

**PHYSICIAN-ASSISTED SUICIDE IN SOUTH AFRICA–
A CONSTITUTIONAL PERSPECTIVE**

BY

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DECLARATION

I, Nomfundo Sipunzi, with registration number 207523116, hereby declare that the thesis entitled:

“PHYSICIAN-ASSISTED SUICIDE IN SOUTH AFRICA - A CONSTITUTIONAL PERSPECTIVE”

is the result of my own unaided research and has not been previously submitted in part or in full for any other degree or to any other University.

Signature.....

Date.....

DEDICATION

I dedicate this work to my children Piko and Qhawekazi Sipunzi.

ACKNOWLEDGEMENT

I am indebted to a number of people who have directly and indirectly assisted me in writing this dissertation. I would like to thank my children who have been patient and supportive as I spent most of what would have been family time on this work.

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ABSTRACT

Physician-assisted suicide is a form of active euthanasia where a physician, in response to a request from a terminally ill patient, assists such patient to commit suicide or provides the patient with means of committing suicide.¹ Active euthanasia is illegal in South Africa. In a circumstance where physician-assisted suicide may be requested in a jurisdiction in which active euthanasia is still illegal, this therefore raises questions about balancing the realization of the rights to life and human dignity with the rights of the patient to self-determination or respect for patient autonomy. The right to life; to dignity; to freedom and security of a person; to privacy and to health care, food, water and social security, amongst others, are guaranteed in South Africa.²

The state has a duty to respect, protect, promote and fulfil these rights by ensuring their full and equal enjoyment as they are also founded on the values and principles of human dignity, equality and freedom. These rights are not unique to South Africa, they are also enshrined in various international instruments and declarations³ that form part of the international customary law. In the South African context, the meaning of “right to life” has been pronounced upon by the constitutional court.⁴ It is thus necessary to consider the question as to whether the equal realization of these rights particularly in the healthcare environment, should also include that the terminally ill are allowed, in certain circumstances, to decide when and how to end their lives with or without the assistance of a medical practitioner without attracting any adverse legal consequences. In South Africa, patient autonomy and the rights of patients to decide if they want a particular treatment, even if their choice will cause them to die, are protected rights. However, there is no clear legal framework or mechanism that guides those who seek to exercise these rights, for instance where a terminally ill patient opts for some form of euthanasia and the extent to which they could exercise this choice without violation of any laws of the Republic or risking punishment. There are various forms of euthanasia

¹ P Casterns and D Pearmain. Foundational principles of South African Medical Law, Chap 2: 204

² Bill of Rights, Chapter 2 of the Constitution of the Republic of South Africa

³ For example, The Universal Declaration of Human Rights. (1948), and the African Charter on Human and Peoples Rights, Art 16

⁴ 1995 ZACC 3 391

that a patient and/or the healthcare professional involved might choose to employ in order to hasten one's death, but euthanasia in any form is illegal in South Africa, unless the court orders otherwise. The debate on this subject is influenced by various factors, including the advancing medical technology that have the effect of prolonging one's life, the developments in jurisprudence on cases that are taken through the courts and the convictions of various interest groups.

This dissertation considers euthanasia in general, and analyses local South African developments and international advances in the law and public opinion, with the intention of promoting the progressive evolution of South African law on this subject.

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CHAPTER ONE INTRODUCTION

The purpose of this dissertation is to examine the concept of the right to life in the South African context in comparison with the right of terminally ill patients to decide when they can be legally assisted to end their lives within the legal framework and without adverse consequences to those assisting them. This study seeks to clarify the extent to which these rights may be freely guaranteed in the Bill of Rights without resulting in healthcare professionals who care for them in contravention of any laws and failing in their professional and ethical responsibilities.

This dissertation shall examine the practice in jurisdictions such as The Netherlands and Belgium which were among the first to legalise euthanasia, as well as in constitutional democracies such as India and Canada which have similar constitutions to that of South Africa. It is noteworthy that Canada has recently legalised physician-assisted suicide in some form. India, on the other hand, has not. Before euthanasia was legalised in these countries the procedures and circumstances under which euthanasia could be permitted were developed over time by various institutions with interest, including the courts.

In light of the recent South African judgments and public discussions on the subject, an understated need for a clear legal framework on the resolution of relevant competing rights in relation to physician-assisted suicide exists, and suggestions and recommendations shall be made.

1.1 RESEARCH QUESTION

The focus of this dissertation is what should be done within the prescripts of the South African constitution to clarify the legal position and proposing a suitable legal framework on the subject of physician-assisted suicide.

The following questions will be addressed to achieve the purpose of this study:

1. What is the background or history of euthanasia?
2. What is the current legal position in South Africa?
3. What is permissible in other jurisdictions in terms of foreign law (a comparative analysis)?
4. What would be appropriate legislation for South Africa?
5. How will the medical profession be affected if a suitable legislation is passed?

1.2 RESEARCH METHODOLOGY

The research will be library based with no collection of data, surveys or interviews.

This dissertation will be structured in the following sequence:

Chapter One shall provide a brief introduction of the topic under discussion. The chapter will comprise of the research question, the research methodology and the literature review.

Chapter Two shall trace the historical background of euthanasia as a concept that became a controversial worldwide subject. It shall provide the definition of various forms of euthanasia as understood and defined in sources by various authors with legal and medical backgrounds.

Chapter Three will mainly focus on the current legal position in South Africa, looking at the position in common law, the constitutional framework, the statutes that regulate the healthcare sector and the profession of medicine, and the developments in policy on euthanasia. The emphasis will be mainly on the Bill of Rights, looking closely at those rights that are central to the discussion on the implementation of euthanasia in any given form. This chapter shall also look at the discussion paper of the South African Law Commission on "euthanasia and the artificial preservation of life and end of life decisions", Project 86 of 1997 where a study of the legal position of the subject in South Africa, coupled with a comparative study of the same in other countries was done and a proposed draft bill with recommendations was developed.

Chapter Four will provide an overview of the legal and policy position in various other jurisdictions that have legalised euthanasia in one form or another, including Canada, where physician-assisted suicide was legalised in June 2016, and Belgium and The Netherlands where some forms of euthanasia were legalised in 2002. The developments in India shall also be discussed, mainly to assess the role of the courts and the influence of their Constitutional frameworks.

Chapter Five shall conclude with a comparative analysis of the positions in the various jurisdictions and the influences that such may have on potential South African legislation with recommendations guided by the South African legal framework and the bill drafted by the South African Law Commission, whilst ensuring that the end product remains constitutionally competent.

1.3 LITERATURE REVIEW

Information sources shall include international law, domestic and selected foreign legislation, domestic and foreign case law, research by various scholars and the developments in South Africa's policy framework. These will also include journal articles, books, discussion papers by commissions, and papers by scholars who have weighed in on the continuing debate. Case law will be used to assess the role played by courts in various jurisdictions, and their application of legal principles to the merits of specific and unique cases presented by litigants. There shall be an analysis of the contribution of other professional bodies in regulating the medical profession on the responsibilities and role of healthcare practitioners to their individual patients and, their profession.

A brief view of some of the authors will suffice in this introduction. In "Foundational Principles of South African Medical Law"⁵, Carstens and Pearmain, infuse the law and the medical science into the current South African constitutional dispensation. They

⁵ P Casterns and D Pearman *Foundational Principles of Medical Law*. (2007) Chapter 2

create a comprehensive study on the application of our constitutional values, principles and the law in general into the field of medicine.⁶

In “Medical Law Text, Cases and Materials”⁷, Jackson highlights the experiences and dilemmas of people in the United Kingdom on end of life decisions through court judgments. The author looks at the legal developments in “The Netherlands, Switzerland, Belgium and Luxembourg, where euthanasia is legal”⁸, and a comparative study of the United Kingdom where euthanasia is still illegal and investigates how practices in the medical profession, including court judgments, contribute to the gradual development of policy direction and legislations.⁹

In “Principles of Medical Law”,¹⁰ Grubb, Laing and McHale provide a balanced analysis of how in the United Kingdom the common law and regulations or statutory law position itself on euthanasia or end of life decision making impact on the experiences of terminally ill patients who would wish to exercise their autonomy, as well as the dilemmas of those in the medical profession. Their account reflects identical challenges to those experienced in South Africa.

In a detailed review, Griffiths, Meyers and Adamin Euthanasia and Law in Europe¹¹ describe the substantive law applicable to some “forms of euthanasia and physician-assisted suicide and the position in European countries that do not have a structured legal framework on the subject.”¹²

“The South African Law Reform Commission (Project 86) on euthanasia and the artificial preservation of life was established by the South African Law Commission Act, Act 19 of 1973.”¹³ The Commission’s report considered various view points, including court

⁶ P Casterns and D Pearman *Foundational Principles of Medical Law*. (2007) Chapter 2

⁷ E Jackson *Medical Law Text, Cases and Materials* 3 ed (2013)

⁸ <http://www.polity.co.za/pdf/SAHCRReport.pdf>

⁹ E Jackson. *Medical Law Text, Cases and Materials*. 3 ed. (2013)

¹⁰ Grubb Laing McHale eds *Principles of Medical Law* 3ed (2012)

¹¹ Griffiths Meyers and Adam *Euthanasia and the law in Europe* 3 ed (2008)

¹² Ibid

¹³ South African Law Commission Discussion Paper 71 Project 86 “Euthanasia and the Artificial Preservation of Life” 1997

judgments on euthanasia and/or artificial preservation of life and scholarly contributions with recommendations to the government on a competent framework for the South African context concluding by developing 'A Draft Bill on End of Life Decisions'¹⁴. The proposed bill included requirements that should be met before a medical practitioner carry out the patient's request, namely:

- "The patient must be terminally ill;
- be subject to extreme suffering;
- be mentally competent;
- that a second independent medical practitioner must confirm the diagnosis; and
- that findings must be recorded in writing, based on an informed consent and a well-considered and repeated requests of the patient."¹⁵

This proposal is yet to be considered by law makers for implementation as a legislation that addresses various concerns, questions and interests on the subject.

¹⁴ Ibid

¹⁵ I Currie and J De Waal. *The Bill of Rights Handbook*. 6 ed. (2013) 258

CHAPTER TWO EUTHANASIA IN GENERAL

This chapter shall trace the meaning and development of the practice of euthanasia as a concept, and include a background of the controversial debate that has been ongoing.

2.1 Definitions and forms of euthanasia

“The word euthanasia was first used in a medical context in the seventeenth century to refer to painless, happy death, during which it was a physician’s responsibility to alleviate the physical sufferings of a body.”¹⁶ According to life.org.nz, “In ancient Greece, suicide of the patient who was suffering extreme pain and had an incurable terminal illness was made easy and for this reason, the physician gave him medicine (a poisoned drink). “In ancient Rome, euthanasia was a crime and this action was regarded as murder.”¹⁷ “According to the historian N.D.A. Kemp, the origin of the contemporary debate on euthanasia started in 1870.”¹⁸

According to SA Strauss,¹⁹ “during the nineteenth century the word “euthanasia” came to be used in the sense of aid to the dying and the destruction of the so-called “worthless” life and to-date, it is used as a synonym for active mercy-killing.” Euthanasia is classified in various forms, depending on the method and mechanism used, to hasten one’s death.

Physician-assisted suicide, the main focus of the discussion, “is where a physician supplies information and/or means of committing suicide, by for instance giving a prescription for a lethal dose of sleeping tablets to a patient in order for them to terminate their life.”²⁰ Put differently, it is done by providing a competent patient with a method for the patient to use with the primary intention of ending his or her own life; the patient himself or herself needing to have to administer the medication directly or

¹⁶ Euthanasia. Wikipedia. <https://simple.m.wikipedia.org> Accessed in July 2016

¹⁷ www.life.org.za.nz/euthanasia/about_euthanasia/history-euthanasia “The General History of euthanasia/the life resources charitable trust” Accessed in July 2016

¹⁸ Ibid

¹⁹ SA Strauss. *Doctor, patient and the law*. 3 ed. (1991) 342

²⁰ P Casterns and D Pearmain. *Foundational principles of South African Medical Law* (2007) Chap: 2, 204

through a machine.”²¹“Active euthanasia involves unlawfully and intentionally causing the death of a human being through a direct act.”²²“Physician-assisted suicide is thus a moral dilemma and a controversial subject that has captured the interest of media, public, politicians and the medical profession.”²³

“Passive euthanasia involves the hastening of the death of a person by withdrawing some form of life-sustaining support and letting nature take its course.”²⁴ The most common method is where the patient is given a large dosage of morphine to control pain, in spite of the likelihood of the pain-killer suppressing respiration and causing death earlier than it would have otherwise have happened.²⁵

“Voluntary euthanasia can be described as the causing of death of the patient with their consent or where there is an advance directive in the form of a living will whilst involuntary euthanasia is where the causing of death of a patient is not the wish of that patient.”²⁶

According to Nordqvist,²⁷“this type of euthanasia is known as assisted suicide (assisted dying), or doctor-assisted suicide, or more loosely termed mercy killing, inferring the taking of deliberate action with the express intention of ending a life to relieve intractable (persistent, unstoppable) suffering.”“Since 2009, voluntary euthanasia has been legal in Belgium, Luxembourg, The Netherlands, Switzerland and the states of Oregon and Washington in the USA.”²⁸ Nordqvist argues “that the definition between active and passive euthanasia is not clear-cut, citing an example that if a doctor prescribes increasing doses of opioid analgesia (strong painkilling medication) which may eventually be toxic for the patient, some may argue as to whether active or passive

²¹ F Khan and G Tadros. “Physician-assisted suicide and Euthanasia in Indian Context: Sooner or Later the Need to Ponder.” (2013) Jan-Mar 35(1): *Indian J Psycho Med* 101-105 and also see P Carsterns and D Pearmain. *Foundational principles of South Arican Medical Law, 2007*

²² Ibid

²³ <http://www.mercatornet.com/careful/view/14830>

²⁴ P Casterns and D Pearmain. *Foundational principles of South African Medical Law, (2007)* Chap: 2 204

²⁵ Ibid, 203

²⁶ Ibid. 204

²⁷ C Nordqvist. “Euthanasia and Assisted Suicide.” (8 Apr. 2016) *Medical News Today. Med Lexicon, Intl.* 2017
<[http:// medicalnewstoday.com/articles/182951.php](http://medicalnewstoday.com/articles/182951.php)> (Accessed: 11 Jan 2017)

²⁸ Ibid

euthanasia is taking place.²⁹ In most cases, the doctor's action is seen as a passive one.³⁰ Many claim that the term "active" is incorrect, because there is no intention to take life.

Nordqvist defines "active euthanasia as a procedure where lethal substances or forces are used (directly) to end the patient's life, including life ending actions by the patient or somebody else, a process that has attracted much controversy and a variety of strong views based on religious, moral and ethical perspectives."³¹

From a medical perspective, in Med Lexicon's medical dictionary³², "euthanasia is a quiet, painless death or the intentional putting to death of a person with an incurable or painful disease intended as an act of mercy". Active euthanasia is "*the mode of ending life in which the intent is to cause the patient's death in a single act (also called mercy killing)*", whilst "*passive euthanasia is a mode of ending life in which a physician is given an option not to prescribe futile treatments for the hopelessly ill patient.*"³³

The definitions and the classifications also do not reveal substantial differences on the understanding of the concept, but rather a reflection of various professional backgrounds. In this research, the terms "physician-assisted suicide, euthanasia and doctor assisted suicide" shall be used interchangeably and unless where a distinction is explicitly pointed out.

2.2 The debate on euthanasia

During the 15th and the 16th centuries, authors in Germany and England raised the question whether, in certain cases, euthanasia was permissible, and this spread to other countries.³⁴ "In the nineteenth century in Germany, the debate became public where some spoke of destruction of lives that are unworthy to be lived, some referring to the

²⁹ Ibid

³⁰ C Nordqvist. "Euthanasia and Assisted Suicide." (8 Apr. 2016) *Medical News Today. Med Lexicon, Intl.* 2017 <<http://medicalnewstoday.com/articles/182951.php>> (Accessed: 11 Jan 2017)

³¹ Ibid

³² Ibid

³³ Ibid

³⁴ PH Schepens. Euthanasia: Our Own Future? 3(4):1988 *Issues in Law & Medicine.* 372

mentally ill, the feeble-minded, deformed and retarded children.”³⁵ This led to a policy where children born with defects, mental retardation and genetic diseases were subjected to a euthanasia program which was later extended to include healthy Jewish children, and subsequently extended to adult Jews, gypsies, mental patients, Russians and prisoners in concentration camps.³⁶ These were also clearly human right violations, including possibly genocide and war crimes. Since then, however, various countries and jurisdictions continued to develop varying policies and laws on euthanasia for its medical purpose. “After criticism of the practice, including by the courts, in 1948 The Universal Declaration of Human Rights was declared and which provided that everyone has the right to life, liberty and security of person.”³⁷ In the African human rights context, “human beings are inviolable”³⁸. “Every human being shall be entitled to respect for his or her life and the integrity of their person and no one may be arbitrary deprived of this right.”³⁹ This became international customary law and rendered the practice of various forms of euthanasia controversial, reigniting a debate which raised legal and ethical implications of the practice.

In South Africa, euthanasia remains a subject of debate among various disciplines and the courts continue to develop the jurisprudence on the subject, reflecting on the developments in society and the advancing medical technology as will be illustrated hereunder. Central to the discussions are varying and competing rights that are enshrined in the South African Constitution Bill of Rights, the main issue being the extent to which patient autonomy may be respected or realized with minimal or no state interference in the realization of these rights, including the right to determine when one should end their lives when terminally ill.

From these definitions and when looking at the background history of euthanasia and the debates, it can be noted that it still remains controversial worldwide.

³⁵ K Moodley. *Medical ethics, law and human rights: a South African perspective*. 1 ed. (2011) 267

³⁶ *Ibid* 268

³⁷ Universal Declaration of Human Rights. (1948) Article 3

³⁸ African Charter on Human and People's rights (Banjul Charter) (1981) Article 4

³⁹ *Ibid*

CHAPTER THREE

THE CURRENT LEGAL POSITION OF EUTHANASIA IN SOUTH AFRICA

In this chapter, the exercise of patient autonomy and self-determination in relation to other rights including the rights to life, human dignity, freedom and security of person, and the interpretation of these rights by various courts in application to specific disputes that had to be resolved, will be considered in terms of the debate on euthanasia. Developments in government policy in response to growing demands for consistency in realization of competing rights regarding euthanasia will be reflected upon.

3.1 COMMON LAW POSITION

In South Africa, anyone who unlawfully and intentionally caused the death of another human being is guilty of murder.⁴⁰ Depending on the circumstances in such a case, “a conviction shall be followed by a minimum sentence of fifteen years up to a sentence of life imprisonment.”⁴¹ Where it is established that one lacked the intention to cause death of another human being, but that they were negligent in their conduct, they may be convicted on a lesser offence of culpable homicide, which carries a lesser penalty. Factors that may be raised in order to avoid a conviction by anyone accused of having caused the death of another include those that exclude unlawfulness, namely necessity, private or self-defence.⁴²

McQuoid-Mason submits “that doctors are not liable for murder if they withhold or withdraw treatment or provide palliative treatment to hasten death when a patient has made an advance directive, where treatment is futile or where the burden of risk outweighs the benefit of treatment”; this is passive euthanasia.⁴³ It is on the basis that one is not caused by another to die but that the patient died as a result of their existing illness or condition. McQuoid-Mason also says that “living wills should also be

⁴⁰ JM Burchell. *Principles of criminal law*. 2 ed. Chap: 48 (2005) 466; CR Snyman. *Criminal law*. 4 ed. Chap: 15, 421

⁴¹ Criminal Law Amendment Act, Act 105 of 1997, Section 51

⁴² *Ibid*

⁴³ McQuoid-Mason DJ “Emergency medical treatment and “do not resuscitate” orders: when can they be used?” (2013) 103(4) *SAMJ*, 223; *C v. Hurst* 1992 4 SA 630 D, where the deceased had a living will with advanced directive.

understood not to be wills in the general sense but as merely a standing request to medical staff to act in a specific manner in specific circumstances and may be a legitimate refusal of consent to treatment, which medical practitioners are obliged to comply with".⁴⁴

Some argue that the distinction between passive and active euthanasia is artificial because both acts require a positive act on the part of another person as passive euthanasia may involve the pulling off of a plug of a ventilator or turning down of a pacemaker.⁴⁵ In this context, it would appear that in some instances some sectors of society are allowed or permitted by the law to take others' lives without any legal implication. If the right to life is absolute or if the sanctity of life is of paramount importance and also informs our constitutional values, it creates an inconsistency in the manner in which the law is applied. Those who have reflected on this distinction feel that it is only cosmetic, and whether death is a result of omission or commission by the doctor there is still a conduct that led to the death of the terminally ill patient.

3.2 THE CONSTITUTIONAL LEGAL FRAMEWORK

South Africa is "a constitutional democracy and its constitution is based on the values of human dignity, equality, freedom and respect for human rights."⁴⁶ "The Bill of Rights in Chapter 2 of the constitution is the cornerstone of the South African democracy as it guarantees the rights of all people in South Africa, affirming the democratic values of human dignity, equality and freedom."⁴⁷ "Every person in South Africa is guaranteed the right to freedom and security of the person, which includes the right not to be treated or punished in a cruel, inhuman or degrading way, and the right to bodily and psychological integrity, which includes the right to security in and control over their bodies."⁴⁸ "Everyone has the right to life"⁴⁹; has inherent dignity and the right to have their dignity protected."⁵⁰

⁴⁴ *ibid*

⁴⁵ DJ McQuoid-Mason Pacemakers and end-of-life decisions. 2005 (95) *SAMJ*, 566

⁴⁶ The Preamble of the Constitution of the Republic of South Africa

⁴⁷ The Constitution of the Republic of South Africa, Section 7. It also places a duty on the state to respect, promote, protect and fulfil the rights in the BOR

⁴⁸ The Constitution of the Republic of South Africa, Section 12

The Constitution further states that “the interpretation and the direct or indirect application of these rights must promote values that underlie an open and democratic society based on human dignity, equality and freedom; must consider international law and may consider foreign law.”⁵¹ It is the equal realization of these rights that is at the centre and subject of the continuing debate on whether it should be permissible for a terminally ill patient, whose health condition is irreversible, who is competent and continuously request to be assisted to die and to do so without violating any laws or making themselves or their doctors guilty of any crimes. The South African courts have on various occasions given context or meaning to these rights, and in their interpretation of them also developed our common law in line with the values. These interpretations, as it will be outlined below, may in various forms impact on the feasibility of regulating the legality or not of euthanasia in South Africa.

3.2.1 Right to human dignity

This is a right that finds recognition in the international human rights law. “Recognition of the inherent dignity and/of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.”⁵² Section 10⁵³ of the South African Constitution provides that”:

“Everyone has inherent dignity and the right to have their dignity respected and protected.”

“Human dignity is seen by some as a central value of an objective, normative value system, established as a pre-eminent value.”⁵⁴ Oliver Njuh Fuo⁵⁵ “noted that in South Africa, human dignity doubles as a founding constitutional value and a self-standing

⁴⁹ Ibid, Section 11

⁵⁰ Ibid Section 10

⁵¹ Ibid Section 39 (1)

⁵² The 1948 Universal Declaration of Human Rights, Preamble

⁵³ The Constitution of the Republic of South Africa, Section 10

⁵⁴ I Currie and J De Waal. *The Bill of Rights Handbook*. 6 ed. (2013) 250

⁵⁵ O Njuh Fuo. LLD student, North West University (Potchefstroom Campus), South Africa. “*The Role of Local Government in Realising the Rights to social Protection in South Africa*” *sert title of paper*”. Paper presented to the session of the ACNL Working Group on Social and Economic Rights in Africa ANCL Annual Conference: Rabat, Morocco, 2-5 February, 2011.

right. In terms of the Constitution, the concept of dignity has a wide meaning which covers a number of different values.”⁵⁶ In *Le Roux v Dey*,⁵⁷ the court argued that this right is meant to protect both individual right to reputation and a person’s sense of worth as opposed to common law, which gives it a narrow meaning.”⁵⁷ The court also went further and added that dignity relates to the individual’s self-respect. “The protection of the right to human dignity requires all to acknowledge the value and worth of all individuals as members of the society.”⁵⁸ In *Barkhuizen v Napier*⁵⁹ “the values of dignity and freedom were held to underlie the principle of *pacta sunt servanda* (meaning “*agreements must be kept*”), where it emphasized that self-autonomy, or ability to regulate one’s own affairs, even to one’s own detriment, is the very essence of freedom and vital part of dignity.”

It has also been argued that “human dignity is not only a justiciable and enforceable right that must be respected and protected, it is a value that informs the interpretation of all the other fundamental rights and is of central significance in the limitations enquiry.”⁶⁰ Pierre De Vos et al.⁶¹ also state that “human dignity must be interpreted as a right on its own as well as a value that must be invoked to interpret other rights in the Bill of Rights.” In *Dawood and another v Minister of Home Affairs and others*⁶², it was emphasised “that human dignity informs the constitutional adjudication and interpretation at various levels.” “It is a value that informs the interpretation of many other rights, including the right to life, the right to equality, the right not to be punished in an inhuman or degrading way, and is central to the limitation analysis.”⁶³ In its interpretation of the right to human dignity, the Constitutional court also, in *National Coalition for Gay and Lesbian Equality v Minister of Justice*,⁶⁴ held “that it is clear that the constitutional

⁵⁶ I Currie and J De Waal. *The Bill of Rights Handbook*. 6 ed. (2013) 251

⁵⁷ 2011 (3) SA 274 (CC) 138

⁵⁸ *Ibid*

⁵⁹ 2007 (5) SA 323 (CC) 57

⁶⁰ I Currie and J De Waal. (2013) *The Bill of Rights Handbook*. 6 ed. p253, referring to the courts discussion of the link between privacy and dignity in *Dawood v Minister of Home Affairs* 2000 (3) SA 936 (CC)

⁶¹ P De Vos (ed.) et al. *South African Constitutional Law in Context*, 1 ed Chap: 12, (2014) 458

⁶² *Ibid* Chap:12 (2014) 459

⁶³ *Ibid*

⁶⁴ T Currie and J De W⁶⁴ (3) SA 936 *Dawood and another v Minister of Home Affairs and others* 2000 (CC) Para 35, also see P De Vos (ed.) et al. *South African Constitutional Law in Context*, aal. *The Bill of Rights Handbook*. 6 ed. (2013) 252, referring to *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) 29

protection of dignity requires the courts to acknowledge the value and worth of all individuals as members of society.” This means that the right to dignity has the potential to be used by the courts to deal with human rights infringements not specifically addressed by other rights that are explicitly included in the bill of rights. “It may well be that, as society involves and as we recognize new forms of the right to human indignity not captured by the Bill of Rights, the constitutional court may interpret the right to dignity to provide protection to individuals affected by these affronts to their dignity⁶⁵when it comes to the developments medicine and innovations in preservation of human life(my emphasis), making the right to dignity a powerful tool in addressing concerns that arise from realisation of the rights in the Bill of Rights.”

In *S v Makwanyane and Another*⁶⁶, O’Regan indicated that “without dignity, human life is substantially diminished”. She “argued that entrenching the founding constitutional value of human dignity acknowledges the intrinsic worth of human beings, entitled to be treated as worth of respect and concern.”⁶⁷

3.2.2 Right to life

“Everyone has the right to life”⁶⁸. “It is an unqualified right and in terms of the South African constitution, may only be limited in terms of the limitation clause.”⁶⁹ The value and nature of this right was the subject of the discussions and interpretation by the court in *S v Makwanyane*.⁷⁰ This case involved two accused persons who were convicted by the Supreme court of Witwatersrand as a court of first instance on four counts of murder, one count of attempted murder and one count of robbery with aggravating circumstances. They were sentenced to death on each count of murder and long terms of imprisonment were imposed on other counts. Their appeals to the Appellate Division against the sentences imposed were unsuccessful. The constitutional court was called upon to pronounce, inter alia, on the constitutional validity of provisions of the Criminal

⁶⁵ P De Vos (ed.) et al. *Constitutional Law in Context*, Chap: 12, 4

⁶⁶ 1995 (3) SA 391 (CC)

⁶⁷ Ibid

⁶⁸ Section 11 of the Constitution of the Republic of South Africa

⁶⁹ I Currie and J De Waal. *The Bill of Rights Handbook*. 6 ed. (2013) 258

⁷⁰ 1995 (3) SA 391 (CC) para 1

Procedure Act that empowered the court to impose the death penalty on a conviction of murder, with reference to the interim constitution and the limitation clause in section 33(1) of the Interim Constitution.

“The Justices of the court weighed in with strong views on the question that faced the court. Chaskalson J did not invalidate the death penalty on the basis that it was in conflict with the right to life, he held that it was cruel, inhuman and a degrading punishment.”⁷¹

Sachs J raised another possibility that “the right to life may impose a duty on the state to create conditions which will enable all persons to enjoy a human existence, with reference to the state’s responsibility to protect this right, in particular the obligation to make life liveable.”⁷²O’Regan J⁷³ argued “that the sanctity of human life meant that right to life was antecedent to all other rights in the constitution, was intertwined to the right to dignity and therefore incorporates a right to an existence consonant with human dignity.” She further submitted “that the inclusion of the right to life in the constitution was not simply to enshrine existence, but the right to human life and therefore right to share in the experience of humanity and the right to be treated as a human being with dignity, as without dignity, human life is substantially diminished.”⁷⁴“To her, without life, there can be no dignity.”⁷⁵

The Constitutional Court held “that the right to life and dignity are the most important of all human rights and the source of all other rights in the Bill of Rights, that by committing to a society founded on the recognition of human rights everyone is required to give preference to these rights and such must be demonstrated by the state in its business, including the way criminals are punished.”⁷⁶ The courts have been warned to ensure that in considering cases, they should not be influenced by public opinion but by the

⁷¹ I Currie and J De Waal. *The Bill of Rights Handbook*. 6 ed. (2013) 258

⁷² 1995 (3) SA 391 (CC) 353.

⁷³ I Currie and J De Waal. *The Bill of Rights Handbook*. 6 ed. (2013) 267 - 268

⁷⁴ *Ibid*

⁷⁵ *Ibid*

⁷⁶ 1995 (3) SA 391 (CC) para 144.

values of the constitution, the most important of which is the right to dignity and that the right to life, which are inextricably linked to the right to dignity, means something more than existence.⁷⁷

De Waal et al.⁷⁸“observed that, on the question of euthanasia and abortion, there seemed to be a view that the issues encroached on the difficult question of moral philosophy.”On the question raised by Mahomed J on “the meaning of life in cases of euthanasia and abortion, it was acknowledged that from a constitutional perspective, the issues call for the resolution of conflict between the right to freedom and physical integrity and the state’s duty to protect life.”⁷⁹

3.2.3 Right to freedom and security of person

Section 12 of the Constitution of the Republic of South Africa provides that:

- 1) “Everyone has the right to freedom and security of the person, which includes the right-
 - a) Not to be deprived of freedom arbitrarily or without just cause;
 - b) Not to be detained without trial;
 - c) To be free from all forms of violence from either public or private sources;
 - d) Not to be tortured in anyway; and
 - e) Not to be treated or punished in a cruel, inhuman, or degrading way.
- 2) Everyone has the right to bodily and psychological integrity, which includes the right-
 - a) To make decisions concerning reproduction;
 - b) To security in and control over their body; and
 - c) Not to be subjected to medical or scientific experiments without their informed consent.”⁸⁰

⁷⁷ DJ McQuoid–Mason. (2015) Doctor-assisted suicide: what is the present legal position in South Africa, July 105(7) *SAMJ*. (2015)526, referring to *S v Makwanyane* 1995 (3) SA 391(CC).

⁷⁸I Currie and J De Waal. *The Bill of Rights Handbook*. 6 ed. (2013) 267 - 268

⁷⁹ Ibid

⁸⁰ The Constitution of The Republic of South Africa. Section 12

Currie and De Waal⁸¹ say that “the part of “security” denotes the protection of bodily integrity against intrusion by the state and others and the “control” being the protection of one’s autonomy or self-determination against interference.” This section becomes central to those who wish to be assisted to die due to terminal illness and unbearable pain, to be left to determine what is best in their given circumstances.

In interpretation of this section, Currie and De Waal⁸² take us back to Section 11(1) Interim Constitution in the case of *Ferreira v Levin* NO1996 (1) SA 984 (CC) (54). In this case, Ackermann J. proposed a broad and generous reading of the subsection. He noted that the subsection that related to the “right to freedom was a constitutional protection of a sphere of individual liberty.”⁸³ That it also amounted to a presumption against the position of legal and other restrictions on conduct without sufficient reason. He interpreted it to mean the right of an individual not to have obstacles to possible choices and activities placed in their way by the state. Currie and De Waal then argue that “the subsequent Section 12(1) in the Final Constitution went further to specify the aspects that related to physical liberty and security and the aim to protect the bodily integrity of the individual against unwarranted intrusion by the state.”⁸⁴ They therefore argue that “the purpose of Section 12(1) is to protect an individual’s physical integrity against invasion from the public and private sources.”⁸⁵

Section 12(2) is arguably meant to provide protection of bodily self-determination.⁸⁶ For the purpose of my discussion, I shall look closely at Sub subsections (b) “Security in and control over one’s body” and (c) of Section 12(2), as they are most relevant to the issues. “The right to security in and control over one’s body, is in essence a right to be left alone and create a sphere of individual inviolability, and have different meanings.”⁸⁷

⁸¹ | Currie and J De Waal. *The Bill of Rights Handbook*. 6 ed. (2013) 287

⁸² Ibid

⁸³ Ibid

⁸⁴ Ibid

⁸⁵ Ibid

⁸⁶ Ibid

⁸⁷ | Currie and J De Waal. *The Bill of Rights Handbook*. 6 ed. (2013) 287

3.2.4 Right to health care, food, water and social security

“Section 27 of the Constitution of the Republic of South Africa provides for health care, food, water and social security, that

(1) everyone has the right to have access to-

(a) health care services, including reproductive health care,

(b) sufficient food and water and

(c) social security, including if they are unable to support themselves and their dependents, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.”⁸⁸

The right of access to health care encompassed in our Constitution is mainly inspired by Article 25 of the Universal Declaration of Human Rights, which provides in 25(1) that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”.⁸⁹ Article 12 of the International Covenant on Economic, Social and Cultural Rights⁹⁰ echoes the same rights, as it inter alia provides for “the enjoyment of the highest attainable standard of physical and mental health conducive to living life of dignity, to which South Africa is a member state.”⁹¹ Article 12(2)(d) provides for the creation of conditions which would ensure all medical services and medical attention in the event of sickness and this also speaks to the rights on the terminally ill, including respect for autonomy and self-determination of those experiencing ill health.

Our Constitution’s Section 27(1)(a) emphasises universal access to realization of rights guaranteed in this section. Section 27(1)(b) takes it further and poses a positive duty on

⁸⁸ The Constitution of the Republic of South Africa Section 27

⁸⁹ Universal Declaration of Human Rights (1948) Article 25

⁹⁰ International Covenant on Economic, Social and Cultural Rights 1966 Article 12

⁹¹ Ibid

the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. In some cases, the constitutional court was called to interpret the duties of the state when it comes to the realization of the socio-economic rights, including the right to health care, food, water and social security. Such cases include *Soobramoney v Minister of Health*,⁹² where the court also discussed the nature of socio-economic rights. The main contention was on the meaning of “reasonable measures” and “available resources” which qualified the duties of the government in ensuring realization of rights guaranteed in Section 27. The appellant was suffering from various diseases that included irreversible chronic renal failure, his kidneys failed and his life could be prolonged by the use of regular renal dialysis. He wanted this from a public hospital in KwaZulu Natal where he was refused treatment due to limited resources. A policy that was developed by the hospital for provision of the treatment excluded him. The court argued that the parameters of what was “reasonable measures” did not include failure by Government to meet the needs of the most vulnerable groups in society, and that such failure was unreasonable. The court referred to the state duties in Section 7(2) of the Constitution, which imposes “a duty on the state to respect, protect, promote and fulfil the rights in the Bill of Rights.”⁹³ On the question of available resources, the court considered the hospital’s budgetary and resource limitations. It found that the hospital policy was reasonable given the resource constraints that it was confronted by.

In *Minister of Health v Treatment Action Campaign and others*,⁹⁴ The Constitutional Court was approached to pronounce on the constitutionality of the policy that was introduced by the State on the provision of Nevirapine to HIV positive pregnant women. The State had fears about the safety of the drug and decided that it would only be dispensed to women that were at designated sites, as it investigated its efficiency and monitored the dangers that it imposed as well as side effects. There were no timeframes given for this process. It was apparent that the limited provision of the drug was influenced by any budgetary constraints. The court examined the Government’s

⁹² 1998 (1) SA 1696 (CC)

⁹³ *ibid*

⁹⁴ 2002 (5) SA 721 (CC)

policy in that regard, and found it to be unreasonable and unconstitutional and observed that HIV was of great threat to the population, even though it was one of many diseases that required urgent attention. The State was ordered to remove all restrictions that prevented doctors from dispensing the drug in public hospitals and clinics.

In a South African context, The National Health Act, Act No. 61 of 2003, gives effect to Section 27(1)(b) of the Constitution. The National Health Act⁹⁵ “aims to provide the framework for a structured, uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services, and how to provide for related matters.”

3.2.5 The limitation of the rights

Section 36 of the Constitution of the Republic of South Africa provides for instances and the manner of how the rights in the Bill of Rights may be limited. It provides “that the rights in the Bill of Rights may be limited only in terms of law of general application, to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including:

- the nature of the right;
- the importance of the purpose of the limitation;
- the nature and extent of the limitation;
- the relevance between the limitation and its purpose; and
- less restrictive means to achieve the purpose;

and except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.”⁹⁶

The essence of this provision is that it allows for the constitutionally valid limitation of rights in certain instances.

⁹⁵ The National Health Act, Act No. 61 of 2003, The Preamble

⁹⁶ The Constitution of the Republic of South Africa Section 36

3.3 THE POLICY POSITION IN SOUTH AFRICA AND THE SOUTH AFRICAN LAW COMMISSION

The main objective of the South African Law Reform Commission project on this subject⁹⁷ was among others, to consider proposals for possible reform of law with regards to:

- “The circumstances in which it would be lawful for a medical practitioner to cease or authorize cessation of all further life-sustaining treatment of a patient whose life functions are being maintained artificially while the person has no spontaneous respiratory and circulatory functions or his or her brainstem does not register any impulse;
- The right of a mentally competent person to refuse any life-sustaining treatment with regard to any specific illness from which he or she may be suffering, even though such refusal may cause the death or hasten the death of such a person;
- The right of a medical practitioner responsible for the treatment of a terminally ill patient to alleviate pain and distress in accordance with responsible medical practice, by increasing the dosage of medication to be given to the patient, with the object of relieving the pain and distress of the patient and with no intention to kill, even if the secondary effect of this action may be to shorten the patient’s life;
- Whether it would be lawful for a medical practitioner to give effect to the well-informed, considered request of a terminally ill, but mentally competent, patient to make an end to the patient’s unbearable suffering by administering or providing a lethal agent;
- The recognition of a written directive regarding the cessation of medical treatment in cases of terminal illness;
- Recognition of a power of attorney authorising a person to make decisions concerning the medical treatment of the principal in the event of his terminal illness.
- The continuing validity of a power of attorney after the principal has become incompetent;

⁹⁷ South African Law Commission. Discussion Paper 71, Project 86. *Euthanasia and the artificial preservation of life*, “Summary”.

- Those instances in which the chief medical practitioner of a hospital or clinic may, in the absence of a directive of the patient or his agent, decide to discontinue the treatment of the terminally ill patient; and
- The circumstances in which a court may order the cessation of medical treatment or the performance of any medical procedure which would have the effect of terminating a patient's life."⁹⁸

The Commission proposed a legislation that would permit a medical practitioner to carry out a patient's request to die, namely:

- "The patient must be terminally ill;
- be subject to extreme suffering;
- be mentally competent;
- that a second independent medical practitioner must confirm the diagnosis; and
- that findings must be recorded in writing, based on an informed consent and a well- considered and repeated requests of the patient."⁹⁹

"The draft bill proposed also included proposals on palliative care, advanced directives, withholding and withdrawal of life-sustaining treatment and physician-assisted suicide."¹⁰⁰ It recommended that "the so called "Living Will" should be legally recognized in so far as it requests a passive form of cessation of life and that it should be that of a competent person who foresees the possibility that she or he may, as a result of physical and mental disability, be unable to make rational decisions with regard to their medical treatment."¹⁰¹

In its discussion paper in 1997, the Law Commission recommended that doctor-assisted suicide be legalised. There does not seem to be any official response to its proposal or suggestion on how the matter should be addressed.

⁹⁸ South African Law Commission Discussion Paper 71 Project 86 "Euthanasia and the Artificial Preservation of Life" 1997

⁹⁹ I Currie and J De Waal. *The Bill of Rights Handbook*. 6 ed. (2013) 258

¹⁰⁰ K Moodley. *Medical ethics, law and human rights: a South African perspective*. (2011) 270

¹⁰¹ P Casterns and D Pearmain. *Foundational principles of South African medical law*. Chap:2 (2007) 209

3.4 INFORMED CONSENT AND THE PATIENT

Section 8 of the National Health Act¹⁰² dealing with informed consent provides “that every user has the right to participate in any decision affecting his or her personal health and treatment.” This will be done by ensuring that informed consent is given either in writing or verbally or by conduct and as contemplated in Section (6)(1). It requires that every health care provider must inform the user (patient) of:

- “The user’s health status except in circumstances where there is a substantial evidence that the disclosure of the user’s health status would be contrary to the best interests of the user;
- the range of diagnostic procedures and treatment options generally available to the user;
- the benefits, risks and the consequences generally associated with each option; and
- the user’s right to refuse health services even where the implications, risks and obligations of such refusal have been explained.”¹⁰³ Section 7(1)(e) provides “that health services may not be provided to a patient without informed consent unless any delay in provision of the health service to the user might result in his or her death or irreversible damage to his or her health, and the user has not in any way refused that service.”¹⁰⁴ In Section 7(2), “the act provides for instances where a patient or user may be subjected to a health service without their consent.”¹⁰⁵

3.5 PROFESSIONAL CONDUCT OF HEALTH PROFESSIONALS

“The World Medical Association adopted strong resolutions condemning both euthanasia and physician-assisted suicide practices and urged all national medical associations and physicians to refrain from the same, even if national laws allow or decriminalised the practice.”¹⁰⁶“In South Africa, the professional conduct of healthcare practitioners is regulated and monitored by the Health Professions Council of South

¹⁰² The National Health Act, Act No. 61 of 2003, The Preamble

¹⁰³ Ibid

¹⁰⁴ Ibid

¹⁰⁵ Ibid

¹⁰⁶ The World Medical Association Declaration on Euthanasia, adopted by the 53rd WMA, Washington DC, USA, October 2002 and reaffirmed with minor revisions by the 194th WMA Council Session, Bali, April 2013

Africa (HPCSA), which is a statutory body established in terms of the Health Professions Act.”¹⁰⁷ The main purpose of the HPCSA is “to ensure quality health standards for all South African citizens, to protect the public, to guide the medical profession as it strives to enhance the quality of health by setting healthcare standards of training, competence and their compliance.”¹⁰⁸ With regards to withholding and withdrawing treatment, the HPCSA guidelines provide for a good practice framework on procedures to be followed, the choice of options and the communication of decisions including records of such decisions.¹⁰⁹ These guidelines are, amongst others, informed by the principles of the World Medical Association Declaration on Terminal Illness,¹¹⁰ which emphasises the duty of physicians to heal, where possible, to relieve suffering and to protect the best interests of their patients as well as their responsibility to assist patients in maintaining an optimal quality of life through controlling and addressing their psychological needs, as well as to enabling patients to die with dignity and in comfort, respecting their autonomy. The guidelines issued by the HPCSA prohibit active euthanasia by stating that they are based on the premise that any medical intervention where the health care professional’s primary intention is to end the patient’s life is both contrary to the ethics of health care and unlawful.¹¹¹ These guidelines are also in line with The National Health Act, Act No. 61 of 2003, which provides for the patient to mandate in writing a person to act on their behalf when they are no longer able to do so.¹¹²

In a South African context, patient autonomy means that the health practitioners recognise and respect the rights of mentally competent patients to make decisions for themselves after being given the available options. Mentally competent patients or their legal proxies may refuse treatment, even if such refusal may result in their death.¹¹³

¹⁰⁷ Health Professions Act, Act 56 of 1974

¹⁰⁸ P Castens and Debbie Pearmain. *Foundational Principles of South African Medical Law*. (2007)251

¹⁰⁹ HPCSA, Guidelines for the withholding and withdrawal of treatment Booklet 12

¹¹⁰ DJ McQuoid-Mason *Stransham-Ford v Minister of Justice and Correctional Services and Others: Can active voluntary euthanasia and doctor-assisted suicide be legally justified and are they consistent with the biomedical ethical principles?* Some suggested guidelines for doctors to consider. November 2015, Vol. 8, No. 2 SAJBL. 40

¹¹¹ DJ McQuoid-Mason *Stransham-Ford v Minister of Justice and Correctional Services and Others: Can active voluntary euthanasia and doctor-assisted suicide be legally justified and are they consistent with the biomedical ethical principles?* Some suggested guidelines for doctors to consider. November 2015, Vol. 8, No. 2 SAJBL. 38

¹¹² One such case is *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D), although it precedes the National Health Act

¹¹³ *Ibid*

3.6 ROLE OF THE COURTS IN DEVELOPMENT OF THE LAW ON EUTHANASIA

Interpretation of the Bill of Rights and development of common law when interpreting any legislation require the court, tribunals and any forum to promote the values that underlie an open and democratic society based on human dignity, equality and freedom; must consider international law and may consider foreign law.¹¹⁴“When interpreting any legislation and when developing the common or customary law, every court, tribunal or forum must promote the spirit and purport the objects of the Bill of Rights.”¹¹⁵ According to Fabricius J,“Interpretation and application is not a matter of discretion or personal inclination, but rather constitutionally imperative; personal thoughts or one’s feelings are not relevant and do not enter the picture at all in the decision making.”¹¹⁶

In a case of passive euthanasia,*Clarke v Hurst NO and others*,¹¹⁷ Doctor Clarke was having a procedure done under epidural anaesthesia when his blood pressure dropped; he suffered cardiac arrest but was resuscitated but remained with brain damage due to cerebral anoxia and went into a persistent vegetative state. Clarke had signed a living will before he fell ill in which he clearly expressed he should not be artificially kept alive if he had no prospects of living independently. His wife was his executor and had the power to withhold further medical treatment and to discontinue nasogastric feed. She approached the court for an order to withdraw or withhold further treatment of her husband and to discontinue the nasogastric feed. The court granted an order for the removal of the patient’s naso-gastric tube on the basis that such conduct would not be unlawful, referring to the legal convictions of society. The court felt that it was entitled to exercise its discretion in cases of this nature, even though ordinarily, Mrs. Clarke would have been acting unlawfully if she were to authorize the discontinue of an artificial, life-sustaining mechanism.

¹¹⁴ The constitution of the Republic of South Africa, Section 39 (1)

¹¹⁵ Ibid

¹¹⁶ *Stranham-Ford v Minister of Justice and correctional services and others* 2015(4) All SA 109 (GP) para 10

¹¹⁷ *Clarke v Hurst NO and Others* 1992 (4) SA 630 D

In *S v Williams*,¹¹⁸ the deceased was shot in the neck, resulting in severe damage of the jugular vein and carotid artery. It was later found that his brain and brain stem were dead. The deceased was kept alive by artificial respiration until it was disconnected on the instructions of the doctor and death ensued a few minutes later. On appeal, the court held that the disconnection of the respiratory machine could not be seen as the act that caused the death, but that it was a mere termination of a fruitless effort to sustain the deceased's life, who was already clinically dead. It concluded that the death of the deceased was caused by the accused, the person who fired the gunshot. On this matter, however, the patient was brain dead and thus legally dead.

On active euthanasia, in *S v Hartman*,¹¹⁹ the accused, a doctor and the son of the deceased, was charged with the murder. The deceased was suffering from cancer, his medical condition was advancing and irreversible. His son gave him an excessive dose of morphine which resulted in his death within minutes of the dosage. In a murder conviction, the court held that the deceased had not made a request for a dose that would cause his death and that the son's conduct was with sufficient intention to cause death. However, the attitude of the court towards the sentence appeared to have been influenced to a great extent by the convictions of the community and a reflection on the changing attitudes towards the ending of life of the terminally ill. The court observed that punishment served the public interest in serving as a deterrent, and the court accepted that there were no probabilities that the accused would repeat the offence. The sentence was imprisonment for a period of a year, which was suspended. Although this case and the sentence imposed by the court ignited a live debate on the question of euthanasia, it brought no change to the legal position in principle in this country.

In *S v Marengo*¹²⁰ the accused, a 45-year-old woman, had intentionally caused the death of her terminally ill father by firing shots at him, using his firearm. On a charge of murder, She stated that she could no longer endure her father's suffering.¹²¹ The court

¹¹⁸ 1986 4 SA 1188 A

¹¹⁹ 1975 (3) SA 532 (C)

¹²⁰ October 1990 WLD as discussed by SA Strauss. *Doctor Patient and the Law – A selection of practical issues.* (2001) 342

¹²¹ The report of the South African Law Commission page 69

found that she was a victim of extreme circumstances which would never be repeated. The court held that imprisonment would totally destroy her as she was already isolated and traumatized by her father's situation. She was sentenced to three years' imprisonment, which was suspended.¹²²

In *Stransham-Ford v Minister of Justice and Correctional Services and others*,¹²³ the applicant was an advocate with various other qualifications, had worked as an Accountant and Tax Practitioner and worked all over the world. He suffered from terminal stage four cancer that had spread to his lower spine, kidneys and lymph nodes, and had no psychiatric disorder. He had tried various forms of medication, including palliative care, to no avail. He had only a few weeks to live. "He sought (a) a declaratory order that he request a medical practitioner, to end his life or to enable him to end his life by administration or provision of some or other lethal agent; (b) an order declaring that the medical practitioner who administered or provided some or other lethal agent to him, shall not be held accountable and shall be free from any civil, criminal or disciplinary liability that could arise from the cessation of his life or the administration nor provision of the lethal agent; and (c) to the extent required the development of common law which would declare his other prayers lawful and constitutional in the given circumstances."¹²⁴

In the *S v Makwanyane*¹²⁵ judgment, O'Regan J's interpretation of the right to life was that "the right to life is, in one sense, antecedent to all other rights in the constitution and that without life, it would not be possible to exercise any other rights in the constitution". Fabricius J in agreement took it further, and added, "that any pious uncoupling of moral concern from the reality of human and animal suffering has caused tremendous harm to mankind throughout the centuries." When dealing with the role of dignity in our constitution, he argued that the "principle of human dignity as a central value of the objective, normative value system established by the constitution has a pre-

¹²² Ibid.

¹²³ *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) All SA 109 (GP) para 12

¹²⁴ Ibid para 4

¹²⁵ Supra

imminent value.”¹²⁶ He further argued “that recognition and protection of human dignity is the cornerstone of the new political order and fundamental to the constitution.”¹²⁷

The court in the Stransham-Ford case also dealt with its constitutional duty to develop the common law as provided in Section 39 of the Constitution as it does not give the courts discretion in this regard. This is a positive duty that required the court to give effect to the applicant’s constitutional rights, including its duty to interpret the constitution and uphold it without fear or favour, and base its decision and reasons on that. The court also expressed a view that the current legal position on assisted suicide is so because it was established before the current constitutional era. It then found that “there was no dignity in having severe pain all over one’s body, being dulled with opioid medication; being unaware of your surroundings and loved ones; being confused and disillusioned; being unable to care for your own hygiene; dying in a hospital or hospice away from your home and dying at any moment in a dissociative state, unaware of one’s loved ones being there to say goodbye.”¹²⁸ The court also agreed with the assertion “that the distinction between active euthanasia and passive euthanasia did not make legal sense as both procedures required a medical practitioner to recognize and ensure that a terminally ill patient’s dignity is protected, by an omission namely discontinuing of treatment in passive euthanasia, then by commission on active euthanasia.”¹²⁹

It was argued that the irony is that the state and the medical profession allowed abortion, and homosexuality in the face of objections that were informed by religious self-righteousness, with justification or rejection of such objections. The argument was therefore that realization of the applicant’s right to be assisted to die was as sacrosanct to him and the state also had the duty to promote, protect and uphold in the same spirit. The court agreed with such argument and acceded to the applicant’s request. When the

¹²⁶ At paragraph 12

¹²⁷ Ibid

¹²⁸ De Rebus- Issue June 2015 “*Judge’s ruling in assisted suicide case divides South Africa*”

¹²⁹ Ibid

judgment of the court was delivered, the applicant had already succumbed to his illness and died few hours before. The court ordered that:

1. "The applicant was found to be mentally competent;
2. The applicant had freely and voluntarily, and without undue influence requested the Court to authorize that he be assisted in an act of suicide. The applicant was terminally ill and suffering intractably and had severely curtailed life expectancy of some weeks only;
3. The applicant was entitled to be assisted by a medical doctor, who was willing to do so, to end his life, either by administration of a lethal agent or by providing the applicant with the necessary agent to administer himself.
4. No medical doctor was obliged to accede to the request of the applicant;
5. The doctor who acceded to the request of the applicant would not be acting unlawfully, and hence, shall not be subject to prosecution or subjected to disciplinary proceedings for assisting the applicant.
6. This order shall not be read as endorsing the proposals of the draft bill on End of Life as contained in the South African Law Commission Report of November 1998 (Project 86) as laying down the necessary or only conditions for the entitlement to the assistance of a qualified medical doctor to commit suicide.
7. The common-law crimes of murder or culpable homicide in the context of assisted suicide by medical practitioners, insofar as they provide for an absolute prohibition, unjustifiably limit the applicant's constitutional rights to human dignity, (s. 10) and freedom to bodily and psychological integrity (s. 12 (2) (b)), read with S. 1 and 7, and to that extent are declared to be overboard and in conflict with the said provisions of the Bill of Rights.
8. Except as stipulated above, the common-law crimes of murder and culpable homicide in the context of assisted suicide by medical practitioners are not affected."¹³⁰

The Minister of Justice and Correctional Services and other interest groups took this judgment on appeal to the Supreme Court of Appeal (SCA). Their main contention was

¹³⁰*Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP) para 26

the potential impact and legal implication of the judgment in future similar cases. The appeal was upheld by the SCA on three main points.¹³¹ The court firstly found that the applicant's claim was entirely centered around the applicant, and when he died the case became moot, his claim ceased to exist and there was no need for the court of first instance to then make an order on an application that did not exist. The SCA ruled that the court was not permissible to continue with the judgment after it was alerted to the death of the applicant. There was therefore no need for the court to develop common law in offences of murder and culpable homicide, which were some of the subjects of contention in this matter.

“Secondly, the SCA found that the court of first instance erred when it failed to distinguish between the legal implications of an order that authorised a medical practitioner to administer a lethal substance to a patient with the patient's consent and a medical practitioner prescribing drugs that the patient could take, if he or she wished, in an act of suicide.”¹³² The court emphasised that the current legal position is that no one may consent to his or her killing, and if that happens, such conduct is murder.¹³³ The court also identified a gap in the development of common law on the question of consent by the patient and therefore a need for further interrogation to consider if common law could be developed to allow for a defence of consent by those who may be charged for murder or culpable homicide in similar circumstances. The SCA argued that the court erred when it made an exception to the criminal law principles of murder when it dealt with the case of the applicant. Lastly, the court felt that, due to the haste in which this case was initially presented, facts relevant to inform the application of relevant legal principles were not all given to the court. Such facts included, the omission to disclose that the applicant had expressed reservations about committing suicide and that the applicant had gone into a coma when the matter was heard. It was found that such omissions meant that the court was deprived of an opportunity to determine all relevant issues that would have informed a fair, balanced and informed

¹³¹ *Minister of Justice and Correctional Services v Estate Stransham-Ford* (531/2015) 2016 ZA SCA 197 (06 December 2016)

¹³² ¹³² Ibid

¹³³ Paragraph 41

conclusions. In all, the judgment of the SCA does not reveal any fundamental opposition to the application of relevant legal principles to the questions that the court of first instance confronted. In my view, their opposition was more on the likely implications to the greater public and to the current common law positions and its interpretation.

In response to the Stransham judgment, McQuoid-Mason¹³⁴ proposed guidelines for the medical profession when dealing with the implications of active voluntary euthanasia and doctor-assisted suicide before engaging in such assistance:

1. “, there is a court order stating that a doctor may assist the patient to commit through voluntary active euthanasia, and that such a doctor may not be subject to criminal prosecution, a civil action or disciplinary proceedings by the HPCSA;
2. Ethically, the biomedical ethical principles indicate that it is justified to assist the patient Legally to commit suicide’
3. The patient’s autonomy can be respected because the patient is mentally competent, has not been unduly influenced, has made the decision freely and voluntarily, and has not requested the doctor something illegal or unethical- in which case the doctor should decline and use other biomedical ethical principles to come to a decision
4. The terminally ill patient with a hopeless prognosis has been encouraged to undergo palliative care before seeking assistance to commit suicide;
5. Further treatment of the patient is futile;
6. The mentally competent patient has indicated that she or he still wishes to be subjected to voluntary active euthanasia;
7. The patient’s next-of-kin have been consulted;
8. The doctors have preserved careful records of all the steps taken by them before and while assisting the patient to end his or her life.”¹³⁵

¹³⁴ DJ McQuoid-Mason. *Stransham-Ford v Minister of Justice and Correctional Services and Others: Can active voluntary euthanasia and doctor-assisted suicide be legally justified and are they consistent with the biomedical ethical principles? Some suggested guidelines for doctors to consider.* November 2015, Vol. 8, No. 2. *SAJBL*

¹³⁵ Ibid

On the question of alternatives to physician-assisted suicide, palliative care may be an option. “The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families facing life-threatening illness through the prevention and relief of suffering, early identification and impeccable assessment and treatment of pain and other physical, psychological and spiritual aspects.”¹³⁶ In South Africa there is no specific legislation that provides for the establishment of palliative care, either as a discipline within the healthcare or as means of regulating the existing industry. At present, The Hospice Palliative Care Association of South Africa, working with other partners, rely on foreign donors, provide integrated comprehensive care and support palliative care in the country.¹³⁷ They work closely with government departments to identify policies and procedure and to assist the implementation of welfare structures in hospitals, clinics and communities. “In 2012, the HPCSA petitioned the Minister of Health to ensure that palliative care is accessible, available and affordable to South Africans facing advanced illness and to ensure that, at the end of their lives, patients are treated with dignity and experience relief of suffering.”¹³⁸ Researchers have also emphasised a need for palliative care for patients with chronic illness and the recognition of the need for doctors to assess patients and develop a care plan to address their needs in conjunction with treatment aimed at controlling the disease.¹³⁹

In the matters of Hartman and Marengo, which involve active euthanasia the Law Commission pointed out that in these cases, “the courts reflected the sense of justice of the community regarding the blameworthiness of the accused by imposing very light sentences.”¹⁴⁰ These cases all relate to instances where the accused’s main purpose of killing the deceased persons was to end their suffering. It would seem, although the law rendered them guilty of murder, their conduct was to an extent condoned by *boni mores* of the community.

¹³⁶ Bill Muhlenberg’s commentary on the issue of the day “Palliative Care Versus Euthanasia” Culture Watch 2010

¹³⁷ L Gwyther. (2014) Palliative care in chronic diseases, vol. 104 n.2. *S.Afr.med.j*

¹³⁸ *Ibid*

¹³⁹ *Ibid*

¹⁴⁰ South African Law Commission discussion paper 71, Project 86. “Euthanasia and Artificial Preservation of Life”.

These cases are also an illustration of the extent of powers given to the courts when it comes to end of life decisions. The success of any case of euthanasia depends on the court's interpretation and application of relevant legal principles to the facts of a given case. I submit that this unfairly bestowestoo much power on the courts, especially if the legal position on the realisation of rights in the Bill of Rights is informed by the founding values of our Constitution. Some argue that each application for doctor-assisted suicide by terminally ill patients who wish to die in dignity must be considered on its merits, as there remains no clear guideline or frameworkfor dealing with such instances.¹⁴¹This, in my view, is what creates confusion and frustration, including putting the affected in a difficult position as this ambiguity creates an environment of uncertainty.

The approach of the various courts to cases referred to above illustrate the extent of confusion experienced by those who wish to exercise their autonomy and self-determination. In the cases of Clarke and Marengo, the courts condoned the intentional killing of the patients when they allowedthe doctorsto remove life support. In my view, this implied that their illnessrendered them unworthy of protection by the law. In the case of Stransham-Ford, the court granted order for the deceased to be aided to die. In Clarke's case the court granted an order that the nasl-gastric feeding be discontinued.

The legal decisions conflict with Constitutional provisions as they stand and with health professional ethical codes.These are examples where the courts appear to have an inordinate power to simply decidewhether the lives of people can be taken or spared without any legal implications and contrary to the common-law principles of murder. At the end of it all, inconsistencies within the system render it unpredictable and confusing to those that would want to consider the available options and alternatives in any given circumstances.

In the next chapter, we shall see how other jurisdictions deal or dealt with similar situations.

¹⁴¹ DJ McQuoid –Mason Doctor-assisted suicide: What is the present legal position in South Africa. July 2015, Vol. 105, No. 7. *SAMJ*. 526

CHAPTER FOUR PHYSICIAN-ASSISTED SUICIDE IN OTHER JURISDICTIONS

This chapter shall examine the legal position with regard to euthanasia in various other jurisdictions.

It shall focus on those with similar constitutional legal frameworks as South Africa, such as India which is a constitutional democracy which is often classified as a developing state like South Africa, and Canada which is developed state but also a constitutional democracy. The other similarities include that these countries all observe the doctrine of separation of powers between the organs of the state with checks and balances between these organs. Their legal frameworks are also influenced to a great extent by the same international customary law, like the Universal Declaration of Human Rights.

A further focus will involve The Netherlands and Belgium which legalised euthanasia in some form or other. The current position in The Netherlands is that a doctor is permitted to kill a patient who has produced a request which is well considered, voluntary and whose suffering is unbearable with no prospects of improvement. Two physicians must certify that the patient's condition was incurable and unbearable after the patient had been fully informed about their condition and palliative care.¹⁴² In Belgium, patients must be mentally competent, over the age of 18 years and their repeated request for euthanasia must be explicit, clear and durable.¹⁴³ The difference between The Netherlands and Belgium is that in Belgium, after two physicians certified that there are no available alternatives, a third independent physician must be consulted to confirm that all conditions were met.

The Canadian position is similar in many respects to Belgian law in this respect. In India, all forms of euthanasia remain against the law.

¹⁴² The Termination of life on Request and Assisted Suicide Act 2001

¹⁴³ The Belgian Act on Euthanasia of May, 28th (2002) Chap: II Section 3

4.1 THE LEGAL POSITION IN CANADA

4.1.1 The Canadian Rights Charter

“The Constitution of Canada is the supreme law of Canada, and any law inconsistent with its provisions is, to the extent of the inconsistency, of no force or effect.”¹⁴⁴ It states that “everyone has the right to life, liberty and security of the person, and the right not to be deprived of these except in accordance with the principles of fundamental justice.”¹⁴⁵ “All rights protected under the Canadian Charter for Rights and Freedoms are subject to reasonable limitation as prescribed by the law and as they can be demonstrably justified in a free and democratic society.”¹⁴⁶ “By the beginning of the 19th century, the Canadian medical profession was already engaging in discussions on euthanasia and this was later joined by philosophers and theologians.”¹⁴⁷ The main focus was on the issue of quality of life and the right to determine when this quality had deteriorated to a point where it was acceptable to cease living.¹⁴⁸

4.1.2 The Canadian Penal Code

Section 241¹⁴⁹ provides that everyone who:

- “Counsels a person to commit suicide or
 - 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.”

In terms of Section 14, “no person was entitled to consent to have death inflicted on him, and such consent did not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.”¹⁵⁰ Two classical cases in which the law around euthanasia and physician-assisted suicide were demonstrated is that of Sue Rodriguez and Gloria Taylor, as will be discussed below.

¹⁴⁴ Constitution of Canada Act 1982 Section 52 (1) Part VII, General

¹⁴⁵ Ibid Section 7

¹⁴⁶ “Physician-assisted suicide and euthanasia in the Netherlands: a report to the House Judiciary Subcom”, Issues in Law & Medicine, Winter 1998 Issue

¹⁴⁷ Euthanasia and assisted suicide in Canada, Publication N. 2010-68 E Library of Parliament 1

¹⁴⁸ Ibid

¹⁴⁹ South African Law Commission Report. Project 86. Euthanasia and the Artificial Preservation of Life Nov 1998

page 64

¹⁵⁰ The Criminal Code and Euthanasia, Section 14

4.1.3 Rodriguez v British Columbia (Attorney General)¹⁵¹

“Sue Rodriguez was suffering from amyotrophic lateral sclerosis and it was declared that due to her condition, she would not live more than a year.”¹⁵²“She wanted to be assisted to comit suicide. She approached the court for an order that wouldstrikedown sections 241 and 14 of the criminal code whichprohibited the terminally ill person from committing physician-assisted suicide.”¹⁵³ She argued that the provisionswere a violation of her right to life; liberty; security of a person¹⁵⁴and equality,¹⁵⁵ which areprotected by the Canadian Charter. In its judgment the court held that the prohibition of physician-assisted suicide did not violate the right to life,liberty, security of the person.

4.1.4 Carter v Canada (Attorney General)¹⁵⁶

In 2009, “Gloria Taylor, was diagnosed with a fatal neurodegenerative disease namely amyotrophic lateral sclerosis, which caused progressive muscle weakness.”¹⁵⁷“As her muscle condition deteriorated to the point that she required a wheelchair and was in pain, she described her condition as an assault on her privacy, dignity and self-esteem. She informed her friends and family of her desire to obtain a physician-assisted death.”¹⁵⁸ “She did not want to live in a bedridden state,stripped of dignity and independence and did not want to die slowly, piece by piece or wracked in pain.”¹⁵⁹“She brought a claim before the British Columbia Supreme Court challenging the constitutionality of the provisions of the Canadian Criminal Code that prohibited assistance in dying.”¹⁶⁰

¹⁵¹*Rodriguez v The Attorney General of Canada and British Columbia* (Attorney General), (1993) 3 SCR 519

¹⁵² *Ibid*

¹⁵³ *Ibid*

¹⁵⁴ Sections 7, 12, and 15 of the Canadian Charter of Rights and Freedoms

¹⁵⁵ *Ibid* Section 15 (1)

¹⁵⁶ *Carter v Canada* (Attorney General) 2015 1 SCR 331

¹⁵⁷ *Ibid*

¹⁵⁸ *Ibid*

¹⁵⁹ *Ibid* Para 11

¹⁶⁰ *Ibid* para 15

Issues to be determined included, inter alia, whether the provisions which prohibited physician-assisted dying infringed¹⁶¹ on her right to life, liberty and security of the person and/or that such provisions were inconsistent with fundamental justice. Also, if the court found that there was infringement, whether such infringement was justifiable under same Charter. The other question was whether the court could grant free-standing constitutional exemption for claimants under the Canadian Charter of Rights and Freedoms in terms of Section 24(1). The trial court had found “that the prohibition against physician-assisted dying violated the rights of competent adults who were suffering intolerably as a result of a grievous and irremediable medical conditions, and concluded that this infringement was not justified and therefor unconstitutional, therefor granting constitutional exemption.”¹⁶² This reasoning was in direct contrast to the earlier Appeal Court decision where it upheld the blanket prohibition on assisted suicide.¹⁶³ The trial Judge argued that in Rodriguez’s case, the right to life, the principles of over breadth and gross disproportionality were not identified and therefore not addressed. It is for that reason that the court believed that it was entitled to revisit the issues. The court’s approach was also informed by the belief that there was a strong consensus that it would be ethical with respect to voluntary adults who are competent, informed, grievous and irremediably ill and where the assistance is clearly consistent with the patient’s wishes and best interests to relieve the suffering, although there was still no clear societal consensus on the issue of physician-assisted suicide.¹⁶⁴

In the SCA, it was argued that the prohibition of physician-assisted suicide deprived some individuals of life, as it had the effect of forcing them to take their own lives prematurely, for fear that they would not be able to do so when they reached a point of intolerable suffering and that one’s response to a grievous and irremediable medical condition was a matter critical to their dignity and autonomy, which was intertwined to the right to make decisions concerning their bodily integrity and medical care, entrenching their liberty. It was also emphasised that the granting of free standing

¹⁶¹ Sections 241 and 14 of the Criminal Code of Canada

¹⁶² Ibid

¹⁶³ *Rodriguez v British Columbia (Attorney General)* 1993 3 SCR 519

¹⁶⁴ *Carter v Canada* 2012 BCSC 886 Paragraph 358

constitutional exemption was not sufficient or addressed the inconsistencies, but that there should be legislative and regulatory measures to protect the rights of patients and physicians or those vulnerable individuals.

On the right to life, the court said that it did not agree that the existential formulation of the right to life required an absolute prohibition on assistance in dying or that individuals could not waive their right to life. To them, such would create a duty to live and not the right to life, and would call into question the legality of any consent to the withdrawal or refusal of life saving or life-sustaining treatment.¹⁶⁵ In agreement with Rodriguez, they held that “the sanctity of life should not be seen to require that all human life be preserved at all cost and in certain circumstances, an individual’s choice about the end of her life should be respected.”¹⁶⁶

On the right to liberty and security of the person it identified two flaws, namely that the prohibition permitted people to request palliative sedation, refuse artificial nutrition and hydration or the removal of life-sustaining medical equipment, which all result in the termination of life either directly or indirectly but denies persons suffering irremediable illnesses the right to request physician-assisted dying. Secondly, by disallowing persons to make medical decisions freely without state interference, the prohibition undermined the very concept of informed consent.¹⁶⁷ The court concluded that an individual’s response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy.¹⁶⁸

The court found that “the prohibition of assisted dying was overboard and the impact on the restriction imposed on one’s life, liberty or security of the person was grossly disproportionate as the measure of the impact should be on the rights of the individual claimant and not on the society or the public.”¹⁶⁹ The court declared “that laws

¹⁶⁵ *Carter v Canada* (Attorney General) 2015 SCC 331 at paragraph 63

¹⁶⁶ *Ibid*

¹⁶⁷ Jordan Casey “Supreme Court of Canada Strikes Down Prohibition against Physician-Assisted Dying in *Carter v Canada: Part II*” the court.ca Charter of Rights & Freedoms? Constitutional Law 11 February 2015.

¹⁶⁸ *Carter v Canada* (Attorney General) 2015 1 SCR paragraph 67

¹⁶⁹ *Carter v Canada* (Attorney General) 2015 1 SCC 5 paragraph 87-89 en.m.wikipedia.org

prohibiting a physician's assistance in terminating life, that determines that no person is entitled to consent to have death inflicted on them, and that such consent does not affect the criminal responsibility of any person who inflicts death on the person who gave consent, were void in so far as they prohibited physician-assisted death for the claimant who clearly consented to the termination of her life and who had a grievous and irremediable medical condition that caused enduring suffering.”

Because the claimant had already passed away, the court did not make an order on the personal exemption, and made no pronouncement on other situations where physician-assisted dying could be sought. The legislative and regulatory measures were left to the parliament and provincial legislatures to address. The court struck down Section 214 and 14 of the Criminal Code and suspended their constitutional invalidity for twelve (12) months to allow for the amendment of the relevant laws in line with its ruling.¹⁷⁰ It found them to be an infringement of Article 7 of the Rights Charter. The court effectively gave adult Canadians who are mentally competent and suffering intolerably and enduringly the right to a doctor's help in dying. The court held that, “in order to justify the infringement of the appellants' section 7 rights under s. 1 of the Charter, Canada must show that the law has a pressing and substantial objective and that the means chosen are proportionate to that objective.”¹⁷¹ “ A law is disproportionate if (1) the means adopted are rationally connected to that objective; (2) it is minimally impairing of the right in question; and (3) there is proportionality between the deleterious and salutary effects of the law”.¹⁷² This assertion reveals requirements that are similar to the limitation clause in the South African constitution.

On 18 June 2016, the legal position on euthanasia changed. Legislation called “Medically Assisted Dying” came with strict rules which do not legalize advance directives, or requests on behalf of minors and mentally ill patients.¹⁷³ In order to qualify for medical assistance in terms of this law:¹⁷⁴

¹⁷⁰ *ibid*

¹⁷¹ *ibid*

¹⁷² *ibid*

¹⁷³ Euthanasia in Canada en.m.wikipedia.org

¹⁷⁴ *ibid*

- “Patients must sign a written request expressing their wish to end their life in front of two independent witnesses who can both confirm it was done free of coercion, 10 days before the date of death.
- Two independent written medical opinions that must confirm that the patient’s medical condition has reached a point that is irreversible, “grievous and irremediable” and far enough along that “a natural death is reasonably foreseeable”.
- Patients must be informed about what palliative care options are available to deal with their end-of-life suffering.
- Consent can be revoked at any time, in any manner.
- Patients must be able to communicate in ways that allow them to express or withdraw consent at all times.”¹⁷⁵

4.2 THE LEGAL POSITION IN BELGIUM

4.2.1 The Belgian Constitution

Belgium is a Federal Constitutional Monarchy with a parliamentary system of governance, “political and constitutional structure and divided into Communities and Regions, each with its own legislative and executive jurisdiction.”¹⁷⁶ “From the day on which the Constitution became enforceable, all laws, decrees, decisions, regulations and other acts that are contrary to it are abrogated.”¹⁷⁷ “Everyone has the right to lead a life in keeping with human dignity. To this end, the laws, federate laws and rules referred to in Article 134 guarantee economic, social and cultural rights, taking into account corresponding obligations, and determining the conditions for exercising them.”¹⁷⁸ Euthanasia is defined in “the Belgian Act on Euthanasia as the intentional termination of life by someone other than the person concerned, at the latter’s

¹⁷⁵ Ibid

¹³⁴ Griffiths, Weyers and Adams. *Euthanasia and Law in Europe*. Chap: 7 (2008)

¹⁷⁷ Article 188 Belgian Constitution

¹⁷⁸ Article 23, Article 134 Laws passed in order to execute Article 39 determine the judicial force of the rules which the bodies that they create enact in matters which they determine. They can confer to these bodies the power to pass federate laws that have the force of law, within the jurisdiction and in the manner that they determine.

request.”¹⁷⁹“A physician who performs euthanasia commits no criminal offence when he/she ensures that:

- The patient has attained the age of maturity or is an emancipated minor, and is legally competent and conscious at the moment of making the request,
- the request is voluntary, well-considered and repeated, and is not the result of any external pressure,
- the patient is in a futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious incurable disorder caused by illness or accident, and
- when he/she has respected the conditions and procedures as provided by this Act.”¹⁸⁰

“As it is the case in The Netherlands, it is possible to make an advanced directive requesting euthanasia but the request must be in writing, signed by the patient, witnessed by two adults, one of whom must have no material interest in the patient’s death.”¹⁸¹

4.2.2 Policy developments in Belgium

To a great extent, the developments in Belgium were influenced by those in Netherlands. During the 1980s, the debate on euthanasia and end of life decisions gained momentum, mainly due to technological developments in medicine and biology, and this led to the setting up of a commission to study the ethical issues involved.¹⁸²The commission looked at a number of issues that were mainly medical in nature, such as the inclination to continue treatment even where there is no longer any benefit for the patient, and the removal and transplantation of organs and tissues, as well as issues involved in medical research.¹⁸³It concluded that active euthanasia should be ruled out, whereas passive euthanasia would be permissible as long as it was accompanied by palliative care and intensive counselling. In 1986, a proposed draft bill to deal with the

¹⁷⁹ The Belgian Act on Euthanasia of May , 28th 2002 , Chap: I, Sect: 2

¹⁸⁰ Ibid

¹⁸¹ E Jackson. *Medical Law Text, Cases and Materials*, 3 ed. Chap: 17 (2013) 941

¹⁸² Griffiths, Weyers and Adams. *Euthanasia and Law in Europe*. Chap: 7 (2008) 276

¹⁸³ Ibid 279

pointless medical treatment of the terminally ill was put forward. This bill mainly proposed the addition of two provisions to the Penal code and in essence, these provisions made it optional for the doctor to continue treatment or reanimation of a patient with or without the patient's request. This proposed draft bill preceded another proposal dealing with patient's rights, namely the right to full information concerning his health when a request had been made and the right of the patient to refuse treatment if pain relief was no longer effective.¹⁸⁴In 1988, a request to carry out research into the practice of euthanasia in Belgium was made to the Federal Government.

In May 1997, the Advisory Committee on Bioethics concerning "The desirability of a Legal Regulation of Euthanasia" was set up to inform and advise Government and the public on problems arising from research and its implementation in the area of biology and health care and to explore the ethical, social and legal aspects of the issues involved, in particular the rights of individuals.¹⁸⁵ This committee consisted of multi-disciplinary experts that included doctors, lawyers, psychologists and sociologists with equal numbers of Catholics and non-religious people. The committee's recommendations contained four different proposals.¹⁸⁶ The first proposal was to change the Penal Code to legalise euthanasia, with a procedure for after the fact control. The second proposal was that the existing Penal Code restrictions be retained in addition to the first procedure of after fact control proposed in the first proposal. The third proposal provided for a procedure for other medical behaviour that potentially shortens life. It also proposed the retention of the existing provisions of the Penal Code but set out grounds on which a doctor could invoke a "state of necessity". The fourth and last proposal was to retain the existing legal situation, that euthanasia should not be allowed under any conditions. The committee also encouraged a parliamentary debate on these proposals as it was also apparent that there was strong support for the third proposal and expressed a willingness for legislation on euthanasia.

¹⁸⁴ Ibid 278

¹⁸⁵ Ibid 279

¹⁸⁶ Ibid 280

In December 1999, the issue of euthanasia was placed on the parliamentary agenda and a bill which sought to embrace the four proposals was set for debate. Following intense deliberations by various political groups in the Senate, in October 2001, the Belgian Senate approved the bill and later in May 2002, the same bill was approved by the Belgian Chamber of Representatives, albeit with amendments. In December 2002, the Law on Euthanasia was submitted to the Constitutional Court in order for it to be assessed with respect to the principles of non-discrimination as provided in Article 10-11 of the Belgian Constitution and the right to life as provided for in Article 2 of the European Convention on Human Rights.¹⁸⁷ The court rejected the argument that people suffering severely could not make a genuine choice and that since the law on euthanasia made the principle of self-determination largely determinative, there could be no sufficient protection against abuse by third parties and therefore made the law discriminatory. It concluded that there was no necessity to interfere with the political decision made on euthanasia.¹⁸⁸

4.2.3 Developments since physician-assisted suicide was legalised in Belgium

Unlike in The Netherlands where the process to legalising euthanasia in some form was mainly led by the courts and the medical practitioners, in Belgium the most active sectors were academics, doctors, lawyers and societal organizations, including those with opposing convictions.

The Belgian law on euthanasia was followed by the law on palliative care, which was passed in June 2002 and guarantees rights of patients to palliative care which corresponds with the professional obligation for the treating physician to provide palliative care.¹⁸⁹ It also seeks to expand the definition of the art of medicine, specifying that the latter encompasses medicine on human beings as well as preventative, curative, continuous and palliative medical practice that concern them.¹⁹⁰ In Belgium, palliative home care is covered by compulsory health insurance. "Palliative care is

¹⁸⁷ Ibid. 291

¹⁸⁸ Ibid.

¹⁸⁹ Article 2. Law on Palliative care, 14 June 2002

¹⁹⁰ As argued in The Dossier of the European Institute of Bioethics "Does the model of Integrated Palliative Care Distort Palliative Care Practice?"

defined as the totality of care for patients whose life-threatening disease no longer responds to curative therapies, mainly aiming at offering patients and next of kin as much quality of life as possible and maximum autonomy.”¹⁹¹“Palliative care is provided in hospitals in their palliative care units, in residential homes and in nursing homes.”¹⁹² It required that palliative care be provided by a multidisciplinary team whose members include a medical department, the nursing department and paramedics department, complemented by a psychologist and a social worker or a social nurse.¹⁹³

In Belgium, the courts did not play a significant role in the developments that led to the passing of a legislation on euthanasia. Sometime after the law had been in operation, in April 2012, Mortier¹⁹⁴ challenged the law on the procedure that was followed when his 64-year-old mother was killed by lethal injection at her own request. His mother suffered from an untreatable depression. When the doctors acceded to her request, her son was not informed about such developments. His main complaint was that the system followed did not respect the feelings of her relatives. He also believed that at least two experts who had assessed her mother did not agree that her illness was beyond treatment. Mortier felt that death of a human being should not be a medical choice but a profound event to be treated with gravity, respect and sadness. His claim was dismissed by the court. He later joined the campaign against the Belgian euthanasia legislation and has taken his case to the European Court of Human rights. He argues that Belgium failed to protect his mother’s right to life.

4.3 THE LEGAL POSITION IN THE NETHERLANDS

4.3.1 The statutory and common law framework

The Netherlands appears to have the most developed laws on euthanasia, even ahead of the USA, which is often considered leader in various fields including in the field of

¹⁹¹ Griffiths, Weyers and Adams. *Euthanasia and Law in Europe*. Chp 7, (2008) 269

¹⁹² Ibid

¹⁹³ Ibid

¹⁹⁴ *Mortier v Belgium*. Adfinternational.org (Alliance Defending Freedom 2016) media summary (Accessed in Nov 2016)

medicine.¹⁹⁵ Article 293 “prohibits the taking of a human life at that person’s express and serious request and this crime is punishable by imprisonment of up to twelve years or by a fine and Article 294 provides that where a death occurred, anyone who assisted to bring about that death by procuring the means for another to commit suicide or inciting on to commit suicide is a crime punishable by imprisonment of up to three years or a fine.”¹⁹⁶ One may escape criminal liability if it is established that they acted out of necessity as provided in Article 40 of the Penal Code which provided that “any person who commits an offence under the compulsion of an irresistible force shall not be criminally liable.”¹⁹⁷ This article appears to include both the notion of mental duress and the notion of necessity.

During 1982, euthanasia had become an admitted practice, there were various testimonials from doctors who had practiced it and there were also tips circulating for the benefit of doctors on how to do it successfully.¹⁹⁸ This was criticized to be in direct contrast to the Hippocratic Oath and Article 3 of the Universal Declaration of Human Rights. In 1985, the State Commission on euthanasia presented its advice and recommended that the law be modified in such a way that a doctor would be allowed to take the life of a patient who asked him to do so.¹⁹⁹ The debate became more public and vigorous and the focus was on whether active voluntary euthanasia and physician-assisted suicide should both be legalized or whether they should remain criminal with rules on how it should be undertaken.

Since 1973, the Dutch courts had gradually been developing exceptions to the express prohibitions on euthanasia and assisted suicide and through a series of court decisions, a set of guidelines, which if followed protected doctors from criminal liability, emerged.²⁰⁰

¹⁹⁵ Ph. Schepens, MD. General Secretary of the World Federation of Doctors who respect human life “Euthanasia: Our own future?” 371

¹⁹⁶ The Penal Code of Netherlands, Articles 293 and 294

¹⁹⁷ Ibid

¹⁹⁸ Ph. Schepens, MD “ Euthanasia : Our Own Future?” Issues of Law & Medicine, Volume 3, Number 4, 1988,376
As was publicized in *The Dutch Review of Medicine, Nederland’s Tijdschrift voor Geneeskunde*

¹⁹⁹ Ibid

²⁰⁰ E Jackson. *Medical Law Text, Cases and Materials*. 3 ed. Chap: 17 (2013) 931

4.3.2 The Postma Case

Doctor Postma's mother, who was also the doctor's patient, was suffering from a brain haemorrhage which made it impossible for her to speak, hear and sit up. Dr. Postma injected her with morphine and curare and this led to her death. In 1973, she was found guilty of contravention of Article 293 of the Dutch Penal Code. The court found that the main purpose of administering the drugs was to hasten death and not to relieve the patient of physical and psychological pain caused by her terminal illness. The court indicated that euthanasia would be acceptable if the patient suffered from an incurable illness, experiencing unbearable suffering, had requested that her life be terminated and that such termination was performed by the patient's doctor or in consultation with him or her.²⁰¹

Although Dr. Postma was convicted, the sentence imposed was lenient and this could be seen as a reflection of the convictions of the community with regards to assisted suicide, in particular the attitudes of the community who came out in great support of the doctors' conduct. This was the first case of euthanasia that was decided on by the court and it triggered a wave of concern in the medical profession and among scientists about the limits of medical care and the patients' determination. This case sparked a social debate which also saw the launch of the "The Dutch Voluntary Euthanasia Society" with the main purpose of advocating for change in the law on euthanasia.²⁰²

4.3.3 The Chabot Case

In 1991, the deceased Bosscher was the patient of the accused, was physically healthy but suffered from severe mental distress after she lost her children, one to suicide and the other to cancer. She refused treatment and maintained that nothing could help her mental suffering and on her request, Dr Chabot assisted her to commit suicide without allowing other experts to consult with her.²⁰³ The doctor was prosecuted under Article

²⁰¹ Ibid

²⁰² T Sheldon. Andries Postma. Feb 10; 334 (7588) *BMJ*. (2007) 320

²⁰³ R Cohen-Almagor "Euthanasia in the Netherlands: The Legal Framework" 2001 Michigan University-DCL Journal of International Law

294 of the Dutch Penal Code after his patient died as a result of fatal dose of sleeping pills that he had prescribed.²⁰⁴ The prosecution argued that he did not act out of necessity as he had failed to invite other experts to examine Bosscher. Four clinical experts that Dr Chabot had consulted before she assisted Bosscher testified in his defence. Three other experts were called by the court and they all agreed with Dr Chabot's approach in Bosscher's case.²⁰⁵ He was acquitted as the court found that the deceased was rational and had not been diagnosed with mental illness. This was overturned by the Supreme Court, and the accused was convicted but no punishment was imposed.²⁰⁶ The Amsterdam Medical Disciplinary Court found him guilty of professional misconduct.²⁰⁷ He was faulted for not insisting on therapy as an alternative to assisted suicide and that the refusal of treatment should have made him to refuse her request²⁰⁸. It was also found that he failed to maintain his professional distance to the case.²⁰⁹

4.3.4 The Alkmaar Case

In 1984, the deceased was an elderly woman who suffered from chronic depression, but not terminally ill.²¹⁰ She urged her physician to "put an end to her agony" saying she did not wish to live any further. The doctor, "convinced that every single day would only be a heavy burden to the patient" decided according to her wishes and assisted her to end her life²¹¹. The court held that necessity as a defence to Article 40 of the Penal Code could be used by physicians and acquitted the accused on that ground. The court emphasised that "the courts should consider whether and to what extent according to professional medical judgment an increasing disfigurement of the patient's personality and or further deterioration of the patients' already unbearable suffering were to be expected and whether it could be expected that soon she would be no longer be able to

²⁰⁴ Ibid.

²⁰⁵ Ibid.

²⁰⁶ Ibid.

²⁰⁷ Ibid.

²⁰⁸ Ibid.

²⁰⁹ Ibid.

²¹⁰ M L Allen " Crossing the rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia" Brooklyn Journal of International Law Vol. 31 Issue 2 2006 Article 5 <http://brooklynworks.brooklynlaw.edu/bjil>

²¹¹ S Gevers "Euthanasia: Law and practice in the Netherlands " Health Law Section, University of Amsterdam, Amsterdam, The Netherlands British Medical Bulletin 1996,52 (No.2): 326-333

die with dignity under the circumstances worthy of a human being and whether there were still opportunities to alleviate the suffering.”²¹² This case signalled that the Courts began to accept euthanasia in cases where death of the patient was not otherwise imminent.²¹³ The court’s approach influenced the conceptual development of euthanasia law and the case established a precedent for courts to rely on physicians in development of ethical standards that would be used by the courts.²¹⁴

4.3.5 Brongersma Case²¹⁵

In April 1998, the deceased was assisted by his doctor to commit suicide. The deceased had had an active life as a politician, but as he grew older his physical condition deteriorated, making him isolated. He approached his doctor, Dr Sutorius, on numerous occasions to end his life. He was simply tired of life and wanted to die as he found his social isolation unbearable and had made attempts on his own but all failed.²¹⁶ The doctor evaluated him and found that he did not suffer from any psychiatric illness which could explain his desire to die.²¹⁷ Dr Sutorius finally agreed to assist him and properly reported what he had done. He stated reasons for the deceased request, which included that the deceased had no disease to be treated. In a controversial judgment, Dr Sutorius was acquitted as the court of first instance accepted his explanation for assisting Brongersma. This decision was overturned by the Court of Appeal. Experts who assisted the appeal court opined that the behaviour of the deceased did not fall within the competency of a doctor and that there was no consensus in the medical profession as to the justiciability.²¹⁸ This was such a unique case in the developments in The Netherlands’ euthanasia law because the judicial-making decision and parliamentary debate were closely interwoven; the key question was whether situations comparable to Brongersma’s would be covered by the proposed law.²¹⁹

4.3.6. Developments in policies on euthanasia

²¹² Physician-Assisted Suicide and Euthanasia in the Netherlands: A report to the House Judiciary Sub-committee on the Constitution, Executive Summary

²¹³ M L Allen “ Crossing the rubicon: The Netherlands’ Steady March Towards Involuntary Euthanasia” Brooklyn Journal of International Law Vol. 31 Issue 2 2006 Article 5 <http://brooklynworks.brooklynlaw.edu.bjil>

²¹⁴ Ibid

²¹⁵ As discussed in Chapter 2 of *Euthanasia and the Law in Europe*. Griffiths, Weyers and Adam. 37

²¹⁶ Ude Vries “A Dutch Perspective: The Limits of Lawful Euthanasia” *Annals of Health Law* Vol 13 2004 Iss. 2, Art. 4 <http://lawecommons.luc.edu/annals>

²¹⁷ Ibid

²¹⁸ *Euthanasia and the Law in Europe*. Griffiths, Weyers and Adam. 37

²¹⁹ Ibid

In 1986, The Royal Dutch Medical Association and the courts approved guidelines that would protect physicians from prosecution. These included: “(a) The patient’s wish to die must be expressed clearly and repeatedly; (b) the patient’s decision must be informed and voluntary; (c) the patient must be suffering intolerably, with no hope of relief; however, the patient does not have to be terminally ill; (d) the patient must have a persistent desire to die; (e) the physician must notify the local coroner that death resulting from unnatural causes has occurred.”²²⁰

These guidelines were also criticized for giving a great deal of discretion to physicians. They were constantly refined and it was announced that physicians should let patients self-administer lethal medication instead of giving patients lethal injection and it was preferred that the consulting physicians should not have a personal or professional relationship with the patient.

In 1990, the Rummelink Commission was set up to investigate the medical practice of euthanasia and physician-assisted suicide. It first reported that involuntary euthanasia was in fact widely practiced in Netherland and was referred to as the ‘termination of life without the patient’s explicit request’.²²¹ Of over 8000 interviewees, it was reported that 4941 were injected with morphine by doctors without their consent; 400 were provided of means for the patients to kill themselves by the doctors; 2300 were killed upon their request and 1040 were killed by the doctors without their knowledge.²²² This Commission reported that doctors did not reveal to prosecutor that cases of active termination of life were without the patients’ request.

Since 1991, The Netherlands implemented a procedure by “which cases of euthanasia and physician-assisted suicide would be reviewed and this procedure was continuously

²²⁰ Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report to the House Judiciary Sub-committee on the Constitution, Executive Summary. The report refers to the Rummelink Report on whose recommendations the guidelines were developed.

²²¹ Rummelink Report- Euthanasia results in the Netherlands- number of cases in 1990
www.euthanasia.com/holchart.html

²²² *Euthanasia and the Law in Europe*. Griffiths, Weyers and Adam. (2008) 37

evaluated and revised.”²²³ Based on the Remmilik Report and the Guidelines on Euthanasia that were issued in 1986, The Dutch Government established a new reporting procedure which was codified and became effective in 1994, and that was also approved by both houses of parliament. In the first review, which was implemented in 1994, doctors were required to report cases to the public prosecutor, who would carry out the initial review, refer to the assembly of prosecutors general and then to the justice minister for final review where a decision would be made on whether the prescribed procedure was followed or not. If not followed, prosecution would follow as euthanasia and physician-assisted suicide remained illegal.

During the second review procedure of 1998, doctors were expected to report to a panel of various experts who would advise the prosecution assembly, but the assembly still made the final decision on whether to prosecute or not.²²⁴ The main questions for the review panels were “whether the patient’s request was voluntary and well considered; whether the patient’s condition was unbearable and hopeless; whether there were no acceptable alternatives for treatment were available; whether the method was medically and technically appropriate; whether another doctor had been consulted before the proceedings and that the case was reported as an unnatural death.”²²⁵

In 1995, guidelines for doctors who chose to accede to patient requests for the hastening of death were adopted by the Royal Dutch Medical Association.²²⁶ The Government decided to put a buffer between the doctors and the prosecutors by creating a regional review committee, which was to review reported cases. This committee had lawyers; doctors and an ethicist and it would make a determination whether a doctor had complied with the requirements of due care.

²²³ *Euthanasia and the Law in Europe*. Griffiths, Weyers and Adam. 37 These were guidelines that followed the court’s findings in Chabot’s case

²²⁴ BD Onwutaeka-Philipsen et al. (add date) “Dutch experience of monitoring euthanasia” Vo. 331 No. 7518. *BMJ*.

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²²⁵ *Ibid*

²²⁶ Also known as the Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG)

On 01 April 2002, “The Termination of Life on Request and Assisted Suicide Act 2001 amended Articles 293 and 294 of the Criminal Code” by inserting exceptions to the Articles.²²⁷ In effect, this legislation “ratified judicial decisions and guidelines of the medical professional associations and prosecutorial practice that had already brought about legal changes in the already existing practice of euthanasia.”²²⁸ The physicians were required to:²²⁹ “(a) hold the conviction that the request by the patient was voluntary and well considered; (b) hold the conviction that the patient’s suffering was lasting and unbearable; (c) has informed the patient about the situation he was in and about his prospects; (d) and the patient holds the conviction that there was no other reasonable solution for the situation he was in; (e) has consulted at least one other independent physician who has seen the patient and has given his written opinion on the requirements of due care referred to in parts a-d; and (f) the physician has terminated a life or assisted in a suicide with due care”.²³⁰ These were the same questions to be considered by the review panel as already discussed.

4.3.5 Experiences in The Netherlands since the legalisation of euthanasia

In April 2002 “when the new law on euthanasia was enacted, a new and revised reporting procedure was implemented in that only those cases that did not meet the requirements for prudent practice were reviewed by the Assembly of Prosecutors General, who could request additional information from the reporting doctor.”²³¹ The same questions as before the passing of the legislation remained for the reviewing panel of prosecutors. It however seemed that some doctors were still performing euthanasia or assisted suicide without completing the appropriate paperwork and registration. This made it difficult to have reliable data of the scale and circumstances under which euthanasia is utilized.²³² In 2001, “the United Nations Human Rights Committee raised concerns about the Dutch scheme and the Committee on Legal Affairs and Human Rights of the European Parliament stated that studies showed a

²²⁷ E Jackson. *Medical Law Text, Cases and Materials*. 3 ed. Chap: 17, End-Of-Life decisions. (2013) 933

²²⁸ *Ibid*

²²⁹ *Ibid*

²³⁰ *Ibid*

²³¹ BD Onwutaeka-Philipsen et al. “Dutch experience of monitoring euthanasia” Vo. 331 No. 7518. *BMJ*. (2005) 691-693

²³² A Grubb, J Laing and J McHale (eds) *Principles of Medical Law*. 3 ed. 21.67

disturbingly high incidence of euthanasia being carried out without the patient's explicit request and an equally disturbing failure by the medical profession to report euthanasia cases to the proper regulatory authority."²³³

Against fears that legalisation of euthanasia increased the rate of involuntary euthanasia, it was argued that "available evidence does not support the drawing of an inference that legalisation in The Netherlands caused an increase in the rate of non-voluntary euthanasia or that the rate is higher when compared to other jurisdictions."²³⁴ On the contrary, "it was argued that the reporting rate of euthanasia and physician-assisted suicide has increased from 41 per cent in 1995 to 54 percent in 2001 and 80 percent in 2005."²³⁵ A recent study revealed that "relatives of those who had died under the Dutch euthanasia law found 92 percent saying they believed that lawful euthanasia or assisted suicide had contributed favourably to the patient's end of life and that there was no evidence that vulnerable people were put under pressure to consent to euthanasia."²³⁶ Some doctors reported positively about the improved efficiency of the reviewing committee and the fact that they were able to give reasons to their judgments after a report was assessed. Some of the factors that contributed to positive feedback on the work of the panel were that the composition of the panel was changed to include doctors or medical professionals. Some still argued that there was a decrease in cases of euthanasia and assisted suicide a decade after it was legalised and that this may have been occasioned by the improvement in palliative care and the introduction of terminal sedation as an alternative to euthanasia and assisted suicide in The Netherlands.²³⁷

4.4 PERSPECTIVE AND LEGAL POSITION IN INDIA

4.4.1 The Constitutional Framework

The Indian legal framework is that of a constitutional democracy and is a developing country. "The right to life and personal liberty is guaranteed by the Indian Constitution

²³³ A Grubb, J Laing and J McHale. (eds) *Principles of Medical Law*. 3 ed. (2012) 21.67

²³⁴ *Ibid*

²³⁵ *Ibid*

²³⁶ *Ibid*

²³⁷ BD Onwutaeka-Philipsen et al. "Dutch experience of monitoring euthanasia" Vo. 331 No. 7518. *BMJ*. 693

under the category of the right to freedom and these rights are available to both citizens and non-citizens.”²³⁸ In India, “anyone who commits murder shall be punished with death or imprisonment for life, and shall also be liable to a fine.”²³⁹“Whoever commits culpable homicide not amounting to murder shall be punished with imprisonment for life, or imprisonment of either description for a term which may extend to ten years, and shall be liable to a fine, if the act by which death is caused is done with the intention of causing death, or of causing suchbodily injury as is likely to cause death,or with either imprisonment of either description for a term which may extend to ten years, or with fine, or both, if the act is done with the knowledge that it is likely to cause death, or to cause such bodily injury as is likely to cause death.”²⁴⁰“If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall be liable to fine.”²⁴¹ The implication of these provisions is that any forms of active euthanasia, physician-assisted suicide, including attempted suicide are punishable offences under Indian Penal Code 1860.

Even though the Indian government announced in December 2014 that attempted suicide,as provided in Section 309 of the Indian Penal Code,would be deleted and repealed as an offence,this has not been implemented. This provision has been challenged on various occasions and it was argued that it violated Article 21 of their Constitution.

4.4.2 Development of the law by the courts

Tellis v Bombay Municipal Corporation 1986 SC 18 LRC (const) 351 SC

This case details how the municipality decided to evict the pavement dwellers including those who were residing in slums in Bombay and were to be deported to their homes of

²³⁸ The Constitution of India , Part III , Article 21

²³⁹ Sections 302 and 303 of the Indian Penal Code 1860

²⁴⁰ Ibid.

²⁴¹ Ibid.

origin in terms of Section 314 of the Bombay Municipal Corporation Act, 1888.²⁴² Those affected approached the High Court with a petition for an order restraining the government and the municipal corporation from implementing this policy. Their contention was that the policy was in violation of Articles 19(right to livelihood) and 21 (right to life) of the Constitution and that some sections of the Municipal Corporation Act were inconsistent with these articles, including Article 14.²⁴³ Their further contention was that they had made homes from which they were evicted and that these homes were nearer to their places of work. The Supreme Court recognised, in principle, that the right to life(interpreted to include the right to livelihood) entitled the group of pavement dwellers, who lived and worked on the street, to resist the evictions.²⁴⁴

Smt Gian Kaur vs The State of Punjab²⁴⁵

The appellants, convicted under Section 306 of the Penal Code for abetting the commission of suicide of their daughter in law, argued that the offence created by this provision was unconstitutional as it was in violation of Article 21 of their constitution. The essence of their argument was that the right to life guaranteed in Article 21 should be interpreted to include the right to die as this was the interpretation in *Rathinam vs Union of India* 1994 SCC (3) 394, which is the decision of the same court that declared Section 309 unconstitutional for violation of Article 21 and that of the Division Bench of the Bombay High Court in *Maruti Shri Pati Dubal, vs State of Maharashtra*, 1987 Cri L. J. 743; in that instance, the Court found that Section 309 of the Indian Penal Code (attempted suicide) was discriminatory in nature and also arbitrary so as to violate the right to equality (Article 14) and the right to life (Article 21) was construed to include the right to die or to terminate one's own life.

The constitutionality of the provisions of Section 309, was dealt with in *Rathinam vs Union of India*, where the court also considered, amongst others, the recommendation of the Law Commission of India, which found Section 309 to be harsh and unjustifiable

²⁴² Paper by Varun Mishra LLM (Corp Law) 2013-2014 National Law University, Jodhpur. *Olga Tellis & ORS. v Bombay Municipal Corporation* AIR 1986 SC 18 <http://www.scribd.com>.mobile.doc (Accessed on 02 Sept 2016)

²⁴³ Ibid

²⁴⁴ I Currie and J De Waal. (2013) *The Bill of Rights Handbook*. 6th ed. 268 footnote 57

²⁴⁵ *Smt Gian Kaur vs The State of Punjab* 1996 AIR 946, 1996 SCC (2) 648

and had recommended its repeal.²⁴⁶The court concluded that this provision deserved to be effaced from the statute book to humanise the penal laws. It held that the provision was cruel, irrational and that it could result in the punishment of persons who had suffered and who would be undergoing ignominy because of failure to commit suicide. It further held that Section 309 was a violation of Article 21, rejected the assertion that an act of suicide was against religion, morality or public policy and argued instead that attempted suicide had no baneful effect on society and cause no harm to others. It declared that Section 309 was unconstitutional and void. The Constitutional Bench of the Supreme Court in *Gian Kaur v State of Punjab*, overruled *Rathinam v Union of India* and held that “Article 21 could not be construed to include within it the right to die as part of the fundamental rights it guaranteed.”²⁴⁷It further held that Section 309 could not be validly regarded as a violation of Article 21, but that it was so harsh that it ought to be removed from the Indian Statutes.²⁴⁸In January 2016, the Indian government informed the constitutional court that a bill based on the Law Commission report was pending consideration, this would also clarify the government’s position on Section 309 of the Indian Penal Code.²⁴⁹

In short, just like in South Africa, everything is there for the implementation of a framework that responds to the evolved convictions of the Indian community.

²⁴⁶ *Rathinam v Union of India* 1994 SCC (3)394 at paragraph 104. The recommendations of the Law commission were accepted by the government and a bill in line with such recommendations was drafted and passed but was not taken any further until 6th Lok Sabha was dissolved

²⁴⁷ As discussed by Farooq Khan and George Tadros. “Physician-assisted suicide and Euthanasia in Indian Context: Sooner or Later the Need to Ponder” (2013) Jan-Mar; 35 (1) *Indian J Psychol Med.* 101-105

²⁴⁸ Ibid

²⁴⁹ Livemint. “Considering law Commission report on passive euthanasia: Government tells Supreme Court”. Jan 2016 www.livemint.com> politics>policy (Accessed: 02 November 2016)

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

When gleaned from all utilised sources in this research, my observation is that the courts have always been central in the development of the legal framework on the subject of euthanasia across the jurisdictions discussed, perhaps with the exception of Belgium. The striking similarities between the South African, Indian and Canadian constitutional frameworks are that these countries are constitutional democracies and embrace the principles of separation of powers between the state organs, which are the executives responsible for the running of the state; the judiciary which enjoys independence from influence of other organs, and the legislature whose task is to make and repeal laws. It is glaringly obvious that on the debate of euthanasia, even though the courts played a central role in the interpretation and the developments of the law on the subject matter, their powers were to an extent limited due to the doctrine of separation of powers. The courts were often forced to leave to the legislators the ultimate responsibilities of repealing and passing of legislation.

It is also apparent from the developments that were followed by the passing of legislations on euthanasia, that these were a response to the *boni mores* of the respective countries that had evolved over lengthy periods, and were a direct product of constant and organised pressure that were put on governments. In Canada, for example, parliament was also bound to observe and respect the doctrine of separation of powers when it responded to a direct order of the court to pass legislation in June 2016, similar to developments in South Africa and India. It would also seem that in line with the separation of powers, the legislator had to work tirelessly to meet the 12 month deadline until they were granted a four months extension by the court. It is not clear why the South African government would want to be in a similar situation. In fact, South Africa has been placed in a better position by those countries that have already implemented laws that dealt decisively with the questions around the controversial concept of euthanasia. South Africa could use these observations and the experiences

of those countries like The Netherlands and Belgium to come up with an even more advanced and progressive legal framework.

Indian and South African courts seem to have the same understanding insofar as the interpretation of the right to life and the value of the right within society. The developments on euthanasia seem to follow the same direction in both countries. For instance, in *Tellis v Bombay Municipal Corporation* 1987 LRC (Const), where the Supreme Court of India recognized in principle that the right to life (interpreted to include a right to livelihood), entitled a group of pavement dwellers, who lived and worked on the streets, to resist eviction. This is in line with the argument of O'Regan *J in S v Makwanyane*, as the court engaged in an interpretation of the right to life, that the right to life and the right to dignity are intertwined as well as that the right to life is more than mere existence, it is the right to be treated as a human being with dignity. In South Africa, the law has been developed to such an extent that the only remaining step is to legislate and/or implement the draft bill proposed by the South African Law Commission. In India, on the other hand, a draft bill proposed by the Indian Law Commission is still waiting for parliament to consider its implementation. From this, it would seem that both countries have nothing in principle that prevent them from implementing legislation on euthanasia in any given form. Just like in India, there is mounting pressure on the South African government authorities to initiate legislation that seeks to provide its population with a clear legal framework for the balanced realisation of all rights that are found to be competing, and also clarify the confusion that is created by the absence of a constitutionally competent guideline.

The rights relevant to the subject of physician-assisted suicide enjoy equal protection in terms of the South African constitution. A legal framework that must be provided is one which strikes a balance amongst these rights while ensuring consistent realisation of these without an obvious compromise of one over the other. This has been the approach in Canada, and South Africa would benefit immensely from their model, as the two countries have similar approaches in our Bill of Rights and the Rights Charter in Canada. The role of the court has been significant in not only interpreting laws created

by the legislators, but also by giving guidance on how the law should respond in addressing the competing and evolving interests of citizens in a particular jurisdiction. In all the jurisdictions discussed, courts play a central role in harmonising the demands of the citizens with the safe guards provided by the state in ensuring that rights of citizens are not violated or disregarded, because the state is concerned about its reputation in the international community.

As also submitted by some, including A Currie and De Waal (p267), with whom I agree, that from a constitutional perspective, the South African Law Commission's proposal does seem to strike a proper balance between the state's duty to protect life and a person's right to exercise the right to physical and psychological integrity, as stated in Section 12(1) and to human dignity as stated in Section 10 of the Constitution. There seems to be no clear principled position or explanation given by the South African Government for its reluctance to implement the proposals and recommendations offered by the South African Law Commission. As a result of the mounting pressure, developments on the convictions or the *boni mores* of those living in South Africa, implementation of these recommendations can no longer be avoidable as the law is meant to be responsive to the convictions of the community within which it operates.

In addition to the bill proposed by the Law Commission, there should be provisions that specifically cater for the establishment of structured and regulated palliative care as in Belgium. It should also be made compulsory for health insurance companies or medical aid schemes to include palliative care in their services. For those who are unable to afford a medical aid scheme, government or public hospitals must each establish a palliative care unit with health professionals to provide the services.

The recent developments in the case of Strachan-Ford are an illustration of the extent of the frustration and dilemma experienced by the ordinary South African and those in the medical profession, who are expected to operate within a given legal framework at a given time and within certain circumstances. Even those opposed to the High Court's judgment do not advance any substantial legally informed arguments against the

proposed legislation. During argument, the opposition can be simply summarised as more of a fear for the abuse of the proposed legislation and violation of rights of vulnerable groups. One does acknowledge that South Africa has a mainly illiterate or unsophisticated community and that these fears are in reality not far-fetched. Before legislation was passed in The Netherlands, the Royal Dutch Medical Association and the courts approved guidelines that would ensure minimal opportunities for abuse of the process. In order to address fears and dangers raised, in a South African context, similar control measures should be part of the legislation. This could be addressed by passing legislation which provides for the establishment of a multi-disciplinary committee that will monitor, regulate, investigate and assess cases for proposed euthanasia. The legislation should also provide guidelines, as proposed by the Law Commission, that would be constantly refined to ensure that the process was safe from abuse.

Furthermore, in The Netherlands, the process appears to mainly give powers to physicians during the decision-making process. The decision-making of patients are greatly dependent on the physician as they diagnose and advise, and may therefore erode patient autonomy. In South Africa, patient autonomy needs to be given more emphasis in line with Section 6 of the National Health Act.

Having learnt from the frameworks of other countries, I propose that, in addition to the requirements proposed by the South African Law Commission, that the following requirements be included in any legislative framework that seeks to address euthanasia:

- That any proposed form of euthanasia be considered with the written informed consent of the patient;
- That only a registered medical practitioner shall assess and represent to a panel established in terms of the legislation the proposal made and the circumstances under which the request was made;
- That the proposed procedure cannot be undertaken without consultation with the family and/or next-of-kin of the patient, provided this is with the consent of the patient;

- That all requests shall be considered if made by persons over the age of eighteen years.

In terms of the procedure for medical practitioners, I recommend that the guidelines to doctors put forward by McQuoid-Mason in response to the High Court judgment in the Stransham-Ford case be included in the legislative framework that will implement euthanasia in South Africa. These are:

- “Legally, there is a court order stating that a doctor may assist the patient to commit through voluntary active euthanasia, and that such a doctor may not be subject to criminal prosecution, a civil action or disciplinary proceedings by the HPCSA;
- Ethically, the biomedical ethical principles indicate that it is justified to assist the patient to commit suicide.
- The patient’s autonomy can be respected because the patient is mentally competent, has not been unduly influenced, made the decision freely and voluntarily, and has not requested from the doctor something illegal or unethical- in which case the doctor should decline and use other biomedical ethical principles to come to a decision.
- The terminally ill patient with a hopeless prognosis has been encouraged to undergo palliative care before seeking assistance to commit suicide;
- Further treatment of the patient is futile;
- The mentally competent patient has indicated that she or he still wishes to be subjected to voluntary active euthanasia;
- The patient’s next-of-kin have been consulted;
- The doctors have preserved careful records of all the steps taken by them before and while assisting the patient to end his or her life.”

In my view, these guidelines are sufficient to ensure that a specified and unambiguous procedure is provided to guide medical practitioners on any proposed processes.

Since the release of the discussion paper of the South African Law Commission, there is no evidence that there had been any meaningful engagement with its recommendations and the proposed draft bill. There have been no significant developments in government policy on the subject matter and no response or reaction to its recommendations.

To any argument against the implementation of a constitutionally competent framework, it must be recognised that all rights included in the Bill of Rights may be limited if such limitation is within the ambit of Section 36. The limitation of the right to life for instance would benefit those affected. Such limitation would also restore their dignity and relieve them of unbearable inhuman suffering as they would have been rendered dependent on others for their livelihood and basic needs. As O'Regan J put it in *Sv Makwanyane*, "... the inclusion of the right to life in the constitution was not simply to enshrine existence, but the right to human life and therefore right to share in the experience of humanity and the right to be treated as a human being with dignity, as without dignity, human life is substantially diminished. To her, without life, there cannot be dignity". The medical conditions of Stransham-Ford and Clarke made it impossible for them to share in the experience of humanity and the quality of their lives was substantially diminished, they no longer wanted to exist because their continued existence was without dignity. The implementation of a constitutionally-valid legal framework that addresses these issues, will ensure that citizens' constitutionally enshrined rights will be realised and protected. If terminally ill people with no prospects of recovery are granted the right to determine for themselves what they wish to do and how it should be done in any circumstances, it will uphold and protect their rights to freedom and security of the person as guaranteed in Section 12 of the Constitution.

As indicated by Ackermann J's "interpretation of the word "freedom" in *Ferreira v Levin* and as used in Section 11(1) of the Interim Constitution, failure to implement this legal foundation will amount to the legal restriction of freedom of citizens without sufficient reason and a violation of the right of an individual not to have obstacles to possible

choices and activities placed in their way by the state.”There can be no fair argument against the implementation of the Law Commission’s recommendations.

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