Physician assisted suicide in South Africa: The Constitution and the Socio-economic Dilemma

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Declaration by Candidate

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ABSTRACT

This research project explores physician assisted suicide in South Africa, as well as whether the current legal position should be reconsidered. It acknowledges that there are justifications that exist in the law such as the South African constitution, the biomedical ethical principles and persuasive foreign law which support physician assisted suicide. However, this research paper submits that the status quo must be maintained because South Africa is not ready for something like physician assisted suicide due to the socio-economic context. There are so many challenges in the health sector. South Africa, as a country, needs to address these first to ensure that terminally ill patients across the country receive the best treatment and care as possible so as to cope with the pain. We cannot allow terminally ill patients to just exercise their "right to die" because the state has an interest in the lives of the people in South Africa and may limit rights if doing so is in a reasonable and justifiable manner.

It would be dangerous to legalize physician assisted suicide in a country like South Africa where there are so many people who sick and do not have the means to exhaust all means available to cope with their sickness. It is such people that may use the route of physician assisted suicide to escape their misery. This paper views physician assisted suicide in light of the socio – economic context in South Africa as opposed to a purely rights based approach that other research papers usually focus on.

Chapter One

INTRODUCTION

1.1 Background of the research

> "Death draws the final curtain on all our lives. How that occurs, and the manner in which we should approach death, has provided grist to the mill of philosophers, poets, politicians, social commentators and comedians down the ages and it is doubtful that any conclusion common to all humankind will ever be reached. Whether we think Socrates was correct to say that 'death may be the greatest of all human blessings', or that Dylan Thomas was right to urge us, when faced with death, to 'rage, rage against the dying of the light', is a matter of personal philosophy and morality on which views diverge and always will. The law injects itself into this debate largely because of the enormous strides modern medicine has made in its ability to prolong life and postpone death. This has changed our understanding of death itself"[1]

The topic of end of life decisions remains fraught with controversy. One of the most controversial aspects of it is the physician assisted suicide aspect. The controversy is rooted in religious, moral and legal considerations. However, the biggest barrier of the practice of physician assisted suicide in South Africa is the existing legal position. Currently, assisted suicide is not permissible under South African Law.[2] Regardless of this fact, a considerable number of academic writers is of the view that the legal convictions of the society have changed and that the status quo needs to change as well, to reflect the current values of society.[3]

In 1998, after being approached by SAVES[4], the president of South Africa at the time, Nelson Mandela, mandated the South African Law Commission to present a proposal on assisted dying and related end of life decisions together with relevant legislation. The result of this mandate was Project 86[5] as well as the End of Life Decisions Bill of 1999. In its proposal, the commission provided the following options:

- The first option upheld the current legal position with regard to end of life decisions. In other words this option proposes that assisted dying must remain unlawful and attract criminal and/or civil liability as it always have; or

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[1] *Minister of Justice and Correctional Services v Estate Stransham-Ford 2017 (3) SA 152 (SCA*) 1.
[2] *Ex Parte Die Minister van Justisie: In Re S v Grotjohn 1970 (2) SA 355 (A*).
[3] http://www.cbc.ca/news/politics/how-20-years-has-changed-the-debate-over-assisted-suicide-1.1334158.
[4] SAVES is an organization which supports the use of living wills in patients where recovery from a medical condition is impossible.
[5]The South African Law Commission's Report 86 on "Euthanasia and Artificial Preservation of Life" 1998.

- The second option proposed that assisted dying must be legalized but the patient, medical practitioners and the family must be involved in making decisions; or
- The third option proposed the legalization of assisted dying subject to the involvement of an institutional ethics committee

In its report, the Law Commission formed the opinion that the first option was suitable for South Africa. While on the other hand, a considerable number of legal academics are of the view that the second option is more suitable. The proposed draft bill was tabled before parliament in the year 2000 but after that it did not receive further attention from the Minister of Health at the time, Manto Shabalala Msimang. Almost 20 years have passed now and nothing has been done about the proposed draft Bill.

Physician assisted suicide became a subject of public focus once again in 2015 when an application permitting this procedure was sought in the South African courts. This occurred in the case of *Stransham-Ford v Minister of Justice & Correctional Services & Others*[6] ("*the Stransham-Ford case"*). The High Court developed the common law as it relates to the crime of murder, in light of the constitutional right to dignity[7] and the right to security in and control over one's body.[8] The High Court did however, specify that its order only applies to the applicant and is not intended create new precedent.[9] In other words the order made by the High Court left the crimes of murder and culpable homicide in general, unaffected.[10] On appeal, the decision was overturned in *Minister of Justice & Correctional Services and Others v Estate Stransham-Ford & Others,*[11] by the Supreme Court of Appeal based on procedural grounds only and left the question of whether the constitution guarantees the right to die open. The court did however, make some suggestions as what should be taken into account should a need to address the issues surrounding end of life decisions arise.

1.2 Literature Review

There are various definitions that have been proposed in an attempt to understand the concept of physician assisted suicide. However, for the purpose of this dissertation, physician assisted

[6] 2015 (4) SA 50 (GP).
[7] Section 10 of the Constitution of the Republic of South Africa, 1996.
[8] Section 12 (2) (b).
[9] *Stransham-Ford supra* (HC Case).
[10] Ibid.
[11]*Stransham-Ford supra* (SCA Case).

suicide refers to a situation where a physician knowingly and intentionally provides a patient with the knowledge and/or means necessary to effect suicide.[12] It includes counselling the patient about the lethal doses of drugs, giving a prescription for lethal drugs or supplying such drugs.[13]

Physician assisted suicide is sometimes erroneously regarded as a form or type of euthanasia.[14] However, a close examination of these phenomena reveals that the two are not the same. Although both are end of life decisions, physician assisted suicide is different from euthanasia in that as far as the former is concerned, the act which leads to the death of the patient is performed by the patient himself or herself.[15] The physician merely gives information on how to do this, the drugs or a prescription for the drugs. On the other hand euthanasia entails the doctor to directly and actively participate in assisting the patient to commit suicide.[16] This dissertation focuses on physician assisted suicide only.

Physician assisted suicide is regarded as a criminal offence in South Africa.[17] However, a number of writers contend that this should be changed for various reasons. Regardless of the fact that there are those who are against the proposed change because they regard killing as intrinsically wrong, a number of individuals support the change since they believe that relief from excruciating pain could justify assisted suicide.[18] One of the authors who supports physician assisted suicide is Strauss. While he acknowledges that the value of life is incalculable, he also notes that there has been a shift from the emphasis of preservation of life towards quality of life.[19] He contends that this change is in accordance with the prevailing boni mores.[20] McQuoid-Mason contends that the four biomedical principles may be applied so as to justify legalized physician assisted suicide.[21] These are the principles of respect for autonomy, beneficence, non – maleficence, as well as justice. Anthony Egan who also supports legalized

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[12] Canadian Medical Association 2007.
[13] Ibid.
[14] KL Frances "Implementing a permissive regime for assisted dying in South Africa: a rights based analysis" (2015) (LLM Thesis) University of Kwa-Zulu Natal 17.
[15] Frances op cit.
[16] Ibid.
[17] *Ex Parte Die Minister van Justisie: In Re S v Grotjohn 1970 (2) SA 355 (A)*.
[18] A Egan "Should the state support the right to die?" (2008) *South African Journal of Bioethics and Law* Vol. 1 (2) 48.
[19] SA Strauss *Doctor, Patient and the Law: A Selection of Practical Issues* (1981) 336.
[20] SA Strauss *Doctor, Patient and the Law: A Selection of Practical Issues* (1984) 385.
[21] 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" (2014) *South African Journal Of Bioethics & Law* Vol. 8 (2) 34 – 40.

physician assisted suicide, argues that the question of morality should be left aside in this debate and that policies that will regulate physician assisted suicide should be put in place, provided doctors are willing to participate in the process.[22] Another proposed justification for allowing physician assisted suicide is the right to die with dignity[23] which is discussed in detail below.

There are also arguments which are against legalized physician assisted suicide. One of those is the argument put forward by Ryan Anderson who contends that physician assisted suicide will corrupt the practice of medicine and thus compromise the doctor-patient relationship.[24] He submits that the primary responsibility of doctors is to heal and preserve life.[25] Physician assisted suicide undermines this curative role since it entails doctors to help patients to die.[26] This, according to Anderson, reduces the patients' trust in doctors, as well as their commitment to patients.[27] The other argument is the one which is based on the socio economic circumstances in South Africa, which is also discussed below.

1.2.1 The "right to die"

The right to die is a notion which is found on the belief that individuals are entitled to end their own lives[28] and a concept which is usually applied in the context of persons who are suffering from terminal illness. Strauss strongly advocates the existence of the right to die regardless of the fact that the common law does not recognize that the individual has ownership over his own body.[29] This is in accordance with the dominus membrorum suorum principle which provides that no person is to be regarded as the owner of his own limbs.[30] Put differently, Strauss is of the view that even though an individual has no ownership over his or her body, he or she may nonetheless make the choice to terminate his or her life. On the other hand,

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[22] Egan op cit 51
[23] S Bhamjee "Is the right to die with dignity constitutionally guaranteed? Baxter v Montana and other developments in patient autonomy and physician assisted suicide" (2010) *Obiter,* Vol. 31 (2).
[24] RT Anderson "Physician assisted suicide corrupts the practice of medicine" (2015) *The Heritage Foundation* Issue 4391:1.
[25] Anderson op cit.
[26] Anderson op cit; LR Kass "Dehumanization Triumphant" (1996) *First Things.*
[27] Anderson op cit 2.
[28] D Benatar "Should there be a legal right to die?" (2010) *Current Oncology* Vol. 17 (5) 2.
[29] Strauss 1984 385.
[30] D Gracia in HA Ten Have et al *Ownership of the Human Body: Philosophical Considerations on the Use of the Human Body and Its Parts in Healthcare* (1998) 68.

Elizabeth argues that no has ever chosen whether or not they want to be born, therefore there can be no right to die.[31] This then raises the question whether the right to die actually exists.

Leon R. Kass submits that the right to die is insubstantial[32] because of the precursors pertaining to the meaning of rights.[33]He engages in a definition of the term "right" in order to determine whether indeed the right to die is actually a right. Kass also refers to philosophers such as John Locke and Thomas Hobbes to explain that although rights such life and liberty are given to human beings by nature, the state of nature supports self-preservation and not suicide.[34] In addition to this argument, Christopher Szabo expresses reluctance to accept the concept of the right to die.[35] He explains that he finds this concept problematic, especially in the psychiatric field because it is discriminatory in that only mentally competent, terminally ill patients may choose whether or not they want to exercise the so called right.[36] Mentally incapacitated but terminally ill patients have no say with regard their deaths.[37] This is a very important point that has been raised here. This may be an issue in all forms of end of life decisions and not only with regard to physician assisted suicide – more especially in cases of unconscious patients who have their families or doctors to make decisions for them.

On the other hand, Grayling is of the view that the right to die is implied in the right to life which is recognised in all legal systems globally.[38] He argues that the right to life cannot be defined to mean bare existence but it means that the life of an individual has to be of a certain minimum quality and that anything below this minimum quality justifies death.[39] Grayling then classifies permanent injury and terminal illness as conditions of life that are below the minimum quality of life.[40] Some jurisdictions have accepted this argument. However, in South Africa the position remains unclear because the Supreme Court of Appeal in *Minister of Justice & Correctional Services v Estate Stransham-Ford*[41] merely stated that there is no unanimity amongst the various jurisdictions, but did not make a decision of its own on the matter. It is submitted in this dissertation that such an assertion cannot be correct because the right to life

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[31] O Elizabeth "The right to die with dignity" (1980) N.Y: Public Affairs Committee. New York.
[32] LR Kass "Is there a right to die?" (1993) *The Hastings Centre Report* Vol. 23 (1) 34.
[33] Kass op cit 38.
[34] Ibid.
[35] CP Szabo "Public deaths and the right to die" (2005) *South African Psychiatry Review* Vol. 8 (2) 41.
[36] Szabo op cit.
[37] Ibid.
[38] AC Grayling "The Right to die" (2005) *BMJ* Vol. 300: 799.
[39] Grayling op cit.
[40] Ibid.
[41] *Stransham-Ford supra* (SCA Case).

as contained in the constitution relates to an individual in relation to the state and not just the individual alone.

According to McQuoid-Mason, a terminally ill patient who suffers from unbearable pain may invoke his or her constitutional rights to privacy, freedom and security of the person and respect for autonomy as well as the protection of human dignity to prove that he or she can indeed decide when to end his or her life, provided there is evidence to show that the patient in question is mentally competent.[42] In other words, McQuoid-Mason is of the view that the mentioned rights in the constitution, protect an individual's choice to terminate his or her own life.

A Canadian court in *Carter v Canada (Attorney-General)*[43] and other previous cases have reached the same conclusion as McQuoid-Mason.[44] In South Africa, the Gauteng High Court held that the rights mentioned above do afford the applicant a choice to end his life and that the common law of criminalizing assisted suicide was thus unconstitutional, but only as far as it relates to physician assisted suicide.[45] Although this judgement was invalidated by the Supreme Court of Appeal, the High Court made a noteworthy comment on how it found it absurd that in a country as free as ours people are not allowed to commit suicide having been duly assisted by professionally trained doctors whereas they are allowed other things including termination of pregnancy.[46] Based on the literature review above, chapter three of this dissertation will show that the right to die does exist and that even though not expressly included in the constitution, other rights in the constitution guarantee its protection.

1.2.2 The Socio Economic Dilemma

In paragraph 1.2.1 above it was indicated that chapter three of this dissertation will show that the constitution protects the right to die with dignity. However, in a country like South Africa there are many relevant factors that need to be taken into account when deciding an issue as huge and sensitive as physician assisted suicide. The socio-economic context is one of those factors. This dissertation looks at this factor especially in relation to the health sector in South Africa. According to Ncayiyana, South Africa is not a safe place to have legalized physician

[42] MA Dada & DJ McQuoid-Mason (eds.) *A – Z of Medical Law (*2011) 28.
[43] *2015 SCC 5.*
[44] *Baxter v Montana Cause No ADV -2007-787.*
[45] *Stransham-Ford supra* 45.
[46] *Stransham-Ford supra* 25.

assisted suicide.[47] He maintains that physician assisted suicide could considered and be regarded as acceptable only in a country which has the very best medical and palliative care, as well as a strong culture of respect for human life.[48] I think that this is a very good suggestion because it captures that there needs be a certain standard in terms of resources that a country must meet before physician assisted suicide can be legalized.

It follows then that the question that we should ask ourselves is whether healthcare in South Africa meets the standard suggested by Ncayiyana. According to Moyakhe, there is still a huge difference between the rich and the poor in South Africa. Access to health care and the quality of health care are determined by one's economic class.[49] The rich are able to access quality treatment including palliative care which is mostly available only the private health sector, for a fee of course. The poor go to public institutions where the quality of care is unsatisfactory and even the resources are inadequate. Statics reveal that 70.5% of the South African population goes to public institutions.[50]

In addition to this, the minister of health, Dr. Aaron Motsoaledi once stated,

> "I think it will help us to start sifting fact from fiction. Fact number one: We are a country, which is spending more money on health but having poorer outcomes – that is a fact"[51]

The previous two statements alongside with statistics, indicate that the South Africa does not meet the minimum standard proposed by Ncayiyana, who also argues that physician assisted suicide should be a measure of last resort and that if we legalize PAS regardless of the status quo, there is a risk that euthanasia will be used as a substitute for medical treatment.[52] Based on this it can be concluded that South Africa needs to improve the situation in the healthcare sector first. This eliminates the risk posed by legalizing physician assisted suicide regardless of the status quo. Accordingly, physician assisted suicide needs to remain legally impermissible until there is proper medical care in the country.

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[47] D Ncayiyana "Euthanasia: No dignity in death in the absence of an ethos of respect for human life" (2012) *South African Medical Journal* 102(6) 334.

[48] Ibid.

[49] NP Moyakhe "Quality healthcare: An attainable goal for all South Africans?" (2014) *South African Journal of Bioethics and the Law.* Vol. 7, No. 2.

[50] http://www.gov.za/ABOUT-SA/HEALTH.

[51] Cited in Moyake op cit 80.

[52] Ibid.

1.3 Statement of Purpose

The purpose of this dissertation is to determine whether or not South Africa should reconsider the current legal position to allow physician assisted suicide. To reach a conclusion, the arguments in favor and against physician-assisted suicide are considered and critically analyzed. The dissertation will also refer to how foreign jurisdictions have addressed this issue and make recommendations on the proper approach to the issue of physician assisted suicide. It is submitted that even though arguments such the one on the existence of the right to die may be legally valid, the current legal position regarding physician assisted suicide in South Africa should be maintained because of the socio-economic challenges that our country is faced with.

1.4 Research Problem

The support for legalizing physician assisted suicide in South Africa has gained momentum. The formation of organizations such as Dignity SA[53], a strong, active and highly influential advocate for physician assisted suicide, is a clear indication of this. In 2014, Dignity SA was involved in the preparations for a court application seeking the similar relief that was sought in the *Stransham-Ford case*.[54] Unfortunately, the applicant died before the matter went to court.[55] Mr. Stransham-Ford then stepped in the place of the deceased application.[56] The organization also made some statements about its involvement in the *Stransham-Ford case* and it also indicated that it was raising funds for the appeal against the High Court decision.[57]

The cause for concern is that due to the *Stransham-Ford case,* South Africa was at the brink of legalizing physician assisted without a proper consideration of the factors that are relevant to the issue. The rights based approach adopted in the case is a valid one. However, it overlooks certain things which are highly relevant factors, especially to a country like South Africa. The rights based approach overlooks the reality that exists in this country i.e. the socio-economic challenges. Therefore, an approach that addresses this is required and would be very useful in deciding whether or not to change our law. Such an approach is the socio-economic approach adopted in this dissertation.

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[53] http://www.dignitysa.org/.
[54] *Stransham-Ford supra* 75 – 76.
[55] *Stransham-Ford supra*.
[56] Ibid.
[57] Ibid.

1.5 Significance of research

Numerous studies and other types of writings have been published on physician assisted suicide, both in South Africa and globally. However, these are typically motivated by legal, ethical, philosophical or religious considerations. This study has adopted a different approach which looks at physician assisted suicide in relation to the socio-economic context of South Africa. Accordingly it brings a different view on the topic and encourages the reader to think differently about the whole issue.

1.6 Research questions

The conduct of this research is intended to answer questions listed below:

a) What does the South African law provide with regard to assisted suicide?

b) Does the constitution protect the right to die?

c) What socio-economic constraints does South Africa face?

d) Is South Africa a proper place to allow physician assisted suicide?

1.7 Objectives

The main objectives of this study are to:

a) Explore the phenomenon of physician assisted suicide

b) Examine the legal position on assisted suicide in South Africa

c) Examine the validity of the right to die

d) Consider the socio-economic challenges in South Africa

e) Determine whether physician assisted suicide should be allowed in South Africa.

1.8 Research methodology

This research is conducted through desktop research. This refers to the collection of information from secondary sources such as books, journal articles, newspaper articles, internet

sources and other public documents.[58] This means that there will be no interviews conducted or interaction with people in relation to the research. Both qualitative and quantitative research methods will be employed. Qualitative research is defined as research that focuses on the collecting non-numerical data and the interpretation of such data so as to understand the area of question.[59] Quantitative research is the direct opposite of qualitative research.[60]

1.9 Over view of chapters

Chapter One lays down the background of this research project and states its purpose, as well as the research problem; the chapter enumerates the research questions and objectives of the research; and outlines literature review, the significance of the research and research methodology.

Chapter Two sets out the legal position with regard to physician assisted suicide in South Africa

Chapter Three examines the right to die with dignity as well as whether or not it is a constitutionally protected right.

Chapter Four discusses the socio-economic constraints that exist in South Africa in relation to the physician assisted suicide debate.

Chapter five carries the conclusion.

1.10 Conclusion

This chapter is the general introduction to the research topic of physician assisted suicide in South Africa. The purpose of the study is to determine whether it is advisable for South Africa to decriminalize the latter practice. A possible solution is also sought through the conduct of the study. The author has conducted literature review on physician assisted suicide to gain understanding on the topic and have an idea how have various governments, scholars and writers dealt with the issue. Equipped with this, the author then formulates her own line of reasoning.

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[58] https://www.b2binternational.com/assets/ebooks/mr_guide/04-market-research-ch4.pdf.
[59] https://www.thoughtco.com/qualitative-research-methods-3026555
[60] Ibid.

Chapter Two

THE SOUTH AFRICAN PERSPECTIVE OF PHYSICIAN ASSISTED SUICIDE

2.1 Introduction

The debate surrounding physician assisted suicide as well as other related aspects of end of life decisions has gained momentum over the recent years not only in foreign jurisdictions, but also in our own country. Organizations are fiercely lobbying for the "right to die with dignity."[61] It is important to note that suicide, which involves an act of intentionally bringing about the death of oneself,[62] is no longer a criminal offence in terms of South African law.[63] However, as far as assisted suicide is concerned, a different approach applies. In the course of determining whether or not South Africa should adopt a different legal approach with regard to physician-assisted suicide, it is necessary to examine the current law relating to it. This chapter discusses South African law as it relates to physician assisted suicide, as well as the manner in which our courts have dealt this issue previously.

2.2 An Overview of the Law

South Africa does not have legislation which regulates physician assisted suicide. Although there have been suggestions for such, the legal position as it relates to assisted suicide in general (including physician assisted suicide) is dealt with as dictated by the common law only. In terms of the common law, a doctor who aids a patient to commit suicide commits a criminal offence and may be found guilty of murder or, depending on the circumstances, culpable homicide. This principle was established in the case of *Ex Parte Die Minister van Justisie: In re S v Grotjohn*[64] which is discussed in detail below.

2.3 Ex Parte Die Minister van Justisie: In re S v Grotjohn[65]

The South African courts have been confronted with the issue of assisted suicide prior to the *Grotjohn decision*. However, the current best-known and most authoritative case on assisted

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[61] http://www.dignitysa.org/blog/.

[62] *Minister of Justice and Others v Estate Stransham-Ford 2017 (3) SA 152 (SCA)* 30.

[63] *R v Peverett 1940 AD 213.*

[64] *1970 (2) SA 355 (A).* Referred to as *"Grotjohn"* hereafter.

[65] *Grotjohn* supra

suicide is a subsequent decision by the Appellate Division (now known as the Supreme Court of Appeal) in the *Grotjohn case*. The *Stransham-Ford case*[66] which actually dealt with physician assisted suicide amongst other things, recently came before the South African courts. Nonetheless, the *Stransham-Ford case* will not be dealt with in this chapter because it was overturned on appeal and thus did not become precedent.

2.3.1 The Facts

This case involves a couple that was unhappily married and whose marriage was close to a breaking point. The deceased was the accused's wife who suffered from manic depression and was also partially paralyzed. She had denied the accused conjugal rights, who then had an extra-marital relationship with another woman whom he married after the death of Mrs Grotjohn. On the day in question, Mrs Grotjohn had complained that the gun owned by the accused would not shoot since it had been broken and required repairs. The accused took the gun and fired one shot from the balcony to prove that the gun would work regardless of the fact that it was broken. A heated argument later ensued between married couple, concerning the extra marital affair. The argument continued to a point where Mrs Grotjohn became extremely angry and threatened to kill herself. The accused fetched the fully loaded gun from elsewhere in their apartment and handed it to his wife, telling her that she must shoot herself if she wants because she is a burden. Mrs Grotjohn took the gun and shot herself to death.[67]

The accused was arrested and subsequently charged with murder. The Witwatersrand Local Division acquitted him of this charge. The court's decision was based on the reasoning that Mrs Grotjohn's death came about through her own independent action which then became a new intervening act, thereby breaking the chain of causation between the actions of the accused and her death. However, after the decision of the court a quo, the Minister of Justice at the time, submitted the following questions to the then Appellate Division for decision and as empowered by article 385 of the Criminal Procedure Act,[68]

> "a) Whether encouraging, providing the means for or helping a man or woman to commit suicide was a crime; and
> b) If so, what crime?" [69]

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[66] *Stransham-Ford v Minister of Justice and Correctional Services 2015 (4) SA (50).*
[67] *Ex Parte Die Minister van Justisie: In Re S v Grotjohn 1970 (2) SA 355 358 – 360.*
[68] Act 56 of 1955.
[69] *Grotjohn supra 359 D.*

2.3.2 The Judgement

The Appellate Division first dealt with the issue of suicide and attempted suicide, although this was not asked by the Minister of Justice. After a lengthy discussion of the legal opinions of various legal scholars and approaces by foreign jurisdictions, the court held that suicide as well as attempted suicide, are no longer a criminal offence according to South African law.[70]

The court then turned to first question asked by the Minister and held that "whether or not a person who instigates, assists or puts another in a position to commit suicide, would be guilty of an offence, would depend on the circumstances of each case." However, the criminal liability of the accused must be established as formulated by the ordinary principles of criminal law. The Appellate Division answered this question in light of the element of causation. The court explained that the deceased's conduct does not serve as a new intervening act which breaks the chain of causation and exonerates the accused because it is not completely independent of the accused's conduct. For the deceased's act to function as a new intervening act, the act in question must be a completely independent act in that it must be separate from and be unconnected to accused's prior conduct.[71]

The court explained further that where the deceased's act is part of a chain of events set in motion by the accused, any foreseeable possibility which he desired to bring about a certain outcome, indicates that it cannot be correctly said that the accused did not have the requisite intention. Saying so would be allowing him to hide behind the suicide committed by the deceased. Although the act by the deceased is a self-contained act and an immediate cause of death, it does not mean that it is completely separate from the act by the accused. It is reasonably foreseeable that the accused's conduct or behaviour may be an immediate leading cause of the action by the deceased. Therefore, a person who gives another means to effect suicide contributes to the deceased's act, as well as it consequences.[72]

The Appellate Division then turned to the second question submitted before it and decided that if an assisted suicide succeeds, that is to say, if the person who sought help with committing suicide indeed dies, the accused will be guilty of murder regardless of the fact that the fatal act was committed by a non-criminal hand of the deceased. The reason for this is that the accused

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[70] *Grotjohn supra 359 -363.*
[71] *Grotjohn supra at p363 – 364.*
[72] *Grotjohn supra 364.*

unlawfully and intentionally contributed to the death. However, if the suicide fails and the person does not die, the accused will be guilty of attempted murder. Depending on the circumstances of each case, in a successful suicide, the accused may be found guilty of culpable homicide.[73]

2.4 Causation

In the paragraphs above it was indicated that physician assisted suicide may result in a conviction for murder or culpable homicide in terms of South African law. Murder is a consequence crime. Since this is the case, the prosecution bears the burden of proving beyond a reasonable doubt that a sufficient causal connection exists between the conduct complained of and the prohibited consequence.[74] If not, either because there is no connection at all or the connection is too remote, the accused cannot be found guilty. Causation may be classified into two categories, namely factual causation and legal causation. Both must be proven in order to secure a conviction. This is because it is possible for the conduct in question to be the factual cause of the prohibited consequence but not the legal cause.

2.4.1 Factual Causation

Factual causation is concerned with proving whether or not the accused is the actual cause of the prohibited consequence complained of.[75] To establish this courts apply the "conditio sine qua non" or "but for" test.[76] In cases of positive conduct the question that is asked is, "had it not been for the accused's conduct would the consequence in question have occurred at all or when it did."[77] The purpose of this question is to remove the conduct of the accused from the chain of events and if the results would differ or remain the same.[78] If after the elimination of the accused's conduct the consequence disappears, it means that his or her conduct is indeed the actual cause of the consequence. However, if after the elimination the consequence nonetheless results, then the conduct of the accused is not the actual cause. With omissions liability, the conduct which the accused failed to perform when he should have is added to the chain of events.[79]

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[73] *Grotjohn supra 365.*
[74] J Burchell *Principles of Criminal Law* 4th ed. (2013) 91.
[75] Burchell op cit 94.
[76] Burchell op cit.
[77] Burchell op cit.
[78] Burchell op cit.
[79] Burchell op cit.

2.4.2 Legal Causation

Legal causation is intended to establish how sufficiently closely connected is consequence in question to the conduct of the accused.[80] The more remote it is, less likely it that the accused will be held liable. The purpose of legal causation is to establish whether the accused should be held responsible. Courts apply various tests including the direct cause test, proximate cause test and the new intervening act test. The latter is described as an "abnormal intervening event which serves to break the chain of causation."[81] What is normal or abnormal depends on the standards of general human experience. This inquiry is not concerned with whether or not there was an additional event in the chain, but whether such an event warrants the exoneration of the accused. According to Burchell, a number of factors are important in establishing the kind of acts or events that may break the chain causation[82] However, an event which would under normal circumstances qualify as a new intervening act may disregarded if it was foreseen by the accused or due to his or her negligent or intentional conduct.[83]

The *Grotjohn decision* established the principle that helping another to commit suicide is unlawful. By giving the patient a lethal drug, prescription for lethal drugs or advice on lethal drugs and their doses the physician sets in motion a chain of events that might lead to or actually cause the death of the patient. He or she provides ammunition to help the patient achieve the desired result. Although the patient voluntarily takes the drug and does so on his or own, there is reasonable foresight that upon administration of the lethal drug, the patient will die. Therefore the patient's conduct is disregarded as a new intervening act. Accordingly the conclusion is that a link exists between the conduct of the physician and the patient's death. It is on this basis that a conviction for murder or at least, depending on the surrounding circumstances, conviction for culpable homicide is justified.[84]

2.5 The Guidelines of the Health Professions Council of South Africa

The Health Professions Council of South Africa is a statutory body which was established in accordance with the Health Professions Act[85] which regulates health professions in the country. The Act controls, amongst other things, training, professional conduct and ethical behaviour

[80] Burchell op cit.
[81] Burchell op cit 95.
[82] Ibid.
[83] Ibid. 105.
[84] *Grotjohn supra* p365.
[85] Act 56 of 1974.

and ensures compliance with healthcare standards.[86] The Council regulates health professions in order to protect patients. Consequently, the Council has set out guidelines contained in a number of booklets.

Booklet 7 is relevant to the issue dealt herewith. In terms of these guidelines, physician assisted suicide is condemned and regarded as unethical.[87] The guidelines reiterate that physicians have the duty "to heal, relieve pain and suffering and protect the best interests of patients" even in the case of incurable illness.[88] The Guidelines also deal specifically with the duty of healthcare workers involved with terminally ill patients. Their primary duty is to help patients maintain optimal quality life by controlling the symptoms of the illness and thereby enabling the patient to be comfortable and have a dignified death.[89] The healthcare workers are required to have due regard for patient autonomy, inclusive of the right to refuse treatment or request palliative care that may in the course of alleviating pain, hasten death.[90] However, the guidelines expressly provide that physicians are prohibited from assisting patients to commit suicide and should refrain from doing so.[91] Emphasis is placed on administering treatment that will alleviate pain and enable patient in the terminal stages of illness to feel as comfortable as possible.[92] In addition to the HPCSA guidelines there is the Hippocratic Oath. The Oath set sets out some ethical standards for medical practitioners and amongst other things, requires them to do no harm to their patients.[93] This may be interpreted to indicate that the Oath does not support physician assisted suicide.

2.6 Some suggestions on the exclusion of criminal liability

It is trite law that if a person is charged with a certain crime, he or she has the right to a raise a valid defence in justification his or her actions or behaviour. The purpose of the defence is to render lawful, conduct or behaviour which is under usual circumstances regarded unlawful.

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[86] Section 3 of the Act.
[87] The Health Professions Council of South Africa Guidelines on the Withholding and Withdrawing Treatment 8.
[88] The Health Professions Council of South Africa Guidelines on the Withholding and Withdrawing Treatment 8.
[89] Ibid.
[90] Ibid.
[91] Ibid.
[92] Ibid.
[93] Walton M & Kerridge I "Do no harm: Is it time to rethink the Hippocratic Oath?" (2014) *Med Educ.* Vol. 48 (1) 19.

Various possible defences have been suggested including consent, medical necessity and compassion.[94]

In some foreign jurisdictions, the courts have accepted that consent may be used as defence in cases of assisted suicide but only to the extent that such occurs within the context of the doctor-patient relationship. This was in the *Baxter case*[95]where the State Supreme Court did not base its decision of the issue in light of the constitution as the trial court had done. Instead, it considered factors that would vitiate consent, with conduct that is against public policy being listed as one of the factors. The court held that there is nothing in its precedent or Montana statutes which indicates that physician assisted suicide is against public policy.[96]

2.6.1 Consent as a legal defence in South Africa

Consent refers a waiver of rights of a person by giving permission for something to be done to them, which is usually guarded against by his or her rights.[97] In the context physician assisted suicide consent would mean that the patient agrees that the physician gives him or her drugs that will cause the death of the former. However, in terms of the general principles of criminal law, consent given by a person does not excuse an offender from committing a criminal offence.[98] This is because in the criminal law context, harm caused by a perpetrator does not affect the victim only but also the society at large.[99] Hence, the power to consent is not vested to the victim.[100] Nonetheless, there are instances where consent may be accepted as a valid defence. This is possible in offences where the unlawfulness of the perpetrator's conduct depends on whether or not the victim had consented to such conduct.[101] For example, sexual offences. In such instances, consent may be used as a valid legal defence if the following requirements are met:[102]

a) "The patient's consent in the circumstances must be recognised by law as a possible defence
b) The consent must be real; and
c) The patient must, in law, have consensual capacity"

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[94] K Klothen "Tinkering with the legal status quo on physician assisted suicide: A minimalist approach" (2013) Vol. 14 *Rutgers Journal of Law and Religion* 377.
[95] *Baxter v Montana 2009 MT 449.*
[96] *Baxter supra 1217.*
[97] Burchell *op cit* 204.
[98] Ibid.
[99] Burchell *op cit* 204.
[100] Ibid.
[101] Ibid.
[102] Ibid.

A person can validly consent to bodily harm or the risk of harm, if such harm is not *contra boni mores* or public policy. In the context of the doctor-patient relationship, consent to bodily harm is common in during the course of diagnosis of illness as well medical treatment. Consent in this context is referred to as informed consent which must also satisfy some requirements as formulated by the court in the *Castell case*.[103] On the other hand, physician assisted suicide involves not only consent to bodily harm but consent to conduct which is intended to cause the death of the patient in question. The common law does not recognise an individual's power to consent to being killed and accordingly, the defence of consent is not regarded as a valid legal defence which can purge murder or culpable homicide of the element of unlawfulness.[104]

2.6.2 Medical necessity as legal defence

According to the principles criminal law, an accused can successfully invoke the defence of necessity if he finds himself in a situation where he is confronted with a choice between two evils. The one evil involves suffering some harm (usually death or serious injury) and the other evil involves breaking the law. The person then chooses the latter option in order to avoid suffering harm.[105] This defence is legally acceptable because both legal and social public policy considers it desirable to allow a faced with such a situation to violate the law (the lesser evil) so as to avoid the greater evil.[106]

However, an accused must satisfy the following requirements:[107]

a) "A legal interest of the accused must have been endangered
b) By a threat which had commenced or was imminent
c) But such threat must have not been caused by the accused fault
d) It must have been necessary for the accused to avert the danger; and
e) The means employed for this purpose"

Unfortunately, the existing number cases involving intentional killing are concerned with measuring the life of accused against that of the deceased[108] as opposed to measuring taking the life of a patient who is terminally ill against continued life of the same patient. Some writers quote the English case of Re A[109] as a persuasive law where the defence of necessity might

[103] *Castell v de Greef 1994 (4) SA 408 (C).*
[104] *R v Peverett 1940 AD 213 218; Ex Parte Die Minister van Justisie: In Re S v Grotjohn 1970 (2) SA 355.*
[105] Burchell *op cit* 160.
[106] Ibid.
[107] Ibid.
[108] *S v Bradbury 1967 (1) SA 387 (A); S v Goliath 1972 (3) SA 1 (AD.)*
[109] *Re A (Conjoined twins) [2001] 2 WLR 480.*

work in as far as physician assisted suicide is concerned.[110] That case is distinguishable from physician assisted suicide because there one twin was to be surgically removed from the other because both lives of the twins were to die if this was not done. This sounds like a case of active euthanasia as opposed to assisted suicide. Another thing is that by looking at the requirements of necessity, one can conclude that a physician might not succeed in raising it as a defence because according to the requirement it must be accused who breaks the law to protect himself. In the case of physician assisted suicide it would be one person who breaks the law to relieve another from a continuing threat (living in pain).

2.7 Conclusion

This chapter examined the position of law in South Africa regarding assisted suicide. The Appellate Division in the *Grotjohn case*[111] laid down the law and declared that assisting a person to kill themselves is a crime, even if it is the deceased that performs the fatal act. Depending on the circumstances of each case, the accused could be found guilty of murder or at least culpable homicide. The guidelines of the HPCSA is in agreement with judicial precedent. They prohibit and discourage physician assisted suicide and neither consent nor medical necessity may be used as a justification.

[110] Klothen *op cit*.
[111] *Grotjohn supra* 365.

Chapter Three

IS "THE RIGHT TO DIE" A CONSTITUTIONALLY PROTECTED RIGHT?

3.1 Introduction

Proponents of physician assisted suicide insist that the law should be changed because persons have the die with dignity. The essence of the right to die argument is that decisions concerning the life and death of a person should be left to the individual.[112] On the other hand, opponents contend that the constitution guarantees the right life only and that the so called "right to die" is not a human right protected by the law.[113] In light of these arguments, this chapter examines whether the right to die, even though not expressly provided for by the constitution, is impliedly protected through other rights in the Bill of Rights.

3.2 The principle of patient autonomy

One of the main arguments in support of the right to die and physician assisted is founded on the principle of autonomy. Autonomy in the general sense refers to the ability persons to make decisions for themselves without interference by others and without limitations that hamper their capacity to make a meaningful choice.[114] Central to the concept of autonomy is who may be characterized as an autonomous person. According to Mappes and DeGrazia an autonomous person is someone has the capacity to make rational and unconstrained decisions and who also has the capacity to act in accordingly.[115]

In the context of health care, autonomy is defined within a set of four cluster principle known as principalism which is one of contemporary health care ethics. It means that a patient has the right to make independent decisions that affect their health.[116] This is the first of the four clusters of principalism. Others are beneficence (act for the benefit of the patient), non – maleficence (do no harm) and justice (fairness).[117] Patient autonomy requires non – interference with the patient's decision and vests the power to decide entirely on the patient

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[112] GAM Widdershoven "Beyond Autonomy and Beneficence: The Moral Basis for Euthanasia in the Netherlands" (2002) *Ethical Perspect* Vol. 9 (2-3).
[113] *Ibid.*
[114] D Van de Reyden "The right to respect for autonomy part 1: What is autonomy all about"' (2008) Vol. 38 (1) *South African Journal of Occupational Therapy* 27.
[115]TA Mappes & D DeGrazia *Biomedical Ethics*, 4th edition. (1996) New York: McGraw Hill, Inc.
[116] K Moodley *Medical Ethics, Law and Human Rights – A South African Perspective*. (2017) Van Schaik Publishers 42.
[117] Ibid. 41.

and is regarded as the pillar of health care professions.[118] Every patient has the right to autonomy, unless it has been declared that he or she does not qualify as an autonomous person. This may be the case where the patient is a minor, suffers from mental incapacity or was unduly influenced or coerced.[119]

It is important to note that the right to autonomy is not explicitly provided for in the Constitution as an independent right. In fact, the courts have held that autonomy does not qualify as a constitutional right but is instead a value underlying the Constitution.[120] However, be that as it may, a close examination of the right to security in and control over one's body[121] and the right to privacy[122] indicates that an argument may be made for an existence of the right to autonomy and such right is protected by the Constitution.

3.3 The right to privacy

The Constitution is the supreme law in the country.[123] The second chapter of the South African Constitution contains the Bill of Rights which sets out the fundamental rights guaranteed to everyone in the country. The Bill of Rights is regarded as the cornerstone of the South African democracy.[124] Section 14 provides,

> "Everyone has the right to privacy, which includes the right to not have –
>
> a) Their person or home searched;
> b) Their property searched;
> c) Their possessions seized; or
> d) The privacy of their communications infringed"

In two South African cases the Constitutional court has held that the right to privacy encompasses "the right of persons live life as he or she pleases and not to be interfered with."[125] In Bernstein v Bester NO,[126] Justice Ackerman describes the right to privacy as one which

[118] Van de Reyden *op cit* 27.
[119] Moodley op cit 42.
[120] *AB and Another v Minister of Social Development 2016 (2) SA 27 (GP) 46.*
[121] Section 12 (2) of the Constitution.
[122] Section 14.
[123] Section 2.
[124] Section 7 (1).
[125] *Bernstein v Bester NO and Others 1996 (2) SA 751 67; NM v Smith 2007 (5) SA 250 (CC).*
[126] *Bernstein supra.*

protects an individual's 'inner sanctum'[127] from erosion by conflicting interests of the community, and more especially from interference by the state. The right to privacy guarantees persons the freedom to make certain fundamentally private choices free from interference.[128] Such choices may include decisions concerning one's body, relationships or home as they are part of the inner sanctum. Medical issues such as physician assisted suicide also fall within this category. The Supreme Court of Appeal has acknowledged this when it commented:

> "Whether we think Socrates was correct to say that 'death may be the greatest of all human blessings', or that Dylan Thomas was right to urge us, when faced with death, to 'rage, rage against the dying of the light', is a matter of personal philosophy and morality on which views diverge and always will. The law injects itself into this debate largely because of the enormous strides modern medicine has made in its ability to prolong life and postpone death"[129]

The argument put forward by those who advocate physician assisted suicide is that the government, by criminalizing physician assisted suicide, deprives individuals the choice to make decisions about their life and death. This is an unwanted interference as well as an infringement of the constitutional right to privacy.

3.4 The Right to Freedom and security of the person

According to section 12 (2) of the Constitution,

> "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."

The focus of this dissertation is on s12 (2) (b), which is the most relevant provision as far as physician assisted suicide is concerned. In analysing this section, Currie and Woolman give the following explanation,

> "Security in' and 'control over' one's body are not synonymous. The former denotes the protection of bodily integrity against intrusions by the state and others. The latter denotes" "the protection of what could be called bodily autonomy or self-determination against interference. The former is a component of the right to be left alone in the sense of being

[127] G Quinot "The Right to Die in American and South African Constitutional Law" (2004) *CILSA* Vol. 37 (2) 161.
[128] Ibid.
[129] *Stransham-Ford supra 1.*

left unmolested by others. The latter is a component of the right to be left alone in the sense of being allowed to live the life one chooses."[130]

From the above passage one can conclude that there is actually an overlap between the right to privacy and the right to bodily and psychological integrity. Another noteworthy thing is that there are no qualifiers to the right. In other words the right give everyone unqualified security and control over their bodies[131] and this in Quinot's view also includes end of life decisions. A proper interpretation of section 12(2) (b) is necessary in order to accommodate the right to die. This entails taking into account that in such a context, autonomy is a very important underlying value.[132]

3.5 Carter v Canada (Attorney General)[133]

This is a Canadian case which dealt with the challenge on the criminalization of physician assisted suicide as being in conflict with the Charter of Rights and Freedoms of Canada. This is an appeal of the judgement handed down by the British Columbia Court of Appeal. The discussion of this case in this chapter is important because our own courts have referred to and heavily relied to it in the unsuccessful attempt to decriminalize physician assisted suicide in the *Stransham-Ford* High Court case.[134] The other reason is that the Canadian Charter and the South African Bill of Rights are to a very large extent similar and the Canadian court gave a very accurate and detailed definition and application of the affected rights. Lastly, the facts in both cases are very similar.

3.5.1 The Facts

In 2009, Gloria Tylor was diagnosed (the appellant) with a fatal neurodegenerative disease which normally leads to loss of the ability to perform basic bodily functions including speech, walking, chewing, swallowing, as well as breathing.[135] She then decided to challenge the constitutionality of the provisions of the Criminal Code that prohibited assisted dying because

[130] Currie & Woolman "Freedom and Security of the Person" in Chaskalson et al *Constitutional law of South Africa Revision Service* 2 (1998) 39.
[131] Quinot *op cit* 158.
[132] Quinot *op cit* 159.
[133] *2015 SCC 5* (*"the Carter case."*)
[134] Especially in the Stransham-Ford High Court case.
[135] *Carter supra 11.*

she did not want to slowly and in extreme pain. She was joined in her claim Hollis Johnson and Lee Carter, who had assisted his mother to end her life by taking her to a suicide clinic in Switzerland.[136] The appellants contended that the provisions that prohibit physician assisted dying deprive competent adults, suffering from incurable medical condition. This leaves the patient to endure intolerable physical or psychological suffering, which is an impairment of their right to life, liberty and security of the person which is protected in s7 of the Charter of Rights and Freedoms.

3.5.1.1 The Canadian Criminal Code

The following provisions were challenged by the appellants:

Section 14 provides that individuals cannot validly consent to death and that in the event that such consent was actually given, the person who caused the death is not exonerated from criminal liability.

> "s21 (1) (b) Everyone is a party to an offence who does or omits to do anything for the purpose of aiding any person to commit it; or
>
> (2) Where two or more persons form an intention in common to carry out an unlawful purpose and to assist each other therein and any one of them, in carrying out the common purpose, commits an offence, each of them who knew or ought to have known that the commission of the offence would be a probable consequence of carrying out the common purpose is a party to that offence.
>
> s22 (1) Where a person counsels another person to be a party to an offence and that other person is afterwards a party to that offence, the person who counselled is a party to that offence, notwithstanding that the offence was committed in a way different from that which was counselled.
>
> (2) Everyone who counsels another person to be a party to an offence is a party to every offence that the other commits in consequence of the counselling that the person who counselled knew or ought to have known was likely to be committed in consequence of the counselling.
>
> (3) For the purposes of this Act, 'counsel' includes procure, solicit or incite.

[136] Ibid.

s222 (1) A person commits a homicide when, directly or indirectly, by any means, he causes the death of a human being.

(2) Homicide is culpable or not culpable.

(3) Homicide that is not culpable is not an offence.

(4) Culpable homicide is murder or manslaughter or infanticide.

(5) A person commits culpable homicide when he causes the death of a human being (a) by means of an unlawful act; …

s241 Everyone who:

(a) counsels a person to commit suicide, or

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

The Canadian Supreme Court examined these provisions and came to the conclusion that only two of them were more relevant in this matter, namely s14 and s241.[137] The other provisions would be affected as long as physician assisted suicide remained a crime.[138]

3.5.2 The Judgement

In examining the offensive provisions of the Criminal Code, the court focused on three provisions of the Charter, namely:

- Section 1 which states that "the Charter of Rights and Freedoms of Canada protects the rights and freedoms contained in it. Such rights and freedoms may be subject only to reasonable limits which are in accordance with the law and can be demonstrably justified in a free and democratic society."
- Section 7 affords "everyone the right to life, liberty and security of the person as well the right not to be deprived of such a right unless the deprivation of the right is conforms to the principles of fundamental justice."
- Section 15 (1) provides that "everyone is equal before the law and enjoys the right to equal protection and equal benefit of the law without being unfairly discriminated

[137] *Carter supra 20.*

[138] Ibid.

against and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

The court explained that to succeed on the claims relating to the violation of s7, the appellants must demonstrate that the mentioned provisions of the Criminal Code interfere with or deprive them of their life, liberty and security of the person. The appellants must also show that the deprivation concerned does not conform to the set principles of fundamental justice (arbitrariness, over broadness and gross disproportionality).[139]

The court proceeded with the analysis of s7 and found that each of the core elements were affected. Firstly, the right to life was affected since the prohibition on physician assisted suicide forced individuals who feared that they would reach a point intolerable suffering to end their lives prematurely.[140] Secondly, the prohibition of assisted dying negatively affected a fundamentally important and personal medical decision and also restricted her control over her bodily integrity.[141] This violated the rights to liberty and security of the person.

The next question to be addressed was whether the interference with the above rights could be justified in accordance with s1. The court found that the interference was not in accordance with s1 of the Charter because there was there was rational link between the purpose of the law and the limitation of the rights in question[142]. Secondly, the limitation was overbroad in that it prohibited everyone from assisted suicide and offered no exception even in cases of necessity.[143] Lastly, the violation was grossly disproportionate because it left the terminally ill to live in great suffering.[144]

Ultimately the court found that offensive provisions could not be saved by s1 of the Charter of Rights and Freedoms and accordingly declared that s241(b) and s14 were unconstitutional and void to the extent that they prohibit physician assisted death for competent and terminally ill adults in great suffering.[145] The sections were suspended for 12 months pending correction by the legislature.[146]

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[139] *Cater supra 55.*
[140] *Carter supra 57 – 58.*
[141] *Cater supra 65 – 66.*
[142] *Cater supra 83.*
[143] *Cater supra 86.*
[144] *Carter supra 90.*
[145] *Carter supra 127.*
[146] *Carter supra 128.*

3.6 Stransham-Ford v Minister of Justice & Correctional Services & Others[147]

Although the *Grotjohn case* established the relevant principles on assisted suicide in general, the courts were confronted with the issue of physician assisted suicide specifically in the *Stransham-Ford cases*. The cases deal with both issues of active voluntary euthanasia, as well as physician assisted suicide. However, this chapter focuses only on the latter aspect of the judgement.

3.6.1 The Facts

The applicant was 66 year-old terminally ill Advocate Robert Stransham-Ford. He was diagnosed with prostate cancer in 2013, which later affected the lower spine, kidneys and lymph nodes. The applicant's health had significantly deteriorated and he was in severe pain. As a result, he could not sleep nor cope with the pain without the aid of morphine and other painkillers. According to medical advice, the applicant had only a few weeks to live. Advocate Stransham-Ford then made an urgent application to the North Gauteng High Court for an order permitting him to request a medical practitioner to end his life or enable him to do so. The order, if granted, would also declare that such medical practitioner would be immune to liability arising from any criminal, civil and disciplinary proceedings.[148]

Being aware of the current legal position on physician assisted suicide, the applicant also sought development of the common law in light of the Constitution. For this contention, he invoked section 39 of the Constitution as well as the right to dignity,[149] and the right to bodily and psychological integrity.[150]

3.6.2 The Judgement

The High Court considered the current legal position and restated that both active voluntary euthanasia and physician assisted suicide are unlawful. The court felt, however, that a development of the law is required and that the applicant rightly relied on s39 of the constitution. The section deals with the interpretation of the Bill of Rights. It provides that when courts to interpret the latter they must:

> "a) promote values that underlie an open and democratic society based on human dignity, equality and freedom,

[147] *2015 (4) SA 50 (GP)* (the *"Stransham-Ford case.")*
[148] Stransham-Ford *supra* 53 – 56.
[149] Section 10 of the Constitution.
[150] Section 12 (2) (b).

b) consider international law and

c) may consider foreign law."[151]

The court explained that it is required in terms of this section to promote the spirit, purport and objects of the Bill of Rights when engaging the interpretation of legislation or when developing the common law or customary law.[152] This means in its attempt to develop the common law, the court needs to do so in light of the Bill of Rights. The court also stated that courts may develop the common law in order to give effect to a right that is not protected by the common law.[153] The High Court pointed out that the current legal position with regard to the issue at hand was established prior to the constitutional dispensation. Since South Africa is now a constitutional dispensation, the law must be developed to give effect to the rights of the applicant.

Judge Fabricius emphasised the importance of the right to dignity in the South African constitutional dispensation. He reiterated that the right to dignity is the touchstone of our political order. Not only is it a justiciable and enforceable right which is worthy of respect and protection but all the other rights in the Bill of Rights are interpreted in light of human dignity as a constitutional value. The court agreed that the applicant's life, taking into account his health condition, is not one with dignity.

The judgement records that at least 10 foreign countries permit assisted suicide or voluntary active euthanasia. The court particularly refers to the *Carter case*[154] decided by a Canadian court because of the big similarity it found between the Canadian Charter of Rights and the South African Bill of Rights. In the *Carter case,* it was found that the prohibition of assisted suicide with regard to competent terminally ill persons was a violation of the rights to life and liberty and security of a person. This violation could not be justified according to s 1 of the Charter. Relying on this decision and the above reasoning, Judge Fabricius granted the order sought by the applicant.

3.6.3 The Appeal

Unfortunately, the High Court decision overturned in an appeal to the Supreme Court Appeal[155]

[151] Section 39 (1).
[152] Section 39 (2) of the Constitution.
[153] Section 8 (3) (a).
[154] *Carter v Canada (Attorney-General) [2015] SCC 5.*
[155] *Minister of justice and Others v Estate Stransham-Ford 2017 (3) SA 152 (SCA).*

The court gave the following three explanations. Firstly, the applicant died two hours before the High Court delivered its judgement. The Supreme Court of Appeal explained that when the applicant died, his claim no longer existed as his legal personhood had terminated. The trial judge should have rescinded the order as soon as he was made aware of this fact.
Secondly, the law was not examined adequately and was incorrectly interpreted. The authorities relied upon by the court with regard to active voluntary euthanasia and physician assisted suicide were incorrect and thus the court examined the incorrect law.

Lastly, the order was based on incorrect and limited factual basis and without affording interested parties a proper opportunity to be heard. It was not disclosed that the applicant had changed his mind about his manner of death and that he was in a comatose before the case was heard. In addition, the matter was brought as an urgent matter. Consequently, the court could not obtain sufficient evidence in deciding the complex issues involved.
The Supreme Court of Appeal discussed the law in depth but declined to entertain the development of the common. It left the task to the legislature and made some suggestions as to what should be taken in to account when addressing the matter.

3.7 Limitation of the rights in the Bill of Rights

The South African Constitution affords everyone certain human rights. These rights are listed in the Bill of Rights which contained in Chapter 2 the Constitution. However, the protection of these rights is not absolute. The Constitution also contains a general limitation clause[156] which sets out the criteria for the justification of restriction of the rights in the Bill of Rights. The general limitation clause provides:

> "Limitation of Rights
>
> 36 (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all the relevant factors including:
>
> a) The nature of the right
> b) The importance of the purpose of the limitation
> c) The nature and extent of the limitation

[156] Section 36 of the Constitution.

d) The relation between the limitation and its purpose
e) Less restrictive means to achieve the purpose

(2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights"

A limitation of a right involves a two-legged inquiry which first asks whether a right in the Bill of Rights has been infringed.[157] If the answer is in the positive the next question asked is whether the infringement can be justified as a permissible limitation.[158] A limitation of a right may be regarded as permissible and therefore justifiable if the criteria in s36 (1) is satisfied. The criteria entails the limitation to be (a) in terms of law of general application, and (b) reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. Each of these requirements are explained below.

3.7.1 Law of General application

There are three interpretations to this requirement. First it means that the limitation must be permitted by law and such law must one of general application.[159] It appears that the term 'law' refers to all types of legislation, the common law, as well as customary law.[160] Law of general application means that the law in question must apply impersonally and equally. This serves as a tool which prevents the legislature from singling out a particular group of persons for punishment and is also in accordance with the principle of rule of law.[161] Put differently, the requirement in question prevents the possibility of unfair discrimination and inequality.

With regard to assisted suicide, its prohibition is sourced from the common law as set out in the *Grotjohn case*[162] and confirmed in the *Stransham-Ford cases.*[163] In addition the prohibition applies to all persons who seek assistance in committing suicide.

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[157] I Currie & J De Waal *The Bill of Rights Handbook* (2016) 153.
[158] Ibid.
[159] Currie & De Waal op cit 155.
[160] Cheadle *et al South African Constitutional Law: The Bill of Rights* (2005) 2nd ed. 30 -39; Currie & De Waal op cit 156.
[161] De Vos et al *South African Constitutional Law in Context* (2014) 361.
[162] *Grotjohn supra*.
[163] *Stransham-Ford v Minister of Justice and Correctional Services & Others 2015 (4) SA 50 (GP)* (the High Court case); *Minister of justice and others v Estate Stransham-Ford 2017 (3) SA 152 (SCA)* (the Appeal case) More especially the Appeal case confirms this.

3.7.2 Limitation must be reasonable and justifiable

Once it has been established that a limitation of a right in the Bill of Rights is in terms of law of general application the next step involves determining whether the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.[164] This part of the inquiry tests whether the law that limits a rights does so for reasons that are acceptable. It also rests whether the law is reasonable in that it does not invade rights any more than it needs to achieve its purpose. To satisfy this part of the limitation inquiry then it must be shown that there is sufficient proportionality between the infringement of the right in question and the purpose of the law. In doing so, the factors listed in subsection (1) (a) – (e) are considered.

a) Nature of the right

According to Woolman this factor involves examining the nature of the right and its importance in society.[165] In other words, this factor measures the ability of the right to be limited.[166] Although it is trite law that rights are not absolute, some rights due to their very nature appear to be incapable of being limited or at least can only be limited in very particular circumstances.[167] As explained in chapter two of this dissertation, the prohibition of physician assisted suicide affects the rights protected in section 14 and section 12 (2) (b) of the Constitution. Both of these rights are amongst those rights which are regarded as very important in an open and democratic society like South Africa.

b) Importance of the purpose of the limitation

This factor requires limitation in question to serve a purpose and the purpose must be worthwhile and important in a constitutional democratic society.[168] The purpose of the prohibition on physician assisted suicide to protect the vulnerable people in society. Through protecting the vulnerable, the state protects the right to life as contained in the constitution and also fulfils its duty to promote, protect and fulfil rights in the Bill of Rights. Protecting the vulnerable in society is generally understood to mean protecting those who are more prone to

[164] Section 36 (1) of the Constitution.
[165] Woolman 12 – 49.
[166] Cheadle op cit 708 – 709.
[167] Currie & De Waal op cit.
[168] Currie & De Waal op cit.

becoming victims of undue influence or pressure, such as the elderly, the sick, the disabled and the poor.[169]

In a South African context protection of the vulnerable would certainly be considered a constitutional purpose. It is a very important purpose considering our history as a nation, the large number of people living with illness and the poverty levels in the country.

c) Nature and extent of the limitation

This factor is concerned with assessment of the manner in which the limitation affects the right concerned. The question asked considers whether the limitation is serious or minor infringement of the right in question. The assessment is in keeping with the proportionality inquiry.

d) Relationship between the limitation and its purpose

With this factor, the question that is asked is whether the means employed achieve the accepted purpose. In other words, "is there a rational link between limiting measure and the purpose it seeks to achieve?"[170] Establishing a rational connection between the two requires a causal link between the law and its purpose: the law must tend to serve the purpose for which it was designed to serve. The prohibition of physician assisted suicide is intended to protect the life of vulnerable patients from dying through the hand of a physician. This prohibition serves its purpose because cases of such a nature have been very rare in South Africa. On the other hand, legalizing physician assisted suicide exposes them to the risk especially since there is no way of actually proving that the request and consent is genuine. The *Stransham-Ford cases*[171] are evidence of this. The fact that Mr Stransham-Ford had changed his mind about proceedings only came to light on appeal of the High Court Judgement. There was also doubt as to his true intention.

e) Less restrictive means

Limiting a right entails achieving a result that is in proportion to the cost of the limitation. A limitation will not be regarded as proportionate is there other means that that could achieve the same result that would either not limit the right at all or will limit it only to a lesser extent. In

[169] Frances op cit 108.

[170] De Vos *et al 371.*

[171]*Stransham-Ford v Minister of Justice and Correctional Services & Others 2015 (4) SA 50 (GP)* (the High Court case); *Minister of Justice and others v Estate Stransham-Ford 2017 (3) SA 152 (SCA)* (the Appeal case).

the present case it seems that prohibition of physician assisted suicide is the only way to achieve the protection of vulnerable persons.

3.8 Conclusion

Autonomy is a very important value in any democratic society founded values of human dignity, equality and freedom. It allows people to make the most personal and important decisions including matters concerning life and death. Even though it is not contained explicitly in our Constitution, the rights to privacy and psychological and bodily integrity protect autonomy by ensuring non-interference and control over one's body. This means that indeed individuals do have the right to die and there is a case for its protection by the Constitution. The Carter gives a good interpretation of relevant constitutional rights, thereby making it strong persuasive foreign law. The similarities between our Bill of Rights and the Canadian Charter in addition justify the reliance of the Court in Stransham-Ford and the reference to it. Bearing in mind that assisted suicide is a very sensitive matter, if assisted suicide would be allowed in South Africa in light of the rights discussed in this chapter, it would have to be limited to terminally ill patients but who have the mental capacity to request physician assisted suicide.

Chapter Four

THE SOCIO-ECONOMIC DILEMMA IN SOUTH AFRICA

4.1 Introduction

Proponents of physician assisted suicide contend that terminally ill but competent patients should be allowed to commit suicide with the assistance of a doctor because the right to die is a constitutionally protected right. A close examination of some rights in the Bill of Rights in the previous chapter indicated that indeed the constitution guarantees such a right even though not expressly for. However, as far as end of life decisions are concerned, the law is not the only relevant factor. There are other factors that should that play an important role which should be taken into account in making the decision whether or not to change South Africa's current legal position. The socio-economic status of South Africa is one of such factors. This factor is particularly important because in a country such as ours, everything is, either directly or indirectly, affected by the country's socio-economic status. This chapter examines the latter and focuses primarily on healthcare in the country. The chapter discusses financing, human resources and management in South Africa's healthcare system.

4.2 The Reality in South Africa

It is an established fact that there is a persistent and significant relationship between a person's socio-economic status and his or her ability to access healthcare.[172] There is an overwhelming literature which examines the relationship between a person's economic status and access to healthcare.[173] According to research, access to healthcare is better amongst South Africans that come from more affluent households.[174] In addition to this, a substantially larger proportions of individuals from such households are insured compared to those from poorer households.[175] During the apartheid era, the health care system in South Africa was highly inequitable and

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[172] M Thiede *et al* "Exploring the dimensions of access". In D McIntyre & G Mooney (Eds.)*The economics of health* equity (2007) 103 – 123

[173] CS Christian "Access in the South African public health system: Factors that influence access to healthcare in the South African public sector in the last decade" (2014) University of Western Cape(Master of Economics thesis) 13

[174] S Van Der Berg "Poverty, fiscal incidence and social outcomes" (2002) A paper commissioned by GTZ (German Agency for Technical Cooperation) on behalf of the Policy Co-ordination and Advisory Unit in the Presidency for the ten year review of government policy, Stellenbosch 19; F Booysen " Urban-rural inequalities in healthcare delivery in South Africa" (2003) Development Southern Africa Vol. 20 (5) 669

[175] Ibid.

fragmented.[176] It was racially divided into fourteen separately operating authorities.[177] Health services for the majority black population were heavily underfunded and rural areas were neglected with a system that disproportionately favoured urban hospital care.[178] In 1994 apartheid came to an end when South Africa transitioned into a constitutional dispensation based on the realization of human rights and transformation of the inequities of the apartheid years.[179] Nonetheless, the South African health system still shows many of the design features of its fragmented and contested past. Although it has been more than two decades since this change occurred, the truth is that there still exists significant inequality between the rich and the poor in this country.[180] The quality of healthcare a person receives depends on his or her economic status.[181] This is because the South African government that took over in 1994, inherited the two-tier health care system from the apartheid government which divides the provision of health into the public and private sectors. The former is primarily financed through taxation while the latter receives funds from medical aid schemes.[182] There are significant disparities between the two sectors in terms of finance, human resources and management.[183]

As a result of the big difference between the rich and the poor, what one finds is that the rich go to private health care facilities because they have medical aid or other means to pay for their medical expenses. On the other hand, with 55% of poverty levels in South Africa,[184] the poor can access health care only from public clinics and hospitals where health care is available at no fee. The leading barrier to access to health care from the private sector is the price charged by private hospitals and clinics.[185] A majority of the country's population cannot afford private health care, thereby turning to service offered in public health care facilities. Statistics reveal that South Africa has a general population of 55. 9 million.[186] Out of this population, seven in

[176] South African Human Rights Commission "Health care and Health care services for Children." In 3rd Economic and Social Rights Report Series (2000).
[177] H Schneider et al "The promise and the practice of transformation in South Africa' Health System." In Buhlungu et al (eds.) *State of the Nation* (2007) 290.
[178] Ibid.
[179] L Forman and JA Singh "The Role of Rights and Litigation in Assuring More Equitable Access to Health Care in South Africa."
[180] NP Moyake "Quality healthcare: An attainable goal for all South Africans" (2014) *South African Journal of Bioethics & Law* Vol. 7 (2) 81.
[181] Ibid.
[182] CM Flood & A Gross (eds.) *The Right to Health at the Public/ Private Divide: A Global Comparative Study* (2014) Cambridge University Press 289.
[183] Ibid.
[184] http://www.statssa.gov.za/?p=10334
[185] https://getsavvi.co.za/community/health/millions-of-south-africans-without-healthcare-cover.
[186] http://www.statssa.gov.za/?cat=17.

every ten South African households (approximately 70%) use public clinics and hospitals.[187] This not only puts pressure on the public health care system, but it also has a negative effect on the quality of health care provided in the public sector.[188] Quality includes very long waiting hours, rude staff, unavailability of drugs, uncleanliness and incorrect diagnosis and high mortality rates compared to the private sector.[189]

4.3 Financing in the health care sector

Health care in South Africa is financed through various mechanisms including taxation, medical aid schemes and out – of - pocket payments.[190] Comparisons between the two health care sectors indicates that currently, the private sector accounts for largest share of the total health care financing yet only 8.6 million of the country's population employ private services.[191] Out of the 8.3% of its gross domestic product on health care in 2013 – 4% in the public sector and 4.3% in the private sector.[192] So, approximately 40% of healthcare is financed through taxation, 45% through private medical schemes and 14% through out of pocket payments. Private health per capita expenditure is estimated to be 6 times more than public health per capita expenditure. When calculated in actual figures this is R12 859 per beneficiary per annum in contrast with R2 857 per annum for a beneficiary in the public health sector.[193] This division of expenditure has remained relatively constant in the years subsequent to 2013[194] and indicates a skewed distribution of resources.

4.4 Human Resources in the health care sector

There are three major challenges with regard to human resources in the health care sector in South Africa. The one is that our country has a significant shortage of health care workers and the other is that there is a maladministration of the available workforce, between the public and

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[187] http://www.gov.za/ABOUT-SA/HEALTH.
[188] J Ataguba & J Akazili "Health care financing in South Africa: Moving towards universal coverage" (2010) *CME* Vol. 28 (2) 74.
[189] S Ranchod et al "South Africa's hospital sector: old divisions and new developments" *South African Health Review* 105
[190] Ataguba & Akazili op cit.
[191] Ibid. 75
[192] A Gray et al "Healthcare and Pharmacy practice in South Africa" (2016) *Canadian Journal of Hospital Pharmacy* 37.
[193] Ibid.
[194] Ibid.

private health sector, as well as between urban and rural settings.[195] In 2017, a total of 44 949 medical practitioners were registered with the HPCSA[196] although the actual number of practising doctors might be lower because the register of the HPCSA includes doctors that are out of the country, those that have retired or who are simply not working.[197] Out of this total number of registered doctors approximately 80% work in the private health sector.[198]

Similarly with nurses, 270 437 of them were registered with the South African Nursing Council[199] but statistics further reveal that only 50% of the total number of registered nurses serve in the public sector while the other 50% serves only 16% of the South African population in the private sector.[200]

Lastly, healthcare workers are leaving the public health industry and migrate the private health industry, or they emigrate from South Africa.[201] The Colleges of Medicine of South Africa conducted a survey on South African doctors and there was a total of 2 229 participants in the survey.[202] The objectives of the survey were to find answers to the following questions:

- "Why doctors move from the state sector to private practice
- Why doctors choose to emigrate
- What are the doctors' views on whether their working environment is conducive to delivering quality care"[203]

The survey found that doctors migrate to the private sector because of the dissatisfactory working conditions and security and secondary to this was the reason that there are no suitable posts.[204] Remuneration which was usually suspected as the main reason, only came as a third reason. However, a remarkable difference was noted on the views of doctors from the private sector and those from the public industry regarding critical areas of the work place.

- Sixty-one percent of doctors from the public practice stated that the supply of medicines was inadequate, whereas only ten percent from private practice shared the same view.

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[195] Gray op cit.
[196] www.hpcsa.co.za/Publications/Statistics
[197] www.hsrc.ac.za/en/review/november-/public-service-doctors
[198] Ataguba & Akazili op cit 75.
[199] www.sanc.co.za/stats/Stats2016/Year%201016%20Provincial%20Distribution%20Stats.pdf
[200] https://www.medicalbrief.co.za/archives/nursing-shortage-compromising-sas-healthcare/
[201] Van der Spuy et al "Money isn't everything – CMSA doctor survey shows some noteworthy results" (2017) *South African Medical Journal* Vol. 107 (7) 550.
[202] Ibid.
[203] Ibid.
[204] Ibid.

- Sixty-six percent in the public sector indicated that there was a shortage of infrastructure and equipment, while only twenty percent in the private sector shared the same view.
- Forty-eight percent in the public sector said nurses and supporting staff are inadequate, compared to twenty-one percent in the private sector.
- Thirty-nine percent in the public sector indicated that hygiene and management were of a poor general standard, while only five percent indicated this in the private sector.

4.5 Validity of the slippery slope argument

The slippery slope argument is relevant to both euthanasia and physician assisted suicide. Although it is often raised as a stand-alone argument the writer has incorporated it into the broader socio-economic argument. The reason for this is that it is linked with the economic status in that some terminally ill patients who come from poverty stricken homes and accordingly cannot afford proper and quality medical treatment, may opt for physician assisted suicide as a substitute for treatment after they have been let down by the public health care system.[205] So we will then have a situation where patients who have not exhausted the available treatment because they do not have the financial means to do so, choose physician assisted suicide instead.

The essence of the argument may be found in the words of Lode when he states, "We should resist some practice or policy on the grounds that allowing it could lead us to allow some other practice or policy that is clearly objectionable"[206] Schauer goes on to explain that "between top and bottom may be many little steps, many gradations, and the slope is slippery because it is impossible to decide where to draw the line"[207] Keown gives two interpretations of the slippery slope argument which he collectively refers to as a 'practical slippery slope'[208] The first interpretation proposes that the acceptance of one form of euthanasia will lead to even other unacceptable forms of euthanasia.[209] For example acceptance of voluntary euthanasia may open the flood gates for involuntary euthanasia. The second interpretation postulates that euthanasia and physician assisted suicide, which are originally regarded as measures of last

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[205] Ncayiyana op cit 334.
[206] E Lode "Slippery Slope Arguments and Legal Reasoning" (1999) *California Law Review* Vol. 87 (6) 1471.
[207] F Schauer "Slippery Slopes" (1985) *Harvard Law Review* Vol. 99 (2) 378.
[208] J Keown *Euthanasia, ethics and public policy: an argument against policy* (2002).
[209] Keown op cit 76.

resort in exceptional cases, could over time be regarded as more acceptable and opted for as a first choice.[210] The second interpretation is more relevant to this dissertation.

The slippery slope argument has received a lot of criticism and some authors have described it as a fallacy. They submit that there is would be no slippery slope if the following preventative measures are put in place:[211]

- Requirement of explicit written consent by the person seeking euthanasia or assisted suicide
- Mandatory reporting of all cases
- Administration by a physician only
- Second opinion and consultation with another physician

In 2001 Netherlands was the first country globally, to legalize euthanasia and physician assisted suicide.[212] Safeguards were then put in place, including the installation of five review committees which accessed whether in all the cases the law has been complied with and everything seemed to be under control.[213] In 2007, a medical ethicist and a member of one of Dutch review committees, Prof Theo Boer wrote,

> "….there doesn't need to be a slippery slope when it comes to euthanasia. A good euthanasia law, in combination with the euthanasia review procedure, provides the warrants for a stable and relatively low number of euthanasia."

However, seven years later he changed his mind and warned Britain against legalizing euthanasia after he noticed the drastic hike in the number of assisted suicides in the Netherlands – an indication that euthanasia was then being used as a substitute treatment mode by cancer patients.[214] In a public appeal to the House of Lords he explains how things have spiralled out of control in the Netherlands;

> "Beginning in 2008, the numbers of these deaths show an increase of 15% annually, year after year. The annual report of the committees for 2012 recorded 4,188 cases (compared with 1,882 in 2002). 2013 saw a continuation of this trend and I expect the 6,000 line to

[210] Keown op cit 79.
[211] J Pereira "Legalizing euthanasia or assisted suicide: the illusions of safeguards and controls" (2011) *Current Oncology* Vol. 18 (2) 39.
[212] Ibid. 38.
[213] T Boer "Assisted dying: don't go there." *Daily Mail* (UK), 9 July 2014.
[214] Ibid.

> be crossed this year or the next. Euthanasia is on the way to become a 'default' mode of dying for cancer patients.
> Alongside this escalation other developments have taken place. Under the name 'End of Life Clinic,' the Dutch Right to Die Society NVVE founded a network of travelling euthanizing doctors. Whereas the law presupposes (but does not require) an established doctor-patient relationship, in which death might be the end of a period of treatment and interaction, doctors of the End of Life Clinic have only two options: administer life-ending drugs or send the patient away. On average, these physicians see a patient three times before administering drugs to end their life. Hundreds of cases were conducted by the End of Life Clinic. The NVVE shows no signs of being satisfied even with these developments. They will not rest until a lethal pill is made available to anyone over 70 years who wishes to die. Some slopes truly are slippery.
> Other developments include a shift in the type of patients who receive these 'treatments'. Whereas in the first years after 2002 hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted in being aged, lonely or bereaved. Some of these patients could have lived for years or decades."[215]

Belgium also has the similar problems as the ones referred to by Boer. Physician assisted suicide is no longer limited only to terminally ill patients with severe pain and suffering but also to psychiatric patients, as well as people who are merely lonely, aged or bereaved.[216] This circumvention of the safeguards in many cases, serves as evidence of the validity of the slippery slope as defined by Keown.

4.6 Palliative care

Before discussing the background, it is necessary to understand palliative care and what it is all about. The word 'palliative' comes from the Latin word 'pallium' which when translated means to cloak or cover.[217] There is no single definition of palliative care. However, one of the definition provides that palliative care is a multidisciplinary approach to specialized

[215] Ibid.
[216] JV Larsen "Legal assisted suicide in South Africa" (2015) *South African Medical Journal* Vol. 105 (7) 2.
[217] S Milligan & S Potts in E Stevens (ed.) et al *Palliative Nursing: Across the Spectrum of Care* (2009) 5.

medical and nursing care of terminally ill patients.[218] It is a holistic approach to the care and support of such patients and their families which takes into consideration physical, psychological, emotional and spiritual needs.

Central to the concept of palliative care is the provision of relief from symptoms, pain, physical stress and mental stress caused by terminal illness.[219] Palliative care does not hasten or postpone death but merely enables coping with the disease while death nears.[220] Depending on the seriousness of the disease, the pain killers given to patients range from non-opioids (e.g. paracetamol, aspirin, etc.) for mild pain, to weak opioids (e.g. codeine and Tramadol) and strong opioids (morphine) for moderate and severe pain.[221]

Although pain relief and symptom management have always been a part of medicine, little attention has been paid to them until recently because health care workers had limited or no training in the subject.[222] Palliative care actually developed during the second half of the twentieth century when physicians working with terminally ill patients were confronted with patients who had incurable diseases and experienced severe chronic pain.[223] This forced the physicians to focus their attention on treating the pain and other related symptoms.[224]

The development of the discipline and culture of palliative care is largely attributable to Cicely Saunders and who is also the founder of the first modern hospice.[225] She introduced pain management which proved to be effective, insisting that when people are in the process of dying, they need dignity, compassion, and respect, as well as rigorous scientific methodology in the testing of treatments.[226] Saunders also came up with the concept of 'total pain' which encapsulates the idea that physical, spiritual and psychological pain can be interwoven, therefore the physical, spiritual and psychological aspects of the patient need to be attended.[227]

Palliative care became of international interest in 1986 when the World Health Organization ('the WHO') and its Expert Committee on Cancer Pain Relief and Active Supportive Care

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[218] http://www.who.int/hiv/pub/imai/primary_palliative/en/

[219] Ibid.

[220] Ibid.

[221] A Barnard & E Gwyther "Pain management in palliative care" (2006) *South African Family Practice Journal* Vol. 48 (6) 32.

[222] L De Lima & T Pastrana "Opportunities for palliative care in public health" (2016) *Annual Review of Public Health* Vol. 37 359.

[223] De Lima & Pastrana *op cit*.

[224] Ibid.

[225] Milligan & Potts op cit 7.

[226] Ibid.

[227] Ibid.

established the WHO's Cancer Relief Programme.[228] The WHO raised awareness about the seriousness of cancer pain which is a neglected public health issue. Even though millions suffered from pain daily, a very small fraction received treatment.[229] Through this programme the WHO then introduced the analgesic ladder, a pain management method, which was publicized through a campaign called 'Why not Freedom from cancer pain.'[230]

4.6.1 Integration of palliative care into South Africa's health care

Although palliative care has been proved to be very helpful, the challenge that exist is that many countries in the world do not include it in their national governmental plans.[231] Cognizant of this challenge and the importance of palliative care, in 1990, the WHO developed a public health strategy to integrate palliative care into health care systems that already exist within various countries worldwide.[232] The strategy contained advice and guidelines on implementing national palliative care programmes in countries all around the world. The strategy also identifies what the integration of palliative care into public health care entails so that it may succeed:

- "a government policy to ensure the integration of palliative care services into the structure and financing of the national health-care system;
- an educational policy to provide support for the training of health-care professionals, volunteers and the public;
- a drug policy to ensure the availability of essential drugs for the management of pain and other symptoms and psychological distress, in particular, opioid analgesics for pain relief."

The provision of palliative care in South Africa is currently not regulated by law.[233] In the absence of policy which supports palliative care, numerous challenges arise and it becomes a challenge to introduce or even maintain palliative programmes.[234] For example South Africa nurses cannot give patients some opioids. Addressing this challenge entails:[235]

- "enactment of legislation that acknowledges palliative care as part of our health care system

[228] WHO (1990) Cancer pain relief and palliative care. Rep. WHO Expert Comm. 19.
[229] De Lima & Pastrana op cit 358.
[230] Ibid.
[231] World Health Organization (2007) Palliative care module 5.
[232] De Lima & Pastrana op cit 362.
[233] DJ McQuoid-Mason & M Dada *A-Z of Medical Law* (2011) 312
[234] World Health Organization (2014), Global atlas of palliative care at end of life 27.
[235] Ibid.

- national standards of care describing palliative care
- clinical guidelines and protocols
- establishment of palliative care as a medical specialty
- a national strategy on the implementation of palliative care"

South Africa is regarded as having one of the most advanced palliative care systems in Africa.[236] There is an extensive network of hospice organizations that care for people with chronic and life threatening diseases.[237] However, as it is the case in numerous other countries, South Africa does not recognize palliative care in its government plans and palliative care is provided outside government health service. In fact, Uganda is the only African country that has included palliative care in its national government plans and policies.[238] This means that in South Africa only some terminally ill patients have access and the supply is limited only to some areas of the country.

There is a need to integrate palliative care into South Africa's public health care system. Not only will this enhance the availability of palliative care, but it will also enhance the affordability to the target population. This is particularly important in this country where there are still socio-economic issues as discussed in the previous chapter.

Albertus correctly argues that the need to integrate palliative care may be inferred from the right to have access to health care[239] which is contained in our Constitution.[240] In terms of s27 (1) (a) of the Constitution the state is required to "introduce reasonable legislative and other measures to ensure the progressive realization of the right to have access to health care." The latter right has been defined to include "the prevention, treatment and management of illness and the preservation of mental and physical well-being through services by the . . . health professions."[241] This means that palliative care falls within the ambit of s27 of the Constitution. Accordingly, this lack of law which specifically deals with palliative care and related aspects of terminal illness is arguably, discrimination.[242]

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[236] https://www.health-e.org.za/2013/09/19/need-rethink-palliative-care-south-africa/
[237] Ibid.
[238] D Clarke *et al* "Hospice and Palliative Care Development in Africa: A Multi-Method Review of Services and Experiences" (2007) *Journal of Pain and Symptom Management* Vol. 33 (6) 706.
[239] MC Albertus "The right to health in respect of terminally ill persons in South Africa" (2014) *Speculum Juris* Vol. 28 (2) 156.
[240] Section 27 of the Constitution.
[241] J Mubangizi & B Twinomugisha "The right to health care in the specific context of access to HIV/AIDS medicines: What can South Africa and Uganda learn from each other?" (2012) *African Human Rights law Journal* 109.
[242] Albertus op cit 157.

4.6.2 Education about palliative care

The problem with palliative care it highly neglected and is only available to some of the terminally ill patients in this country.[243] Therefore the value of educating people about palliative care cannot be stressed enough. Although policy is regarded as the fundamental component which allows palliative care to be introduced in various countries, education is one of the factors responsible for the success of palliative care.[244]

Discussions about terminal diseases and its related aspects are not a popular subject among the public.[245] Therefore education about terminal illness, and more especially the aspect of palliative care, is necessary. Such education should be extended to diverse audiences including policy makers, health care workers non-professional health care workers and the general public. This will create an understanding about the concept of palliative care, who is it intended for, the value off palliative care, the services offered and the benefits to the patient and the family.[246] Imparting such information will raise awareness and knowledge on palliative care and change their attitude towards this discipline.[247] As far as the public is concerned this could change its perception of physician assisted suicide as the only way to achieve a painless and dignified death. Palliative care achieves the same result.

4.6.3 Training of health care workers

Health care workers play a very important role in caring for patients. Therefore, the importance of training them is strongly emphasized. A body of knowledge on the science of palliative care and palliative medicine has accumulated over the past 40 years. However, a vast majority of health care professionals in the world have little or no knowledge on the principles and practices of palliative care.[248] To address this issue, in 2004, the WHO recommended that governments should include provide at least basic training on palliative care to health care workers at all levels and that medical schools should include it in their curriculum.[249] The suggestion made was that training should be provided in three levels:

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[243] De Lima & Pastrana op cit 360
[244] World Health Organization (2007) Palliative care module 5: 32.
[245] Albertus op cit 157.
[246] World Health Organization (2007) Palliative care module 5: 32.
[247] Ibid.
[248] World Health Organization (2014), *Global atlas of palliative care at end of life* 27.
[249] Ibid.

- basic training for all health care practitioners
- intermediate training for those working routinely with terminally ill patients
- specialized training for practitioners who manage patients with more than routine symptom management needs

4.6.4 The availability of palliative care medication

Access to opioid medication for pain control is a big challenge globally. Statistics reveal that 80% of the population in the world does not have adequate access to opioid medications.[250] Therefore, national governments must ensure that drugs which are essential for the management of pain and related symptoms are available to those who them. The WHO recommends that such drugs should be included in a list of essential medicines that exists in each country. [251] This ensures that decisions regarding resources are based on what is indicated by the needs of the majority of the population.[252] The WHO also provides a model list of essential medicines, including palliative care drugs, as a guide for countries to develop their own essential drugs list.[253] The International Association for Hospice and Palliative Care has recently published a list of 34 drugs that experts consider essential for palliative care.[254]

4.7 Conclusion

The South African health care industry is in crisis and it would be extremely risky to allow physician assisted suicide. The proposed safeguards are simply not enough considering the picture painted by the findings highlighted in this chapter. Considering our socio-economic circumstances, the risk that physician assisted suicide might be used as a substitute for treatment is real. Such may be inferred from the cases in the Netherlands and Belgium. Noteworthy is the fact that these countries are so much better than South Africa. Both in terms of their well developed economies and well organised health care systems. Instead of opting to legalize physician assisted suicide, the best solution to pain and suffering is palliative care.

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[250] World Health Organization (2007) *Palliative care Module 5*: 28.
[251] World Health Organization (2007) *Palliative care module 5:* 35.
[252] Ibid.
[253] Ibid.
[254] Ibid.

South Africa can barely manage its health system to afford everyone basic health care needs, how will it cope with the management of something so serious and sensitive such as physician assisted suicide? Especially since things have spun out of control in these better organized countries. Hence, the limitation on the practice is necessary and is accordance with the constitution.

Chapter Five

CONCLUSION

5. 1 Introduction

The aim of this study was to determine whether or not the South African legal position as it relates to physician assisted suicide should be changed. This is done through the examination of the factors which are relevant to the issue. In addressing the issue the writer considered the arguments that have been put forward as part of the debate which surrounds end of life decisions and particularly the aspect of physician assisted suicide. The writer proceeds by discussing the position of the common law since it is currently the only authority for the preposition. The position of the constitution in relation to physician assisted suicide is also examined together with the socio – economic dilemma which South Africa is faced with as a country. The author then makes recommendations in favor of maintaining the status quo regarding physician assisted suicide and draws a conclusion from the entire study.

5.2 Synopsis of findings

5.2.1 Chapter One – Introduction

The purpose of this dissertation was to explore the physician assisted suicide phenomenon and to determine whether it should be allowed in South Africa. The writer conducts literature review on the topic of physician assisted suicide and finds that there is no consensus internationally and locally. The importance of considering all the relevant factors before making such big decision is indicated. The writer highlights the danger of adopting a purely legal approach which is concerned exclusively with what the law provides with regard to a given situation but overlooks the consequences that may follow. The writer acknowledges that even though the law may be correct and indeed the right to die exists. However, the most appropriate approach is to adopt a realist view and look at the situation as it exists. This will lead to the correct decision. The reality in South Africa is that our socio-economic status indicates that South Africa is not fit for legalized physician assisted suicide. Hence, South Africa should maintain the status quo and let physician assisted suicide remain unlawful until there is confidence in healthcare system.

5.2.2 Chapter Two – The South African Perspective of Physician Assisted Suicide

This chapter examined the current position of the law which governs physician assisted suicide in South Africa. The chapter gives a detailed discussion of the *Grotjohn case,*[255] the *locus classicus* on assisted suicide. This was necessary so as to understand why assisted suicide is unlawful in South Africa and the consequences for the perpetrator. The writer explains causation as an element which is very important in the definition assisted suicide as a consequence crime and as a crime of murder or culpable homicide. Since doctors in this country are regulated by the Health Professions Council of South Africa (HPCSA), the writer also provides a brief discussion of guidelines of the HPCSA as it relates to physician assisted suicide. The chapter further critically examines some suggested possible defenses, which some writers argue that they may be adopted to render assisted suicide lawful, but only to the extent that this limited to the doctor-patient relationship and to mentally competent terminally ill patients. These are the defenses of consent and necessity. It is explained why these will not work in South Africa.

5.2.3 Chapter Three – Is The Right to Die A Constitutionally Protected Right?

Central to the topic of physician assisted suicide is assertion that terminally ill individuals should be able to consult physicians for assistance with terminating their lives without attracting any criminal liability because the right to do so is guaranteed by the constitution. This chapter examines the validity of this contention. The writer begins by examining the principle of autonomy is examined since it is the principle that may be relied upon as one which entitles individuals to the right to access to physician assisted suicide.[256] It is noted that even though the constitution does not expressly protect individual autonomy, a scrutiny of the right to privacy[257] and the right to security over ones bodily integrity[258] indicates that autonomy is impliedly protected by the constitution.

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[255] *Ex Parte van Die Minister van Justisie*: *In Re S v Grotjohn 1970 (2) SA 355 (A.)*

[256] G Van der Walt "I don't know how I want to go but I do know that I want to be the one who decides' – The right to die – The High Court of South Africa in Robert James Stransham-Ford and Minister of Justice and Correctional Services; The Minister of Health Professional Council of South Africa and the National Director of Public Prosecution (3 June 2015) cases" (2015) Obiter Vol. 36 (3) 810.

[257] Section 14 of the Constitution.

[258] Section 12 (2) (b).

The chapter provides a detailed discussion the *Carter case*[259]- a foreign case heard and decided in Canada. The case gives thorough analysis and application of the rights to privacy, bodily integrity and dignity in light of physician assisted suicide. The South African *Stransham-Ford cases*[260] are also discussed. They are the only cases that actually deal especially with physician assisted suicide and other related aspects of end of life decisions in South Africa unlike the *Grotjohn case*[261] which dealt with assisted suicide in general. After examining all of the above, the conclusion reached is that indeed that right to die is guaranteed by the constitution.

5.2.4 Chapter Four – The Socio-Economic Dilemma

The purpose of this chapter is to discuss the socio-economic circumstances in South Africa. The writer submits that this an important factor which is highly relevant in the physician assisted suicide debate and which is worthy of consideration. The primary focus is mostly on the challenges in the health care sector. The chapter examines the reality as it is lived by South Africans as indicated by statics obtained from surveys conducted around the country, as well as the financing, human resources and human resources in the health care sector. The chapter then examines the validity of the slippery slope argument drawing examples from other countries and it also considers whether the rights to privacy[262] and bodily integrity[263] through which the right to die is protected, can be limited until there is improvement in the South African health care system. After analyzing all of the above, the conclusion reached is the indeed the slippery slope argument is valid and this justifies limitation of the relevant constitutional rights that underlie the right to die.

5.3 Final Conclusion

This dissertation has examined the necessity to change the South African law so as to legalize physician assisted suicide. The results showed that there appears to be a tug of war between the constitution and South Africa's socio-economic circumstances. Whereas the Bill of Rights

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[259] *Carter v Canada (Attorney General) 2015 SCC 5.*

[260] *Stransham-Ford v Minister of Justice and Correctional Services & Others 2015 (4) SA 50 (GP*) (the High Court case); *Minister of justice and Others v Estate Stransham-Ford 2017 (3) SA 152 (SCA*) (the Appeal case.)

[261] *Grotjohn* supra.

[262] Section 14 of the Constitution.

[263] Section 12 (2) (b).

favors legalizing physician assisted suicide, the socio-economic circumstances pull towards a different direction.

The recent court cases in Canada and South Africa have indicated that the constitution does indeed guarantee the right of mentally competent terminally ill individuals to choose the option the option of ending their lives with the assistance of a physician. The *Carter*[264] and the *Stransham-Ford*[265] High Court judgements have indicated that there is a need to change the law prohibiting physician assisted suicide and a legislative framework should be put in place to regulate the process and safeguard it. Reports compiled as required by the Oregon Death with Dignity Act as well as the Washington Death with Dignity Act are often cited as evidence of this view.

On the other hand, the South African socio-economic context and the challenges in the health care sector raise the question whether our country is a suitable place to have legalized physician assisted suicide. A closer look at the latter indicated that it would be very risky to allow physician assisted suicide as this as many are still battling to access at least proper basic health care. On this basis, the limitation of the right to privacy[266] and the right to bodily integrity[267] is justifiable in line with the requirements set out in s36 of the Constitution, especially since there is doubt as to whether introduction of regulatory legislation as advocated by many, would really be able to protect the vulnerable. The situation reported in the Netherlands serves as evidence as why such doubt is reasonable. Accordingly, the scales are tipped in favor of the argument based on the unpleasant socio-economic circumstances and the author finds that physician assisted suicide in South Africa should remain unlawful.

It follows that an alternative solution should be formulated to address the fear of a painful and undignified death that nobody wants to suffer. Integration of palliative care into South Africa's public health care system is necessary so that it is easily available and accessible. Educating people about palliative care will raise awareness and change their perception about terminal illness. Palliative care will give them the hope that they need and the relief from the fear of a painful death.

[264] *Carter supra*.
[265] *Stransham-Ford supra.*
[266] Section 14 of the Constitution.
[267] Section 12 (2) (b).

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UNIVERSITY OF KWAZULU-NATAL™

INYUVESI YAKWAZULU-NATALI

29 June 2017

Ms Ndondo Sikhulumi (213549550)
School of Law
Howard College Campus

Dear Ms Sikhulumi,

Protocol reference number: HSS/0928/017M
Project title: Physician assisted suicide in South Africa: The Constitution and the Socio-economic Dilemma

Approval Notification – No Risk / Exempt Application

In response to your application received on 29 June 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

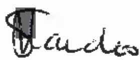
Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further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

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

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

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully



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