 241 at 242-3

<sup>209</sup> *Brink v Kitshoff NO* 1996 4 SA 197 CC; 1996 6 BCLR 752 CC 39

<sup>210</sup> Universal Declaration of Human rights (hereafter "UDHR")

<sup>211</sup> Article 2: "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, and sex, language, religion, political or other opinion, natural or social origin, property, birth or other status".

<sup>212</sup> Section 7 and 9 of the *National Health Act 61 of 2003*

<sup>213</sup> D Meyers, *Medico Legal Implications of Death and Dying* cited in M Otlowski, *Voluntary Euthanasia and the Common-law* (1997) 81

<sup>214</sup> *Ibid Voluntary Euthanasia and the Common-law* (see fn 214)

<sup>215</sup> *Ibid Voluntary Euthanasia and the Common-law* (see fn 214)

as ‘overriding a patient’s refusal of treatment and would be most inappropriate as well as an infringement of the patient’s right to self-determination’.<sup>216</sup>

The right to self-determination has received a degree of recognition on an international plane as it is a fundamental right. Aligning itself to the right to self-determination are the rights to bodily integrity and the right to freely assess one’s quality of life when suffering from an intolerable burden.<sup>217</sup> It is defined as a universal right and by virtue of its existence it entitles individuals with the right to ‘freely determine their political status and freely pursue their economic, social and cultural development’.<sup>218</sup>

Another noteworthy international development is The World Federation of the Right to Die Societies. As the title immediately suggests, it is a formulation of world-wide societal organizations advocating for the establishment and legalization of active and passive euthanasia in recognition of the right to self-determination.

Significant means of advancing awareness can also be found in the establishment of the European Division of the World Federation of the Right to Die Societies. The objective of this foundation is to strengthen the movement in Europe for an individual’s right to die, explore and present common policies on voluntary euthanasia, partake in active research, examine legislative bodies in jurisdictions that have legalised voluntary euthanasia and maintain advisory roles at the House of Lords Select Committee on the Medical Ethics in the United Kingdom.<sup>219</sup>

In the study of voluntary active euthanasia and physician-assisted suicide, it would appear that most jurisdictions premise their rejection primarily on the likelihood of abuse of the practice and the Hippocratic oath which binds doctors as ‘guardians of life’. In most of these jurisdictions<sup>220</sup> any act of assistance towards termination of a patient’s life would result in criminal liability through a charge of murder and disciplinary proceedings. This position is shared in South African law where murder as defined as ‘the unlawful and intentional killing of a human being’<sup>221</sup>. In South Africa, this means that should a patient request physician assistance in terminating his life, such assistance would be deemed as murder irrespective of

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<sup>216</sup> Ibid *Voluntary Euthanasia and the Common-law* (see fn 204)

<sup>217</sup> Cantor, *Legal Frontiers of Death and Dying* cited in M Otlowski, *Voluntary Euthanasia and the Common-law*

<sup>218</sup> Article (1) of the International Convention on Civil and Political Rights (hereafter “ICCPR”)

<sup>219</sup> Ibid *Voluntary Euthanasia and the Common-law* (see fn 204) 288

<sup>220</sup> Jurisdictions such as New Zealand and even South Africa

<sup>221</sup> J Burchell, *Principles of Criminal Law*, 3ed Lansdowne: Juta and Co. Ltd, (2006) 667

the objective to terminate the patient's suffering and not the direct intention to kill, i.e. *dolus directus*.<sup>222</sup> The law does not afford consideration to the patient's condition, disregards the patient's mental capacity and infringes on the patient's right to autonomy and self-determination exercised through his request to be assisted or euthanized. In this instance, it is clear that the patient's right to autonomy and self-determination situated within the ICCPR<sup>223</sup> is being infringed on a large scale.

The Covenant also endorses core principles of the Bill of Rights such as; the right to life<sup>224</sup>; the right not to be subjected to torture, cruel and inhuman or degrading treatment<sup>225</sup>; the right to liberty and security of person<sup>226</sup> and freedom of movement<sup>227</sup>. It is submitted that these international articles bolster the case for euthanasia in that they are rights 'capable of immediate implementation in the sense that they do not require material resources for their implementation'<sup>228</sup>. These rights are amplified to a greater extent as they are endorsed on an international level, therefore arguments advanced in Chapter two which sought to analyse these very same rights can be used to advance and accommodate the debate on euthanasia.

## 3.2. Canada

### 3.2.1. Introduction

Much of the success of the debate about legalizing euthanasia is significantly attributed to societal organizations situated within Canada. These organisations have been instrumental in their plight to help generate an understanding of euthanasia and expounding misconstrued impressions through the facilitation of educational programs. To cite a few primary organizations, they comprise of; Dying with Dignity and The Right to Die Society of Canada (hereafter 'RDSC').<sup>229</sup>

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<sup>222</sup> C R Snyman, *Criminal Law* 5ed (2008) 190

<sup>223</sup> International Convention on Civil and Political Rights (hereafter "ICCPR")

<sup>224</sup> Article 6 of the ICCPR

<sup>225</sup> Article 7 of the ICCPR

<sup>226</sup> Article 9 of the ICCPR

<sup>227</sup> Article 12 of the ICCPR

<sup>228</sup> Ibid (J Dugard, *International Law and the Final Constitution* (1995) SAJHR fn 209) 330 (hereafter "International Law and the Final Constitution")

<sup>229</sup> Other organizational campaigns include Goodbye, A Right to Die Society established in 1991 to promote active voluntary euthanasia and subsequent foundations to create awareness.



To a large extent these organizations fuelled the euthanasia debate and played an active role in advancing human rights, more specifically the right to choice and autonomy. A case in point can be found in 1992 when the RDSC demonstrated their dedication and commitment to euthanasia by initiating court proceedings on behalf of Sue Rodriquez in order to assist her in challenging the constitutionality of the Canadian Criminal Code on the prohibition of assisted suicide.<sup>230</sup> The *Rodriquez* and *Carter* cases became known as the most influential cases in history, landmarked for their contemporary change to the usual taboo perspective maintained on the practice of euthanasia.

### 3.2.2. Case Law

Whilst there are a number of influential cases used to develop the Canadian law and assist the courts in gravitating towards the legalization of euthanasia, for the purposes of this paper there are two significantly influential landmark cases worth mentioning, i.e. *Carter v Canada*<sup>231</sup> and *Rodriquez v British Columbia (Attorney General)*<sup>232</sup>. These cases are noted for their valiant and successfully favourable argument presented in challenging the constitutionality of the prohibition of physician-assisted suicide and euthanasia in conjunction with their rights situated within the Canadian Charter of Rights and Freedoms.

Essentially, the applicant in *Carter v Canada* had been diagnosed with ALS<sup>233</sup> which prompted her to bring an application within which she sought the relief of physician-assisted suicide and specifically challenged the Canadian Criminal Code<sup>234</sup> which prevented her from accessing the relief she sought. Remarkably, the applicant was supported in her cause when four other parties joined her application in advocating for the legalization of physician-assisted suicide. They

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<sup>230</sup> Ibid *Voluntary Euthanasia and the Common-law* (see fn 204 for full citation) 283

<sup>231</sup> *Carter v Canada (Attorney-General)* 2015 SCC 5 (hereafter “Charter v Canada”)

<sup>232</sup> *Rodriquez v British Columbia (Attorney General)* [1993] 3 SCR 519

<sup>233</sup> Amyotrophic Lateral Sclerosis (in *Charter @ 11*): A progressive muscular degenerative disease which would ultimately result in her inability to perform basic bodily functions independently such as the ability to eat, speak, talk, walk, chew, swallow and eventually breath.

<sup>234</sup> The applicant specifically challenged s14; s21; s22; s222 and s241 of the Canadian Criminal Code

were Hollis Johnson, Lee Carter<sup>235</sup>, Dr William Shoichet<sup>236</sup> and the BCCLA<sup>237</sup>. Financial constraints prevented the applicant from travelling to Switzerland to be euthanized and subsequently led her to bring an application to challenge the Constitutionality of section 14<sup>238</sup>; section 21 (1) and (2)<sup>239</sup>; section 22(1)<sup>240</sup>; section 22(2)<sup>241</sup>; sections 222(1), (2), (3), (4), (5)<sup>242</sup>, and lastly, section 241(a) and (b)<sup>243</sup> of the Canadian Criminal Code.

Three fundamental rights of the applicant's that were situated within the ambit of the Canadian Charter of Rights namely; the right to freedom<sup>244</sup>; life<sup>245</sup>, liberty, security of person and equality<sup>246</sup> were considered and impacted on the judgment by the Supreme Court of Canada.<sup>247</sup> The court thereafter concluded that section 241 and 14 of the Canadian Criminal Code created the most resistance in uplifting the prohibition on euthanasia and that whilst section 21, 22 and

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<sup>235</sup> Hollis and Carter had previously assisted Carter's mother in travelling to Dignitas in Switzerland were assisted suicide and tourism assisted suicide is legalised. Carter's mother; Kathleen Carter was able to take a prescribed lethal dose that subsequently led to her death within 20 minutes, in presence of her family. Dignitas is a Swiss non-profit society founded in May 1998, a societal organisation advocating for that provides assistance to terminally ill individuals who wished to end their life in a dignified manner and obtain assistance from qualified medical practitioners. Dignitas have also lead and support a number of court cases and legislative initiatives in advancing end of life decisions and right-to-die laws worldwide and are "spearheads for the world implementation of 'the last human right'." In this regard see: [www.dignita.ch](http://www.dignita.ch) and [https://en.m.wikipedia.org/wiki/Dignitas\\_\(Swiss\\_non-profit\\_organisation\)](https://en.m.wikipedia.org/wiki/Dignitas_(Swiss_non-profit_organisation)) accessed: 10 October 2016.

<sup>236</sup> *Charter* (supra at 232) Dr William Shoichet was a medical practitioner who wanted to assist patients should Canada legalise physician-assisted suicide.

<sup>237</sup> *Carter* (supra 232) The British Columbia Civil Liberties Association is an association that advocates for the end of life decisions, support for patient's right to self-determination and dignity in death as well as the end of life education process, health care policies and patient rights to request assistance.

<sup>238</sup> Section 14: "No person is entitled to consent to have death inflicted on them 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 already given."

<sup>239</sup> Section 21(1)(b): "Everyone is a party to an offence who does or commits 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 anyone 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."

<sup>240</sup> Section 22(1): "Where a person counsels another person to be a party to an offence that 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."

<sup>241</sup> Section 22(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."

<sup>242</sup> Section 222(1): "A person commits suicide 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..."

<sup>243</sup> Section 241 (a): "Everyone who 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."

<sup>244</sup> Canadian Charter of Rights, Section 1.

<sup>245</sup> Supra Canadian Charter of Rights, Section 7.

<sup>246</sup> Supra, Canadian Charter of Rights, Section 15(1)

<sup>247</sup> *Carter v Canada* (Supra see fn 232) 10

222 did contribute substantial weight against the euthanasia debate, it would only be appropriate to refer to those sections if euthanasia were to remain an ‘unlawful act’ or treated as an ‘offence’ in accordance with the provisions of the criminal code.<sup>248</sup>

Whilst the trial court found that the applicant’s rights were unjustifiably limited and prevented her from requesting physician-assisted suicide because of the ban, on appeal the majority bench in the British Columbia Court (hereafter ‘BCC’) found in favour of the appellant. The BCC held in the *Carter* case that Taylor’s fundamental rights were not infringed and on application of the principle of *stare decisis* Taylor’s equality argument had been dispensed with in the *Rodriquez* case which should have ideally bound the trial court.<sup>249</sup>

Additionally, the court held that common-law principles such as *stare decisis*, in as much as it may be binding, is subordinate to the Constitution and not absolute in nature. On that note the court stipulated conditions that may allow binding principles to be revisited. These conditions were present in *Carter* and are; (1) the presence of ‘new legal issues raised’; or (2) ‘if there is significant change in the circumstances or evidence’.<sup>250</sup> The *Rodriquez* case brought about new legal issues in respect of the right to life as well as new evidence which had been constantly introduced on an international level. However, despite these changes courts refused to examine the proportionality of the law in so far as the blanket-ban on euthanasia was concerned.

Despite the similarities shared between these cases, the court held that *Rodriquez* successfully challenged the Canadian Code against her right to freedom and security of person in a manner that correlated with the principles of fundamental justice and that whilst Taylor’s right to equality had been violated; such violation was justified under section 1 of the Charter.<sup>251</sup> Whilst it cannot be agreed with that the violation in the Charter case may have been viewed as justifiable in respect to her right to equality, the *Rodriquez* case held that the right to freedom and security was not justifiably violated and presented a much stronger argument.

It has been accepted that the *Rodriquez v British Columbia (Attorney General)*<sup>252</sup> case is one of the most influential cases in the argument for euthanasia. This case dealt with a 42 year-old appellant who was diagnosed with Amyotrophic Lateral Sclerosis, an anomalous condition which would ultimately lead to significant and severe physical deterioration, the effects of

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<sup>248</sup>*Carter v Canada* (Supra see fn 232) 10

<sup>249</sup>*Carter v Canada* Supra 324

<sup>250</sup>*Canada (Attorney-General) v Bedford* 2013 SCC 72 [2013] 3. S. C. R. 1101 42

<sup>251</sup>*Carter* 324

<sup>252</sup>*Rodriquez v British Columbia (Attorney General)* [1993] 3 SCR 519

which would result in one being unable to execute daily functions such as; speaking, swallowing, breathing or moving without assistance. With a life expectancy of between 2 to 14 months, Rodriguez brought an application for an order declaring section 241(b)<sup>253</sup> invalid and unconstitutional on the basis that it violated her rights situated within the Canadian Charter of Rights and Freedoms<sup>254</sup> and the Constitution<sup>255</sup> to the extent that it prohibited her from requesting physician-assisted suicide.<sup>256</sup>

The dissenting judges on appeal found that section 7 of the Charter afforded the appellant a degree of personal autonomy which in essence protected her right to dignity and privacy especially in relation to bodily integrity. The dissenting judgment sought to indicate that the legislative prohibition on physician-assisted suicide was unjust on the basis that it denied individuals the choice to end their lives merely because they were physically unable to do so, whilst those who were physically able and did not suffer from an intolerable condition were able to commit suicide of their own accord. An interestingly different interpretation was formulated by the dissenting judges who held that contrary to the majority of the court, concern of abuse did not fall within the ambit of the section 7 stage analyses regarding the appellant's right to life but rather, a consideration that must be determined at the next stage of the analyses, i.e. 'whether a limit should be imposed contrary to the principles of fundamental justice may nevertheless be saved under section 1 of the Charter as a limit demonstrably justified in a free and democratic society'<sup>257</sup>.

Nonetheless, the *Rodriquez* case was important because the court was tasked with the difficult issue of determining whether the prohibition on assisted suicide in terms of section 241(b) of the Criminal Code violated Rodriguez's section 7 right to liberty and security of person under the Canadian Charter. The court conducted a two-stage enquiry to determine; (1) whether Rodriguez's section 7 right had been violated in that she was deprived of exercising this right

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<sup>253</sup> Canadian Criminal Code 1985

<sup>254</sup> Section 7, 12 and 15 (1). Sections of the Canadian Charter of Rights are almost identical to the South African Constitutional right to life and provides that "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with principles of fundamental justice".

<sup>255</sup> Section 52(1) of the Canadian Constitution Act 1982

<sup>256</sup> *Voluntary Euthanasia and the Common-law* *ibid* 81 (fn 214 above)

<sup>257</sup> *Voluntary Euthanasia and the Common-law* *ibid* 89 and section 1 of the Canadian Charter: "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".

in a justifiable manner and (2) whether her inability to exercise it amounted to arbitrariness and gross disproportionality of the principles of justice.<sup>258</sup>

Paramount consideration was given by the majority in a joint judgment by Sopinka J who held that one's right to liberty and security of person, as a fundamental right is a protected right that cannot be 'divorced from the sanctity of life'. Life as a value had to be evaluated in conjunction with influencing factors. One of the influencing factors is the right to personal autonomy. As such, the majority found that the section 241(b) prohibition which sought to challenge *Rodriquez*, deprived her of her fundamental right to autonomy, causing her to further endure physical and psychological pain as a result of her medical condition, and subsequently impugned her section 7 right in a manner that was unjustifiable and arbitrary.

Important to the argument in support of euthanasia is the contemporary perspective that the court had on the right to life. The court began by first acknowledging that 'the sanctity of life is one of the most fundamental societal values of life'<sup>259</sup> but further rooted within an understanding of this right was 'a profound respect for the value of human life'<sup>260</sup> and that even within the course of death, an individual's core values could not be dispensed with simply because they were in the winter of their life. Consequently, the court in *Carter* concurred with the court in *Rodriquez* and found that the definition of the sanctity of life encompasses one very important contemporary element i.e. that the sanctity of life 'is no longer seen to require that all human life be preserved at all costs'<sup>261</sup>. In his regard, it is submitted that South African law, with some aspects of law taken from Canadian jurisprudence is susceptible to change and can successfully utilize and adopt this perspective into South African law.

In addition to her section 7 victory, *Rodriquez* argued that that the prohibition impugned her section 12 and 15 rights. These rights were also emphasized within the *Carter* judgment which adopted the findings of the *Rodriquez* judgment and concluded that one's choice regarding the right to life should be respected.<sup>262</sup>

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<sup>258</sup> This two-stage approach and the limitation enquiry influenced South African jurisprudence. Like the core components situated within the South African Bill of Rights, the elements of a justified limitation are adaptations formulated from Canadian jurisprudence.

<sup>259</sup> *Carter v Canada* para 63

<sup>260</sup> *Carter v Canada* 63

<sup>261</sup> *Rodriquez* (see fn 253)595

<sup>262</sup> *Carter v Canada* para 63

It is clear from both the *Rodriquez* and *Carter* judgments that the courts were of the view that there is a degree of concern for ‘the protection of individual autonomy and dignity’<sup>263</sup> as these rights underpinned core personal and freedom-based rights. In addition, these rights, inclusive of freedom and security of person should essentially be free from state interference as they encompass a sense of personal autonomy and choice.<sup>264</sup>

Ultimately, the court acknowledged the right to life, freedom of choice as well as the right to safety and security of an individual as rights that were primal and integral to an individual’s autonomy. Moreover, in its conclusive findings the court held that s241(b) and s14 of the Canadian Code infringed on an individual’s rights of liberty and security of person ‘insofar as they prohibited physician-assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical conditions that causes enduring and intolerable suffering’.<sup>265</sup>

### 3.2.3. Legislation and Procedure – The Canadian Criminal Code

Apart from the Canadian Criminal Code, Canada does not have a separate legislative enactment to regulate euthanasia despite the *Carter* judgment which suspended the application of its ruling in allowing physician-assisted suicide for a period of a year in order to afford the legislature the necessary time it would need to amend its laws. Whilst there is no enacting legislation to date, the *Carter* judgment creates a patient-centred approach focusing on the patient’s right to choice, freedom and autonomy.

Section 241(2)<sup>266</sup> of the Code operates as an exemption in that it exempts a medical practitioner or nurse from being liable for an offense of aiding or abetting a person in committing suicide, which subsequently leads to suicide. However, the exemption from liability is provisional upon medical assistance in dying according to section 241(1) of the Criminal Code.

Additionally, the Criminal Code indemnifies:-

- a. Individuals that assist medical practitioners or nurses in medically assisted suicide<sup>267</sup>;

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<sup>263</sup>*Carter v Canada* 64

<sup>264</sup>*Rodriquez* (see fn 253) 587-8

<sup>265</sup>*Carter v Canada* 27

<sup>266</sup> Canadian Criminal Code (as reviewed September 2016)

<sup>267</sup> 241.3 of the Canadian Criminal Code

- b. Pharmacists dispensing substances further to a prescription that is written by a practitioner in providing medical assistance in dying and dispensing these substances to persons other than medical practitioners<sup>268</sup>;
- c. Any person assisting a patient, under explicit request of the patient to assist them in administering a lethal substance prescribed as part of the medical assistance provision situated within the Canadian Code<sup>269</sup>;
- d. A social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse or other health care professional providing information to any person regarding information on lawful medical assistance.

In an attempt to curb abuse, the Criminal Code defines and describes ‘medical assistance in dying’ as substance administration to a person by a medical practitioner or nurse, upon a patient’s request which ultimately leads to the patient’s death.<sup>270</sup> Alternatively, the prescribed substance may be provided by a medical practitioner or nurse to the requesting person, at his request so that the latter may self-administer the substance which will ultimately lead to their own death.<sup>271</sup>

More importantly, is the eligibility criteria for assisted dying, situated within the Criminal Code. This category sets out the criteria that must be met before a person qualifies for medically-assisted suicide. Medically-assisted suicide will only be rendered when:-

- a. They are eligible – but for any applicable minimum period of residence or waiting period, would qualify one as eligible for health services funded by government in Canada;
- b. They are at least 18 years of age and capable of making decisions regarding their health;
- c. They have a grievous and irremediable medical condition;
- d. They have made a voluntary request for medical assistance in dying that was not made as a result of external pressure; and
- e. They give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.<sup>272</sup>

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<sup>268</sup> 241.4 of the Canadian Criminal Code supra (see fn 268)

<sup>269</sup> 241.5 of the Canadian Criminal Code supra (fn 268)

<sup>270</sup> 241.1 (a) of the Canadian Criminal Code supra (see fn 268)

<sup>271</sup> 241.1 (b) of the Canadian Criminal Code supra (see fn 268)

<sup>272</sup> 241.2 (1) of the Canadian Criminal Code supra (see fn 268)

Relative to the ‘eligible category’ is the defining medical condition that would suggest whether or not a person may qualify for assistance. According to the Code, a person has a medical condition if they satisfy the following criteria for ‘grievous and irremediable medical condition’:-

- a. They have a serious and incurable illness, disease or disability;
- b. They are in an advanced state of irreversible decline in capability;
- c. That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable, and;
- d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.<sup>273</sup>

Thus, section 241 of the Criminal Code categorically highlights the significance of mental capacity, consent and assistance on request. In the process, this eliminates the slippery slope argument against euthanasia that would ultimately lead to societal deterioration and an abuse of the practice.

In addition, it is submitted that these defining sections create a sense of legal certainty amongst the medical field and society. This submission is based on the *Carter* judgment and the subsequent legislative suspension in order to enact legislation to give effect to laws that would regulate euthanasia.

#### 3.2.4. Regulating Abuse

The safeguards utilised by Canada to circumvent and curb abuse are imposed by ‘safeguards’ situated within the Code. The medical practitioner or nurse assisting the patient must satisfactorily prove that there has been compliance with this category before rendering any assistance that will ultimately lead to the person’s death. Essentially they must:-

- a. be of the opinion that the person meets all of the criteria set out in subsection 1 (i.e. eligible criteria);
- b. ensure that the person’s request for medical assistance in dying was:

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<sup>273</sup> 241.2 (2) of the Canadian Criminal Code supra (see fn 268)



- (i) made in writing, signed and dated by the person or by another person and;
  - (ii) signed and dated after the person was informed by a medical practitioner or nurse that the person has a grievous and irremediable condition;
- c. be satisfied that the request was signed and dated by the person – or by another person before two independent witnesses who then also signed and dated the request;
- d. ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;
- e. ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in section (1);
- f. be satisfied that they and the other medical practitioner or nurse practitioner referred to are independent;
- g. ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided for, or – if they and the other medical practitioner or nurse referred to in paragraph (e) are both of the opinion that the person’s death, or the loss of their capacity to provide informed consent is imminent – any shorter period that the first medical practitioner or nurse considers appropriate in the circumstances;
- h. immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and
- i. If the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.

Failure to comply with these safeguards would result in the medical practitioner or nurse incurring criminal liability and:-

- a. on conviction for an indictment, subject them to imprisonment for more than five years; or
- b. On summary conviction, to a term of imprisonment of not more than 18 months.<sup>274</sup>

Therefore, it is submitted that South Africa, sharing the same principles and adaptations from Canadian law can easily adapt and formulate regulations to de-ban euthanasia by developing the common-law and decriminalising euthanasia. Foreign jurisdictions sharing similar legal

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<sup>274</sup> 241.3 (a) and (b) of the Canadian Criminal Code (see fn 268)

frameworks to South Africa have successfully adopted the practice of euthanasia and lifted the prohibition on euthanasia. By lifting the ban these jurisdictions have significantly added value to individual rights and patient autonomy.

### 3.3. *Netherlands*

#### 3.3.1. Introduction

The Dutch position on voluntary active euthanasia is often cited by ‘euthanasia proponents as a model of social reform which demonstrates the benefits of sanctioned active voluntary euthanasia and which ought to be followed in other countries’.<sup>275</sup> Whilst it remained illegal for a long time it was practised openly by medical practitioners.<sup>276</sup> Presently, the law and practices of voluntary active euthanasia in the Netherlands may be an instructive system to other countries that are contemplating legalizing the practice of euthanasia as Netherlands is one of the first countries to have legalized euthanasia approximately 13 years ago. Netherlands’ years of practice without any alarming complaints of abuse is contrary to academics arguing against euthanasia on the basis that the practice will lead to a slippery slope incline of abuse. Whilst this argument is maintained by academics advocating against euthanasia, it is submitted that there is no merit to this argument as voluntary active euthanasia is currently practised in the Netherlands and there is no convincing evidence to indicate that it has led down the slippery slope to involuntary euthanasia.<sup>277</sup> In fact, medical practitioners have indicated that they are hesitant to proceed with such a request made by patients.<sup>278</sup> Nonetheless, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2001) came into effect to facilitate the practice of euthanasia, subsequently acknowledging the right to dignity to encompass the right to choice and consequently prioritising the right to patient autonomy.

#### 3.3.2. Case Law

Case law can be used as a mechanism to track the Dutch developments in so far as euthanasia is concerned. In the *Postma*<sup>279</sup> case the court held that the attempt made by the accused to assist her mother, who requested to be euthanized due to her intolerable medical condition was guilty

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<sup>275</sup>*Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 391

<sup>276</sup>*Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 391

<sup>277</sup>*Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 222

<sup>278</sup>*Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 391

<sup>279</sup> LB Grove (see fn 27) 139

of murder<sup>280</sup>. The court however, did not sanction the accused punitively but gave a one-week suspended sentence and placed her on probation for a year. It is worthwhile to note that the application of this case can be found in the South African case law of *S v Hartmann*<sup>281</sup>.

It has been observed that mercy killings or assisted suicide often arise within a family context, in situations where there is persistence from a terminally ill loved one to be euthanized.<sup>282</sup> Therefore, if active voluntary euthanasia were permitted in these circumstances, it would very likely reduce inevitably and inexpertly performed mercy killings by family members.<sup>283</sup>

### 3.3.3. Legislation and Procedure – The Dutch Criminal Code

It has often been stated that the Netherlands criteria for the implementation of euthanasia provides a useful proposal for jurisdictions that aim to formulate proposals for legislative frameworks in order to regulate both active and passive euthanasia.<sup>284</sup> The Netherlands initially formulated guidelines published by the Royal Dutch Medical Association which stipulate guidelines similar to the following legal regulations:

- (i) Only doctors may carry out euthanasia;
- (ii) Individual doctors are free to refuse to carry out euthanasia;
- (iii) There must be an explicit request by the patient which leaves no room for doubt concerning the patient's desire to die;
- (iv) The patient's decision must be well-informed, free and enduring;
- (v) There is no acceptable alternative (for the patient) to improve his/her condition.
- (vi) The doctor must exercise due care in making the decision and consult another independent medical practitioner.<sup>285</sup>

In addition to the above criteria, the Dutch Criminal Code implements statutory regulations to prevent abuse on a large scale. This is evident in article 293 and 294 of the Code. Article 293 criminalizes the conduct of an individual that murders another, despite the latter's consent to such murder, the perpetrator is sanctioned to a period no less than 12 years imprisonment. Article 294 on the other hand, is more focused on the assistance aspect in that anyone that aids,

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<sup>280</sup> The accused was charged under article 293 of the Dutch Penal Code

<sup>281</sup> 1975 (3) SA 532 (C)

<sup>282</sup> *Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 211

<sup>283</sup> *Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 211

<sup>284</sup> *Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 323

<sup>285</sup> "Doctors' Reform Society Policy Statement" (1988) 49 *New Doctor* at para 3.3 cited in Otlowski at p. 323

incites, or provides the means to assist one in committing suicide, and suicide ensues, such a person, having played an active role in assisting will incur a maximum period of 3 years imprisonment or alternatively, a fourth-category crime.

Notwithstanding these prohibitions, article 40 provides an exception to article 293 and 294 by creating the defence of necessity in order to regulate the conduct of euthanasia. This is similar to South African law and requires the proportionality test to be successfully executed before decriminalizing the culpable conduct. It has been submitted that the application of the proportionality test and necessity can be ‘raised where that which is protected is more worthy of protection than that which was sacrificed, provided that it was protected in the least punishable way’.<sup>286</sup> In this instance, the submission endeavours to convince one that a patient’s life is sacrificed in order to protect him from the prolonged and protracted torture of unbearable pain, and in this instance section 40 indemnifies the physician for acting within the realm of necessity.

The introduction of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2001) subsequently amended article 293<sup>287</sup> and article 294<sup>288</sup> of the Dutch Criminal Code. This represents the present legal status on the practice of euthanasia in Netherlands which maintains the prohibition on euthanasia and physician-assisted suicide. However, the Act creates exceptions and criteria, which acknowledge the presence of certain instances that would dictate when the act of euthanasia and assisted suicide will be deemed legal.

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<sup>286</sup>Dörfling, “‘Genadedood’ in die strafreg – ‘n regsfilosofiese en regsvergelykende perspektief” 1991 (unpublished thesis submitted in partial fulfilment of a Master’s in Law Degree) Faculty of Afrikaans Law Rand University. p 20 fn 19 also cited in LB Grove (see fn 27).

<sup>287</sup> Article 293 (1): “A person who terminates the life of another person at that other person’s express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine of the fifth category.” And Article 293(2): “The offence referred to in the first paragraph shall not be punishable if it has been committed by a physician that has met the requirements of due care as referred to in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures Act) and who informs the municipal autopsist of this in accordance with Article 7 Second paragraph of the Burial and Cremation Act.”

<sup>288</sup> Article 294 (1): “A person who intentionally incites another to commit suicide is liable to a term of imprisonment of not more than three years or a fine of the fourth category where the suicide ensues.” And Article 294(2): “A person who intentionally assists in the suicide of another or procures for that other person the means to commit suicide, is liable to a term of imprisonment for not more than three years or a fine of the fourth category, where the suicide ensues. Article 293 second paragraph applies mutatis mutandis.”

### 3.3.4. Regulating abuse

Evidencing from the Dutch Act on Termination of Life on Request and Assisted Suicide Act are safeguards created to circumvent abuse of the practice of voluntary euthanasia and physician-assisted suicide. Accordingly, the Act contains explicit clauses, which indemnifies an individual and decriminalizes the conduct when certain factors are present, such as:-

- a. The conduct is committed by a physician who has fulfilled the requirements situated within Article 2 of the Act<sup>289</sup>;
- b. ‘Due care’<sup>290</sup> must be exercised and;
- c. The municipal autopsist is informed.<sup>291</sup>

‘Due Care’, as defined within the Dutch Penal Code indicates that the physician *must* firmly believe that a patient’s request is premised on a voluntary and well-considered decision and that the patient’s condition is lasting and unbearable.<sup>292</sup> Interestingly, the South African Draft Bill has initiated the concept of ‘due care’ from the Netherlands and adopted it within option 2 of the South African Draft Bill. Additional factors are imposed within the ‘Due Care’ requirement situated within the Penal Code and suggested in the South African Bill. They are requirements that necessitate:-

- a. That the physician informing the patient of his condition and advise him of the various prospects and medical options available (if any);
- b. That the patient must be convinced that there is no reasonable solution to his condition;
- c. The physician facilitate a consultation with an independent physician that has examined the patient and given his opinion on the patient’s health in writing, such an opinion must correlate with the convictions of the patient’s physician;
- d. That the physician has terminated has terminated a life and/or assisted suicide with due care.<sup>293</sup>

It is submitted that these requirements not only create but also instil a sense of security within society. What is more convincing and seemingly drives the argument for voluntary euthanasia to the extra mile is the fact that provision is made within Option 3 of the South African Draft Bill to implement a semi-judicial committee, which incidentally would also consist of a family

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<sup>289</sup> Article 2 of the Dutch Act on the Termination of Life on Request and Assisted Suicide (Review Procedures Act) 2001.

<sup>290</sup> “Due Care” is defined under Article 2(1) of the Dutch Penal Code.

<sup>291</sup> In accordance with Article 7 of the Burial and Cremation Act

<sup>292</sup> Article 2(1) of the Dutch Penal Code

<sup>293</sup> Article 2(1) of the Dutch Penal Code

member and a member of a multi-disciplinary team to determine whether the patient's request to be euthanized should be approved or rejected. This safeguard in essence, provides substantial support against abuse.

Also providing substantial support to the broad argument for euthanasia, but more specific to physician-assisted suicide, is Article 2(2)<sup>294</sup> which regulates living wills and advanced directives. Essentially, this article permits physician termination to anyone above the age of sixteen years:-

- a. having previously become aware of their condition;
- b. Maintain a reasonable understanding of their interest and;
- c. has executed a written will or advance directive to communicate their request to be euthanized;

To a minute extent, this provision is concerning for a number of factors as there is no indication as to when particularly such an advanced directive can be made, and this affects the capacity aspect of the person. Additionally, it is unclear as to how 'reasonable understanding' can be assessed whether it is a subjective determination based on an individual's capacity or an objective approach. Contrarily to the Draft Bill which creates a threshold on age, in that one has to be eighteen years or older to request active euthanasia, the Dutch law creates and distinguishes between three different categories; individuals between twelve and sixteen, individuals between sixteen and eighteen, individuals above eighteen.

The Bill has also referenced other areas of Dutch law, such as article 3 to 6 which introduces the concept of a multi-disciplinary committee tasked with reviewing and lodging reports regarding decisions taken in respect of active euthanasia and physician-assisted suicide.

### 3.4. Conclusion

There is undoubtedly growing support for the legalization of active euthanasia and physician-assisted suicide internally. The libertarian principle of a patient's right to self-determination presents perhaps the strongest argument raised and shared in the advancement of euthanasia on an international plane as it presents a *prima facie* case for developments within the medical and

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<sup>294</sup> Termination of Life on Request and Assisted Suicide (Review Procedures) Act supra (see fn 290)

legal profession, creating an initiative to enable practitioners to take active steps to assist patients in their final requests.<sup>295</sup>

Legislative provisions in the Canadian Criminal Code and Canadian jurisprudence advance for the practice of euthanasia, and as a fair amount of South African legal framework is adopted from Canadian jurisprudence, which incidentally were also adopted by the court in *Stransham-Ford*, it is submitted that this is the way forward for South Africa to develop its common-law position on euthanasia. Also evident for the move towards legal reform is the practice of voluntary active euthanasia in the Netherlands, advancing the argument that the facilitation of a merciful death at the request of a terminally ill patient does not depreciate the integral fibre of society but enhances and generates respect of the core principle of self-determination and the right to life.<sup>296</sup>

Whilst the argument that the legalization of the practice of euthanasia may lend itself to abuse, it is not uncommon for newly formed and enacted legislation to be ‘potentially open to abuse’.<sup>297</sup> However, appropriate rules, procedures and regulations can bridge the gap in minimizing and later eliminating abuse to create an effective degree of the practice.

More important is the consideration of developments in the field of medicine and technology. Facilitating the implementation requires a transition phase including legislative development and this is what academics advocating for euthanasia aim to achieve; a system of rules that address these developments. Difficulties in implementing pro-euthanasia legislation should not be misconstrued to mean that it is impossibly inevitable and will never be successfully carried out.

Ultimately, all laws are required to withstand difficult transitional periods. Admittedly, there will always be resistance to change in laws but it is because we are dealing with voluntary euthanasia and physician-assisted suicide made at the request of mentally competent patients that the ‘right of [implacable] opponents to reject euthanasia for themselves is not impinged on by creating the opportunity for others who seek it to exercise that choice’.<sup>298</sup> After all, the aim of euthanasia is not ‘societal disposal’ but societal development.

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<sup>295</sup>*Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 323

<sup>296</sup>Angeli, M ‘Euthanasia; (1988) 319 *New Eng. J Med.* 1348, 1350 cited in *Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 228

<sup>297</sup>*Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 231

<sup>298</sup>*Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 256





## CHAPTER FOUR: RECOMMENDATIONS

### 4.1. Introduction

As already established in Chapter two and three, the present [South African law] which ‘prohibits active voluntary euthanasia is a violation of the individual’s liberty and self-determination’.<sup>299</sup> Essentially, one’s choice whether to live or die is a private one, ‘and individuals should be permitted to live their lives according to their own life choices, free of coercion or paternalistic interference’.<sup>300</sup>

The SALC report makes specific recommendations regarding the practice of euthanasia and draws recommendations from and comparisons to other practicing jurisdictions. Amidst these recommendations is the ability of a medical practitioner who may under certain circumstances, authorize the withholding of further medical treatment from a patient whose life functions are being artificially maintained and; a competent person may refuse life-saving treatment with regard to specific incurable illnesses, even though such a refusal may hasten death.

The SALC report also contains recommendations giving doctors the discretion in deciding on a patient’s life, where the patient has left a will stipulating a request for euthanasia or where it is the wish of the patient, who is unable to communicate his request. The aspects of the report are likely to prove tricky as there are three options that the health minister has to decide upon with regards to voluntary euthanasia. The first is confirmation of the present legal position which prohibits voluntary euthanasia and physician-assisted suicide. The second suggests that active euthanasia could be regulated, in a way that gives effect to patients’ wishes, or those of their family. The third option advocates the establishment of a panel or committee which would consider requests for euthanasia, according to a strict criteria.<sup>301</sup>

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<sup>299</sup>*Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 255

<sup>300</sup>*Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 255

<sup>301</sup><http://mg.co.za/article/2001-04-12-euthanasia-not-for-sa> accessed on the 10 June 2016

4.2. *Recommendations of Adaptations, Safeguards, Mechanisms and Procedures into South Africa from jurisdictions implementing Euthanasia, Recommendations from the SALR Report on Euthanasia and General Recommendations:*

In addition to the recommendations implemented by Canada, Netherlands and the SALC Report are general recommendations suggested by the writer. These proposed recommendations are compiled as follows:

- a. The recommendation that there be guidelines and policies for the practice of euthanasia to be practiced in a safe environment without abuse of the practice. These policies should provide some direction for implementing legislation to governing and regulating the practice of euthanasia.
- b. Euthanasia should be a practice which remains exclusive to individuals constantly suffering from a terminal illness which continues to deteriorate and such a person suffering from the terminal illness has no possibility of recovery from such an illness.
- c. Informed consent is a mandatory pre-requisite in instances where the patient is mentally competent and has voiced their request to be euthanized after being fully informed of any medical procedure available to alleviate the intolerable medical condition that will ultimately lead to his/her demise and such a request has been voiced constantly for a period of time.
- d. The appointment of a medical committee or board to evaluate decisions taken regarding euthanasia, by the medical staff on request of a patient to be euthanized. Similarly, the SALC report has recommended that there be a multi-disciplinary committee formulated to assess decisions taken by doctors to euthanize and a consultation process be held with family members, attorneys, and medical practitioners. This committee would be able to facilitate various opinions and responses regarding the decision taken by a medical practitioner to euthanize the patient and generate opinions and concerns in so far as the patient is concerned.

- e. In addition to the abovementioned committee, it is suggested that the Draft Bill should encompass a tribunal, i.e. facilitate the formulation of a tribunal that is able to review decisions taken by medical practitioners and draft periodical or annual reports regarding the implications of euthanasia and whether it is being satisfactorily and properly practiced. Essentially, the tribunal would operate as an ombudsman and fulfil the function of one within the medical profession. This would alleviate the pressure that courts would face and cases can be chaired by an independent arbiter. This would filter out cases based on whether allegations made against a practitioner were in fact credible before it is heard before court.
- f. It is proposed that acts of euthanasia be carried out by medical practitioners, limited only to the profession of a physician and not including nurses. It is further suggested that South Africa adopt this recommendation in order to prevent abuse and insure that the euthanasia is being practiced in a controlled environment with the administration limited only to a patient's treating doctor. This is because treating doctors are expertly equipped with the knowledge of the patient's healthcare and condition; such a doctor is therefore able to diagnose and treat the patient accordingly. In addition, the administration of a lethal dose or prescription of one should only be provided by a doctor as it is a controversially challenging and highly accountable task which should ideally be administered by a professional.
- g. A second opinion from a non-treating and independent physician should be obtained. The independent physician should conduct an examination on the patient and record in writing his findings regarding the patient's condition with such a report to form part of the patient's record and should second the treating doctor's report.<sup>302</sup>
- h. Similar to an indemnity and recommended in the SALC Report is the suggestion that a medical practitioner issues a certificate upon the request of a patient to be euthanized. This 'certificate of request' must be signed by the patient who requests to be euthanized. Should such a patient be unable to sign the certificate then any person above the age of 18 years and with the consent of the requesting patient, may sign on behalf of the

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<sup>302</sup> Refer to a discussion of Canada's system in Chapter three. This recommendation is premised on their procedure.

patient. In this instance, the medical practitioner must witness the signature of the relevant person and where the patient is able to sign the certificate, he must have an understanding of the certificate, after such a certificate is explained to him in a language that he understands.<sup>303</sup>

- i. South African law makes provision for Living Wills. The validity and legal standing of which is a direct indication of the wishes of the writer. This is similar to an advance directive which communicates the request of the patient. Similarities can be seen in both a living will and advance directive in that both documents records significant aspects of a person's wishes and desires. It is submitted that a patient's wish to be euthanized deposed to in a will is not different from that of a patient's directive whilst in a competent state of mind to be euthanized. The only difference is that the former would have placed his wishes in writing whilst the later does so orally whilst suffering from a terminal illness. Ultimately, both patients wishing to be euthanized should be respected and adhered to. There is no legitimate basis upon which such a person's right may be refused especially upon earlier consideration and discussion of a person's right to autonomy and choice.<sup>304</sup>
  
- j. Courts having jurisdiction over persons may be approached in instances where there are no advance directives and a patient is no longer competent to make a decision regarding their health due to their advanced terminal illness. The SALC report makes provisions for court's to be approached and for the treating medical practitioner to submit his opinion to the court, along with the patient's family members being afforded the opportunity to voice their opinion and be included in the court process before a decision to be euthanized is concluded. In these instances, the fear of non-voluntary euthanasia being practiced is curbed as the High Court exercises jurisdiction over all persons within South Africa regarding their status. Although the Court may not be a particularly accessible remedy, any interested party having an interest in a case may still have recourse to approach the High Court for relief.

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<sup>303</sup> Refer to discussion on the SALC Report in Chapter two and three

<sup>304</sup> Refer to Chapter two for the Rights-based discussion

- k. A potent recommendation for the practice of voluntary active euthanasia is the time limits and the period of time within which a patient communicates his/her initial request and either withdraws or reiterates his/her request. Whilst the SALC report on the Draft Bill indicates that the 72-hour period may prove to be burdensome<sup>305</sup>, it is submitted that laws are bound to be burdensome in order to keep members of the public in check and align their behaviours in accordance with accepted standard of conduct and as such it would be beneficial to have a reasonable period of time within which a patient can communicate his intention and thereafter either reiterate his request or withdraw it.
- l. A patient's request for assistance must be voluntary. The guidelines according to the SALC report and even the practice in the Netherlands and Canada require that the treating medical practitioner, upon a patient's request to be euthanized must be satisfied that the patient suffers from an intolerable illness, has the mental capacity to formulate such a request and is a major.<sup>306</sup> It is submitted that as an additional factor the report should include a provision that stipulates that the terminally ill patient should undergo a physiological evaluation by a professional who would be in a better position to analyse the mental and emotional well-being of the patient and that such a request made by the patient is made free of any duress or influence.
- m. Decisions pertaining to minors suffering from incurable terminal illnesses either with or without mental capacity should be determined with the assistance by a guardian or curator. Minors should not be tasked with the responsibility regarding euthanasia and as the High Court of South Africa maintains guardianship over all children, the High Court should be approached for an order granting the practice of euthanasia once it is satisfied that: (1) it is in the best interest of the child, (2) the child has consented and (3) such consent is given with the assistance and consent of the guardian whilst such a child remains under guardianship and the said guardian maintains the same mindset. In instances when the guardian unreasonably disagrees, the minor may have a curator appointed, who will assist the minor and submit a report along with the report of a child psychologist to the High Court.

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<sup>305</sup> See SALC Report, Option 2 at page 229 of the Report

<sup>306</sup> Refer to Chapter three for the International Developments in Canada and Netherlands

- n. Adequate information should be given to the patient from inception regarding his/her condition to enable him/her to be in a position to make an informed decision regarding his/her healthcare and treatment. As an additional suggestion, from the initial diagnoses stage, patients should be informed of the various recourses, procedures and options available to them and what the resulting effect of the procedures will have on them. Upon receipt of this information, patients should be requested to sign an acknowledgment (similar to an indemnity as already mentioned above) which states that they have been properly informed of their condition and at a much later stage, consider their health options before choosing either palliative care or euthanasia. These recordings should be documented within the patient's file and made available to a Review Committee, Medical Tribunal or Ombudsman investigating acts of euthanasia or screening requests by patient's to be euthanatized. Patients that request euthanasia should complete a form which contains; (1) confirmation of the knowledge of their terminal condition in acknowledgment of their terminal illness, (2) confirmation of consent given based on the latest information supplied to them at initial diagnoses stage and throughout their condition, and (3) confirm that consent is given free of any influence or duress in a language that they understand. This form should be witnessed by two independent witnesses and form part of the patient's record as a signed indication by the patient that s/he has an appreciation of his/her illness and the consequences thereof.
  
- o. One of the most important recommendations that can be suggested on the topic of euthanasia is education. Information should be made readily available as to how the practice can be legally elicited and practiced and the repercussions of practising euthanasia without important elements being fulfilled first. Educating society about what euthanasia entails is most important because it provides people with the ability to make informative decisions and form complete opinions about the topic.

Taking into consideration the number of factors and administrative aspects governing the procedural aspect which must be maintained, regard must also be given to an individual's rights to choice and autonomy. Euthanasia is a consideration which must be decided upon and the mere argument that it will lead to abuse or non-voluntary euthanasia holds no tenure within a

developing country that centralizes on important aspects such as reform, freedom and rights-based arguments that advance human dignity, autonomy and security of person.

The Dutch position, often cited by euthanasia proponents as a model, [no doubt owing to its lengthy tenure on the practice of euthanasia], demonstrates the advantages and benefits of practicing euthanasia in other jurisdictions.<sup>307</sup> In a way, the Netherlands and Canada facilitate a model social, legal and medical experiment. It has been submitted that this experiment is open for analysis and may provide important lessons for other countries attempting to legalize euthanasia.<sup>308</sup> Essentially, the Netherlands experience is an indication that euthanasia can be practised in a humane manner in accordance with a patient's wish, serving such a patient's wish without any evidence of large-scale abuse or extension of the practice.<sup>309</sup>

#### 4.3. *Criminal Sanctions – Minimum Sentencing Legislation*

Section 51 of the Criminal Law Amendment Act<sup>310</sup> was enacted to make provision for serious crimes and the sentencing of serious offences. It is submitted that such legislation can be usefully implemented in instances when there is an abuse of euthanasia and perpetrators need to be penalised. Such instances would entail the practice of euthanasia without the consent of the patient or without proper procedures and regulations being adhered to. In these instances, the perpetrator's conduct should be treated as a serious crime. Schedule 2 Part 1 of the minimum sentencing legislation regulates serious crimes pertaining to murder and sentences the perpetrator to life imprisonment when the murder is (a) planned or premeditated; and/or (b) the victim is a minor; and/or (c) is a physically disabled person who, due to such physical disability is rendered vulnerable; and/or (d) is a victim that is mentally disabled as contemplated in terms of the Criminal Law (Sexual offences and Related Matters) Amended Act, 2007; and/or (e) involves the infliction of serious grievous bodily harm.

Essentially a perpetrator committing (a) Part II of Schedule 2 offence may be sentenced in accordance to the following sanctions-

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<sup>307</sup> *Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 391

<sup>308</sup> *Voluntary Euthanasia and the Common-law* *ibid* (fn 204 above) 391

<sup>309</sup> Pabst Battin M, 'Holland and Home: On the Exportability of Dutch Euthanasia Practices' in Aycke and Snook, *Right to Self-Determination* cited in M Otlowski, 'Voluntary Euthanasia and the Common Law at 451

<sup>310</sup> Act 105 of 1997

- (i) a first offender, to imprisonment for a period not less than 15 years;
- (ii) a second offender of any such offence, to imprisonment for a period not less than 20 years; and
- (iii) a third or subsequent offender of any such offence, to imprisonment for a period not less than 25 years;<sup>311</sup>

Part II of Schedule 2 can extend its applicability to practitioners and unauthorised individuals that facilitate the practice of euthanasia without having followed the relative protocol or directive available, should euthanasia be legalised. This enables the High Court or the Regional Court, having jurisdiction over the perpetrator to sanction the perpetrator in accordance to his criminal liability. The decision to sanction a perpetrator for the offence of murder is a decision that can be implemented on account of the perpetrator first undergoing an investigation by a disciplinary tribunal that conclusively finds the perpetrator did not (a) lawfully follow the guidelines available to practice euthanasia and/or, (b) did not have the necessary authority to practice euthanasia, thus enabling the tribunal to submit their report to the prosecutor and the state to proceed with a formal criminal investigation and subsequently charge the perpetrator.

#### 4.4. *Conclusion*

Safeguards against abuse are administrative functions. Upon vigorous application of a legislative procedure and regulations the likelihood of abuse can be curbed, guarded against. Deviations from the procedure can hold physicians criminally liable and subject them to civil disciplinary hearings.

As indicated above, both Canada and Netherlands have been lauded by pro-euthanasia scholars that advocate for the ban to be lifted in South Africa. Both these jurisdictions are admirable for their non-resistance of the inevitable and their liberal interpretation of an individual's right to life, choice, freedom and security of person and his/her right to autonomy.

Whilst it might be a topic that attracts much public sympathy and simultaneously increases antagonism amongst various religious groups, the debate is one that must be pursued from a practical and rights-based point of view exclusive of emotive argument. Although, 'for those

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<sup>311</sup> Schedule 2, Part 1 of the Criminal Law Amendment Act 105, 1997



suffering unbearably and coming to the end of their lives, merely knowing that an assisted death is open to them can provide immeasurable comfort<sup>312</sup> and allowing them to seek death as an alternative, in the manner of their choice is not only an act of mercy but an enunciation of the application of the rights situated within the South African Bill of Rights.

Conclusively, there are various recommendations that can be successfully instilled and implemented within legislation to regulate euthanasia. Such legislation can ultimately lead to the successful implementation of regulations which will give rise to reasonable and practical policies, guidelines and directives in order to curb abuse.

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<sup>312</sup> 'Let Me Die How I Want - Tutu' *Saturday Citizen* 8 October 2016 at 8

## CHAPTER 5: CONCLUSION

The relationship between all human rights is symbiotic in nature i.e. one right cannot exist without depending on the right of another.<sup>313</sup> This means that the right to dignity, equality, life, freedom and security of person are all interrelated rights. Support of such interrelation can be found in *Purhoit*<sup>314</sup> where the court held:-

Human dignity is an inherent basic right to which all human beings, regardless of their mental capabilities, or disabilities as the case may be, are entitled to without discrimination. It is therefore an inherent right which every human being is obliged to respect by all means possible and on the other hand it confers a duty on every human being to respect this right.<sup>315</sup>

The Canadian and Dutch legal regimes are accepted as sources from which South African jurisprudence derives an understanding of its legal regimes and developments. They are also legal regimes that have extensive development in the field of euthanasia. Both of these jurisdictions have endorsed the practice of voluntary active euthanasia and physician-assisted suicide with successful policies and regulating legislation. Similarly, South African law derives fundamental rights and an understanding of these fundamental rights from Canadian and Dutch jurisprudence. Both of the aforementioned jurisdictions, having analysed and assessed the right to life, freedom and security of person, equality, autonomy and dignity in conjunction with a patient's request to be euthanized, have consented to the practice and implemented regulations to that effect. The conclusive outcome of the analysis of these rights by the courts found that the prohibition on euthanasia was unjust and infringed on fundamental human rights on a number of levels that were not compatible with human rights.

It is therefore submitted that South Africa is in a more socially and politically evolved position to develop the common-law by interpreting fundamental human rights more contextually, broadly and contemporarily. In addition, consideration of international changes which

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<sup>313</sup>Mbazira, C "Realizing Socio-Economic Rights in the South African Constitution: The Obligations of Local Government – A guide for Municipalities" *Community of Law Centre, Western Cape* 1.

<sup>314</sup>*Purohit and Moore v Gambia* Communication 241 /2001, 16<sup>th</sup> Annual Activity Report (ACHPR) @para 57

<sup>315</sup>*Supra* (see note above)

contributed in uplifting the blanket ban on euthanasia and physician assisted suicide should be referred to for guidance.

The *Rodriquez* case is without a doubt an advanced milestone and a leading contemporary case. This case indicates the advancements that can be expected in medical and legal development, as well as being a case that encourages the development of the common-law whilst simultaneously enhancing jurisprudence on an international level.

Whilst the *Rodriquez* and *Carter* cases both appear to be influentially probing cases on an international plane, the findings of the *Stransham-Ford* judgment follows close by with its findings that South African law taken from Canadian law should encourage these developments in disbanding the prohibition on assisted suicide and voluntary euthanasia.

The presumption that the likely occurrence of abuse occurring is an inevitability in all areas of law. The fact that legislation may be introduced as a means to curb abuse and limit it says much for the control that the state will be exercising in dispensing with its responsibility to ensure against abuse regarding euthanasia. Therefore by introducing legislation, the state would be able to control the practice of a new piece of legislation such as one that regulates euthanasia. Abuse is expected in newly introduced developments, in all different areas of and aspects of law which introduces new and unfamiliar inventions to society making discoveries such as developments and discoveries in technology, medicine, and even law seem strange to society.

It is understandable that to a large extent the state's concern with the legalisation of euthanasia has much to do with the definition of murder and the relationship it shares with the voluntary and assistance aspect situated within voluntary euthanasia and physician-assisted suicide, respectively. Concerns that the legalization of euthanasia would lead to large scale murders being committed under the pseudonym of voluntary euthanasia and physician-assisted suicide cannot be supported or deemed to be justified in a liberal state upholding fundamental rights such as dignity, life, autonomy, freedom and security of person, and freedom of choice. It has been submitted that the paternalistic stance taken against euthanasia by such states, case in point being South Africa, is unjust because it imposes on one's rights unfairly and arbitrarily.

Initially the concept and reason of murder as a crime was formulated because it affected the state's interest in the lives of those situated within its jurisdiction.<sup>316</sup>

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<sup>316</sup>*S V Robinson* 1968 (1) SA 666 (A)

However, jurisdictions such as Canada, Switzerland, and Netherlands have gravitated towards a patient-centred and rights-based approach after finding that there is substantial and unjustified infringement on the prohibition of euthanasia. The South African case of *Stransham-Ford* is a lucid indication of the evolving position, the need for legal reformation and calls for the development of the common-law stance on euthanasia.

Accordingly, the Draft Bill on the End of Life Decisions Act attempts to create and facilitate a position within South Africa for the advancement of euthanasia and develop the common-law. Apart from the Draft Bill, there has been significant growth and development on an international and national plane for legislative enactments to regulate euthanasia. The law is firmly recognised as an instrument of evolution, constantly adapting to societal growth. As a result of this growth arguments for and against euthanasia are frequently volleyed amongst scholars. Some of these arguments against euthanasia have been premised on the basis that it amounts to murder, however these arguments relative to murder can no longer be championed as a credible arguments dominating the debate. This is because there are many potent factors that have been raised in Chapters three and four which indicate that the prohibition unjustly infringes on fundamental human rights as there are recommendations available within which the practice can be successfully implemented.

Certainly, it is important that there be safeguards available in order to curb abuse and more importantly, prevent instances of abuse from occurring and recurring. On this view it has been submitted that consultation processes be monitored and executed with finesse and that advance directives and certificates be executed and issued only in instances where the wishes of the patients have been communicated in an informed environment and the patient has mental capacity. In addition, recommendations to ensure that the request of a patient is made independently and submitted upon informed consent essentially emphasises the importance of safeguarding patients' rights and ensuring procedures of executing the requests are executed legally, in a transparent, carefully defined and controlled environment free of influence and compulsion.

As it stands, South African law prohibits any form of act executed with intent to kill a person and characterises such an act as murder that will ultimately result in the perpetrator being subjected to punitive procedures and criminal liability. However, comparative jurisprudence sharing similar legislative framework to South Africa has successfully enforced legislative measures which can be effectively recommended and successfully executed within South

Africa. Understandably socio-economic factors create differences amongst South Africa, Canada and Netherlands, it is submitted that South Africa can look to these different jurisdictions for ideas on development in legal framework. These frameworks are recommended as a progressive means to developing the common-law in South Africa, along with the assistance of organizations in support of euthanasia.

In conclusion, euthanasia is a compelling topic, regulating much argument amongst academics worldwide. However, when all is said and done, it will undoubtedly remain a very poignant and sensitive topic both internationally and nationally unless advancements are created and effected through legislation to de-ban the prohibition on the practice in order to accommodate for a more realistic and human rights-based approach. “Closer to home and in South Africa, the debate will undoubtedly continue to simmer amongst many academics as well as medical and legal practitioners all of whom sharing varying opinions about whether or not to allow euthanasia in South Africa”.<sup>317</sup> Ultimately, current case law has now effectively and presumably usurped much of the common-law hold on the topic and made it impossible for South Africa to be sure of the position. Euthanasia has undoubtedly become a topic ripe for the Constitutional Court’s determination. “Whilst many believe that South Africa isn’t ready to make euthanasia legal and that in the first instance importance should be placed on providing quality healthcare, current jurisprudence effectively says otherwise”.<sup>318</sup> Perhaps in the end, it might be worth considering what Professor Davison said in that, “It is the individual who has to accept the consequences and the most important thing is that the intention is about kindness”.<sup>319</sup>

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<sup>317</sup>J Meuwissen, ‘Is Dying a Choice?’ available at <http://www.capechameleon.co.za/printed-issue/issue-18/health/> accessed on 24 April 2016

<sup>318</sup> *ibid* (see fn 318)

<sup>319</sup> *ibid* (see fn 318)

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Reports



17 March 2017

Ms Alia Alli (210503173)  
School of Law  
Howard College Campus

Dear Ms Alli,

**Protocol reference number: HSS/0243/017M**

**New project title:** The "Murder or Mercy" debate surrounding Euthanasia in South Africa: A discussion on the current South African legal position in light of case law, a comparative study to foreign jurisdictions and recommendations made by the South African Law Reform Committee

**Approval Notification – Amendment Application**

This letter serves to notify you that your application and request for an amendment received on 16 March 2017 has now been approved as follows:

- Change in Title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

**PLEASE NOTE:** Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for period of 3 years from the date of original issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

Dr Shenuka Singh (Chair)

/ms

cc Supervisor: Professor Shannon Hoxcor  
cc Academic leader Research: Dr Shannon Bosch  
cc School administrator: Mr Pradeep Ramsewak

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