

**SOUTH AFRICAN LAW COMMISSION**

**REPORT**

**PROJECT 86**

**EUTHANASIA AND THE ARTIFICIAL  
PRESERVATION OF LIFE**

**November 1998**

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**TO DR AM OMAR, MP, MINISTER OF JUSTICE**

I am honoured to submit to you in terms of section 7(1) of the South African Law Commission Act, 1973, (Act 19 of 1973), for your consideration the Commission's report on the investigation into euthanasia and the artificial preservation of life.

**I MAHOMED**

**CHAIRPERSON: SOUTH AFRICAN LAW COMMISSION**

**NOVEMBER 1998**

## INTRODUCTION

The South African Law Commission was established by the South African Law Commission Act, 1973 (Act 19 of 1973).

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## **SUMMARY OF RECOMMENDATIONS AND DRAFT BILL**

The advances made in medical science and especially the application of medical technology have resulted in patients living longer. For some patients this signifies a welcome prolongation of meaningful life, but for others the result is a poor quality of life which inevitably raises the question whether treatment is a benefit or a burden.

Worldwide increased importance is furthermore being attached to patient autonomy. The need has therefore arisen to consider the protection of a mentally competent patient's right to refuse medical treatment or to receive assistance, should he or she so require, in ending his or her unbearable suffering by the administering or supplying of a lethal substance to the patient. The position of the incompetent patient, as well as the patient who is clinically dead, has to be clarified as well.

Since matters concerning the treatment of terminally ill people are at present being dealt with on a fairly **ad hoc** basis, there is some degree of uncertainty in the minds of the general public and medical personnel about the legal position in this regard. Doctors and families want to act in the best interest of the patient, but are unsure about the scope and content of their obligation to provide care. Doctors are furthermore afraid of being exposed to civil claims, criminal prosecution and professional censure should they withhold life support systems or prescribe drugs which may inadvertently or otherwise shorten the patient's life, even if they are merely complying with the wishes of the patient.

The Commission recommends the enactment of legislation to give effect to the following principles:

- \* A medical practitioner may, under specified circumstances, cease or authorise the cessation of all further medical treatment of a patient whose life functions are being maintained artificially while the person has no spontaneous respiratory and circulatory



functions or where his or her brainstem does not register any impulse.

- \* A competent person may refuse any life-sustaining medical treatment with regard to any specific illness from which he or she may be suffering, even though such refusal may cause the death or hasten the death of such a person.
- \* A medical practitioner or, under specified circumstances, a nurse may relieve the suffering of a terminally ill patient by prescribing sufficient drugs to control the pain of the patient adequately even though the secondary effect of this conduct may be the shortening of the patient's life.
- \* A medical practitioner may, under specified circumstances, give effect to an advance directive or enduring power of attorney of a patient regarding the refusal or cessation of medical treatment or the administering of palliative care, provided that these instructions have been issued by the patient while mentally competent.
- \* A medical practitioner may, under specified circumstances, cease or authorise the cessation of all further medical treatment with regard to terminally ill patients who are unable to make or communicate decisions concerning their medical treatment, provided that his or her conduct is in accordance with the wishes of the family of the patient or authorised by a court order.

As regards active voluntary euthanasia, the Commission does not make a specific recommendation. The Commission sets out different options to deal with this issue. These options were identified through comments received:

- \* Option 1: Confirmation of the present legal position:

The arguments in favour of legalising euthanasia are not sufficient reason to weaken society's prohibition of intentional killing since it is considered to be the cornerstone of the law and of all social relationships. Whilst acknowledging that there may be individual cases in which euthanasia may seem to be appropriate,

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these cannot establish the foundation of a general pro-euthanasia policy. It would furthermore be impossible to establish sufficient safeguards to prevent abuse.

\* Option 2: Decision making by the medical practitioner:

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

\* Option 3: Decision making by a panel or committee:

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

The Commission's proposed draft Bill, encompassing the above-mentioned recommendations and options, appears on the next sixteen pages to facilitate reference.

**BILL**

**To regulate end of life decisions and to provide for matters incidental thereto.**

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**To be introduced by the Minister of Justice**

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BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:

**Definitions**

1. (1) In this Act, unless the context otherwise indicates-

'competent witness' means a person of the age of 18 years or over who at the time he witnesses the directive or power of attorney is not incompetent to give evidence in a court of law and for whom the death of the maker of the directive or power of attorney holds no benefit;

'court' means a provincial or local division of the High Court of South Africa within whose jurisdiction the matter falls;

'family member' in relation to any person, means that person's spouse, parent, child,

brother or sister;

'intractable and unbearable illness' means an illness, injury or other physical or mental condition, but excluding a terminal illness, that-

- (a) offers no reasonable prospect of being cured; and
- (b) causes severe physical or mental suffering of a nature and degree not reasonable to be endured.

'lawyer' means an attorney as defined in section 1 of the Attorney's Act, 1979 (Act 53 of 1979) and an advocate as defined in section 1 of the Admission of Advocates Act, 1964 (Act 74 of 1964);

'life-sustaining medical treatment' includes the maintenance of artificial feeding;

'medical practitioner' means a medical practitioner registered as such in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);

'nurse' means a nurse registered as such in terms of the Nursing Act 50 of 1978 and authorised as a prescriber in terms of section 31(14)(b) of the proposed [South African Medicines and Medical Devices Regulatory Authority Bill]<sup>1</sup>;

'palliative care' means treatment and care of a terminally ill patient with the object of relieving physical, emotional and psycho-social suffering and of maintaining personal hygiene;

'spouse' includes a person with whom one lives as if they were married or with whom one

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<sup>1</sup>Editorial note: Now Act 132 of 1998 assented to 11 December 1998, date of commencement to be proclaimed.

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habitually cohabits;

'terminal illness' means an illness, injury or other physical or mental condition that-

- (a) in reasonable medical judgement, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering; or
- (b) causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.

### **Conduct of a medical practitioner in the event of clinical death**

2.(1) For the purposes of this Act, a person is considered to be dead when two medical practitioners agree and confirm in writing that a person is clinically dead according to the following criteria for determining death, namely -

- (a) the irreversible absence of spontaneous respiratory and circulatory functions; or
- (b) the persistent clinical absence of brain-stem function.

(2) Should a person be considered to be dead according to the provisions of sub-section (1), the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of treatment.

### **Mentally competent person may refuse treatment**

3.(1) Every person -

- (a) above the age of 18 years and of sound mind, or
- (b) above the age of 14 years, of sound mind and assisted by his or her parents or guardian,

is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.

(2) Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in subsection (1) is, that such a person's refusal is based on the free and considered exercise of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.

(3) Care should be taken when taking a decision as to the competency of a person, that an individual who is not able to express him or herself verbally or adequately, should not be classified as incompetent unless expert attempts have been made to communicate with that person whose responses may be by means other than verbal.

(4) Where a medical practitioner as contemplated in subsection (2) does not share or understand the first language of the patient, an interpreter fluent in the language used by the patient must be present in order to facilitate discussion when decisions regarding the treatment of the patient are made.

### **Conduct of medical practitioner in relieving distress**

4.(1) Should it be clear to a medical practitioner or a nurse responsible for the treatment of a patient who has been diagnosed by a medical practitioner as suffering from a terminal illness that the dosage of medication that the patient is currently receiving is not adequately alleviating the patient's pain or distress, he or she shall -

- (a) with the object to provide relief of severe pain or distress; and
- (b) with no intention to kill

increase the dosage of medication (whether analgesics or sedatives) to be given to the patient until relief is obtained, even if the secondary effect of this action may be to shorten the life of the

patient.

(2) A medical practitioner or nurse who treats a patient as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and his or her conduct in treating the patient, which record will be documented and filed in and become part of the medical record of the patient concerned.

### **Active voluntary euthanasia**

#### **Option 1:**

No legislative enactment

#### **Option 2:**

### **Cessation of life**

5.(1) Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall give effect to the request if he or she is satisfied that-

- (a) the patient is suffering from a terminal or intractable and unbearable illness ;
- (b) the patient is over the age of 18 years and mentally competent;
- (c) the patient has been adequately informed in regard to the illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;
- (d) the request of the patient is based on a free and considered decision;

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(e) the request has been repeated without self-contradiction by the patient on two separate occasions at least seven days apart, the last of which is no more than 72 hours before the medical practitioner gives effect to the request;

(f) the patient, or a person acting on the patient's behalf in accordance with subsection (6), has signed a completed certificate of request asking the medical practitioner to assist the patient to end the patient's life;

(g) the medical practitioner has witnessed the patient's signature on the certificate of request or that of the person who signed on behalf of the patient;

(h) an interpreter fluent in the language used by the patient is present in order to facilitate communication when decisions regarding the treatment of the patient are made where the medical practitioner as contemplated in this section does not share or understand the first language of the patient;

(i) ending the life of the patient or assisting the patient to end his or her life is the only way for the patient to be released from his or her suffering.

(2) No medical practitioner to whom the request to make an end to a patient's suffering is addressed as contemplated in subsection (1), shall give effect to such a request, even though he or she may be convinced of the facts as stated in that subsection, unless he or she has conferred with an independent medical practitioner who is knowledgeable with regard to the terminal illness from which the patient is suffering and who has personally checked the patient's medical history and examined the patient and who has confirmed the facts as contemplated in subsection (1)(a), (b) and (i).

(3) A medical practitioner who gives effect to a request as contemplated in subsection (1), shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner with whom he or she has



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conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).

(4) The termination of a patient's life on his or her request in order to release him or her from suffering may not be effected by any person other than a medical practitioner.

(5) A medical practitioner who gives effect to a patient's request to be released from suffering as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act provided that all due procedural measures have been complied with.

(6) If a patient who has orally requested his or her medical practitioner to assist the patient to end the patient's life is physically unable to sign the certificate of request, any person who has attained the age of 18 years, other than the medical practitioner referred to in subsection (2) above may, at the patient's request and in the presence of the patient and both the medical practitioners, sign the certificate on behalf of the patient.

(7) (a) Notwithstanding anything in this Act, a patient may rescind a request for assistance under this Act at any time and in any manner without regard to his or her mental state.

(b) Where a patient rescinds a request, the patient's medical practitioner shall, as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record.

(8) The following shall be documented and filed in and become part of the medical record of the patient who has been assisted under this Act:

(a) a note of the oral request of the patient for such assistance;

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- (b) the certificate of request;
- (c) a record of the opinion of the patient's medical practitioner that the patient's decision to end his or her life was made freely, voluntarily and after due consideration;
- (d) the report of the medical practitioner referred to in subsection (2) above;
- (e) a note by the patient's medical practitioner indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a nota

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### **Option 3: Decision by panel or committee**

#### **Cessation of life**

5.(1) Euthanasia may be performed by a medical practitioner only, and then only where the request for the euthanasia of the patient has been approved by an ethics committee constituted for that purpose and consisting of five persons as follows:

- a) two medical practitioners other than the practitioner attending to the patient;
- b) one lawyer;
- c) one member sharing the home language of the patient;
- d) one member from the multi-disciplinary team; and
- e) one family member.

(2) In considering and in order to approve a request as contemplated in subsection (1) the Committee has to certify in writing that:

- a) in its opinion the request for euthanasia by the patient is a free, considered and sustained request;

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- b) the patient is suffering from a terminal or intractable and unbearable illness;
- c) euthanasia is the only way for the patient to be released from his or her suffering.

(3) A request for euthanasia must be heard within three weeks of it being received by the Committee.

(4) (a) The Committee which, under subsection (2), grants authority for euthanasia must, in the prescribed manner and within the prescribed period after euthanasia has been performed, report confidentially to the Director-General of Health, by registered post, the granting of such authority and set forth -

- (i) the personal particulars of the patient concerned;
- (ii) the place and date where the euthanasia was performed and the reasons therefore;
- (iii) the names and qualifications of the members of the committee who issued the certificates in terms of the above sections; and
- (iv) the name of the medical practitioner who performed the euthanasia.

(b) The Director-General may call upon the members of the Committee required to make a report in terms of subsection (4) or a medical practitioner referred to in subsection (1) to furnish such additional information as he may require.

(5) The following shall be documented and filed and become part of the medical record of the patient who has been assisted under this Act:

- (a) full particulars regarding the request made by the patient;
- (b) a copy of the certificate issued in terms of subsection (2);
- (c) a copy of the report made in terms of subsection (4).

**Directives as to the treatment of a terminally ill person**

6.(1) Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive declaring that if he or she should ever suffer from a terminal illness and would as a result be unable to make or communicate decisions concerning his or her medical treatment or its cessation, medical treatment should not be instituted or any medical treatment which he or she may receive should be discontinued and that only palliative care should be administered.

(2) A person as contemplated in subsection (1) shall be competent to entrust any decision-making regarding the treatment as contemplated in that subsection or the cessation of such treatment to a competent agent by way of a written power of attorney, and such power of attorney shall take effect and remain in force if the principal becomes terminally ill and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof.

(3) A directive contemplated in subsection (1) and a power of attorney contemplated in subsection (2) and any amendment thereof, shall be signed by the person giving the directive or power of attorney in the presence of two competent witnesses who shall sign the document in the presence of the said person and in each other's presence.

(4) When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) or (2) regarding his medical treatment or the cessation thereof have been issued, the decision-making regarding such treatment or the cessation thereof shall, in the absence of any court order or the provisions of any other Act, vest in such guardian or curator.

**Conduct in compliance with directives by or on behalf of terminally ill persons**

7.(1) No medical practitioner shall give effect to a directive regarding the refusal or cessation of medical treatment or the administering of palliative care which may contribute to the hastening of a patient's death, unless-

(a) the medical practitioner is satisfied that the patient concerned is suffering from a terminal illness and is therefore unable to make or communicate considered decisions concerning his or her medical treatment or the cessation thereof; and

(b) the condition of the patient concerned, as contemplated in paragraph (a), has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition because of his expert knowledge of the patient's illness and his or her examination of the patient concerned.

(2) Before a medical practitioner gives effect to a directive as contemplated in subsection (1) he shall satisfy himself, in so far as this is reasonably possible, of the authenticity of the directive and of the competency of the person issuing the directive.

(3) Before giving effect to a directive as contemplated in subsection (1), a medical practitioner shall inform the interested family members of the patient of his or her findings, that of the other medical practitioner contemplated in paragraph (b) of subsection (1), and of the existence and content of the directive of the patient concerned.

(4) If a medical practitioner is uncertain as to the authenticity as regard to the directive or its legality, he shall treat the patient concerned in accordance with the provisions set out in section 8 below.

(5) (a) A medical practitioner who gives effect to a directive as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and the manner in which he or she implemented the directive.

(b) A medical practitioner as contemplated in paragraph (b) of subsection (1) shall record in writing his or her findings regarding the condition of the patient concerned.

(6) A directive concerning the refusal or cessation of medical treatment as contemplated in sub-section (1) and (2) shall not be invalid and the withholding or cessation of medical treatment in accordance with such a directive, shall, in so far as it is performed in accordance with this Act, not be unlawful even though performance of the directive might hasten the moment of death of the patient concerned.

### **Conduct of a medical practitioner in the absence of a directive**

**8.(1)** If a medical practitioner responsible for the treatment of a patient in a hospital, clinic or similar institution where a patient is being cared for, is of the opinion that the patient is in a state of terminal illness as contemplated in this Act and unable to make or communicate decisions concerning his or her medical treatment or its cessation, and his or her opinion is confirmed in writing by at least one other medical practitioner who has not treated the person concerned as a patient, but who has examined him or her and who is competent to submit a professional opinion regarding the patient's condition on account of his or her expertise regarding the illness of the patient concerned, the first-mentioned medical practitioner may, in the absence of any directive as contemplated in section 6(1) and (2) or a court order as contemplated in section 9, grant written authorisation for the cessation of all further life-sustaining medical treatment and the administering of palliative care only.

(2) A medical practitioner as contemplated in subsection (1) shall not act as contemplated in subsection (1) if such conduct would be contrary to the wishes of the interested family members of the patient, unless authorised thereto by a court order.

(3) A medical practitioner as contemplated in subsection (1) shall record in writing his or her findings regarding the patient's condition and any steps taken by him or her in respect thereof.

(4) The cessation of medical treatment as contemplated in subsection (1) shall not be unlawful merely because it contributes to causing the patient's death.

### **Powers of the court**

9.(1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may, if satisfied that a patient is in a state of terminal illness and unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, order the cessation of medical treatment.

(2) A court shall not make an order as contemplated in subsection (1) without the interested family members having been given the opportunity to be heard by the court.

(3) A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who have expert knowledge of the patient's condition and who have treated the patient personally or have informed themselves of the patient's medical history and have personally examined the patient.

(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not thereby incur any civil, criminal or other liability whatsoever.



### **Interpretation**

**10.** The provisions of this Act shall not be interpreted so as to oblige a medical practitioner to do anything that would be in conflict with his or her conscience or any ethical code to which he or she feels himself or herself bound.

### **Short title**

**11.** This Act shall be called the End of Life Decisions Act 1999.

## LIST OF SOURCES

Alberta Law Reform Institute **Advance directives and substitute decision-making in personal health care** Report for discussion No 11 November 1991.

Alberta Law Reform Institute and The Health Law Institute **Advance directives and substitute decision-making in personal health care** Joint Report No 64 March 1993.

Barnard, C N "A human cardiac transplant: an interim report of a successful operation performed at Grootte Schuur Hospital, Cape Town" 1967 **S A Medical Journal** 1271.

Benatar, S R "Dying and 'euthanasia'" 1992 **SA Medical Journal** 35.

Bix, B "Physician assisted suicide and the United States Constitution" 1995 **Modern Law Review** 404.

Boister, N " Causation at the death" 1993 **THRHR** 516.

British House of Lords **Report of the Select Committee on medical ethics** 31 January 1994.

British Medical Association **Treatment of patients in persistent vegetative state** September 1992.

Burrows, R "Removal of life support in intensive care units" 1994 **Med Law** 489.

Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide **Of life and death** June 1995.

Chaskalson, M et al (ed) **Constitutional law of South Africa** Kenwyn Juta & Co 1996.

Chesterman, S "Last rights: euthanasia, the sanctity of life and the law in the Netherlands and the Northern Territory of Australia" 1998 **International and Comparative Law Quarterly** 362.

Cica, N **Euthanasia - the Australian law in an international context Part 1: passive voluntary euthanasia** Research Paper 3 Department of the Parliamentary Library Australia 1996-97.

Cica, N **Euthanasia - the Australian law in international context Part 2: active voluntary euthanasia** Research Paper 4 Department of the Parliamentary Library Australia 1996-7.

De Klerk, A "Transplantation of human tissue and organs in South African law" 1992 **TRW** 112.

Dorfling, D F "**Genadedood**" in die strafreg - 'n regsfilosofiese en regsvergelykende **perspektief** (Unpublished thesis submitted in partial fulfilment of the degree Magister Legum) Faculty of Law Rand Afrikaans University 1991.

Dörfling, DF "Eutanasie: die reg van die **curator personae** om verdere behandeling van 'n pasiënt te verbied - 'n nuwe regverdigingsgrond in die Suid-Afrikaanse reg" 1993 **TSAR** 345.

Doyle, D Harris, G & Mac Donald, N (eds) **Oxford textbook of palliative medicine** London Oxford University Press 1993.

Dreyer, L "Redelike dokter versus redelike pasiënt" 1995 **THRHR** 532.

Dworkin, R **Life's dominium: an argument about abortion and euthanasia** London Harper Collins 1993.

Dyer, C (ed) **Doctors, patients and the law** Oxford Blackwell 1992.

Earle, M "'Informed consent': is there room for the reasonable patient in South African law?" 1995 **SALJ** 629.

(xxx)

Ebrahim, A F M "The noble Qur'an on the end of human life" **al-'ilm** Vol 16 1996.

Eekelaar, J "White coats or flak jackets? Doctors, children and the courts - again" 1993 **The Law Quarterly Review** 182.

Finnis, J M "**Bland**: crossing the Rubicon?" 1993 **The Law Quarterly Review** 329.

GAO **Patient Self-determination Act: providers offer information on advance directives but effectiveness uncertain** Report No HEHS-95-135 January 1995.

Goolam N M I "Euthanasia: reconciling culture and human rights" 1996 **Med Law** 529.

**Government Response to the Report of the Select Committee on Medical Ethics** Cm 2552  
London HMSO May 1994.

Griffiths, J "Assisted suicide in the Netherlands: the **Chabot** case" 1995 **Modern Law Review** 232.

Griffiths, J "Assisted suicide in the Netherlands: postscript to **Chabot**" 1995 **Modern Law Review** 895.

Hu, P "The acceptability of active euthanasia in China" 1993 **Med Law** 47.

Hunt, T M A & Milton, J R L **South African criminal law and procedure Vol 2** 2nd ed Cape Town Juta 1982.

Kapp, M B "'Ageism' and right to die litigation" 1994 **Med Law** 69.

Kennedy, I & Grubb, A **Medical law: text and materials** London Butterworths 1989.

Keown, J "The law and practice of euthanasia in the Netherlands" 1992 **The Law Quarterly Review** 51.

Keown, J "Physician assisted suicide and the Dutch Supreme Court" 1995 **The Law Quarterly Review** 394.

Keown, J "Restoring moral and intellectual shape to the law after **Bland**" 1997 **The Law Quarterly Review** 481.

Keown, J (ed) **Euthanasia examined: ethical, clinical and legal perspectives** New York Cambridge University Press 1995.

Kuhse, H "'No' to the intention/foresight distinction in medical end-of-life decisions" Paper presented at 11<sup>th</sup> World Congress on Medicine and Law Sun City July 28- Aug 1 1996.

Labuschagne, J M T "Dekriminalisasie van eutanasia" 1988 **THRHR** 167.

Labuschagne, J M T "Menseregte na die dood: opmerkinge oor lyk en grafskending" 1991 24 **De Jure** 141.

Labuschagne, J M T "Die reg om waardig te sterf, aktiewe eutanasia en bystand tot selfdoding" **SAJC** 1995 8 224.

Labuschagne, J M T "Dodingsmisdade, sosio-morele stigmatisering en die menseregtelike grense van misdaadsistematiesing" 1995 **Obiter** 34.

Labuschagne, J M T "Beeindiging van mediese behandeling en toestemmingsonbekwames" 1995 16 **Obiter** 175.

Labuschagne, J M T "Aktiewe eutanasia en professionele hulpverlening by selfdoding van n psigiatriese pasient" 1995 **SALJ** 227.

Labuschagne, J M T "Frenchay Healthcare NHS Trust v S [1994]2 All ER 403 (CA): Eutanatiewe beeindiging van mediese behandeling " 1996 **SACJ** 80.

Labuschagne, J M T "Aktiewe eutanase van n swaar gestremde baba: n Nederlandse hof herstel die **ius vitae necisque** in n medemenslike gewaad" 1996 **SALJ** 216.

Labuschagne, J M T "Aktiewe eutanase: mediese prerogatief of strafregtelike verweer? " 1996 **SALJ** 411.

Labuschagne J M T "Menseregtelike status van die strafregtelike verbod om hulpverlening by selfdoding" unpublished.

Law Commission **Mentally incapacitated adults and decision making: an overview** Consultation Paper No.119 London HMSO 1991.

Law Commission **Mentally incapacitated adults and decisionmaking: a new jurisdiction** Consultation Paper No 128 London HMSO 1993.

Law Reform Commission of Canada **Report on euthanasia, aiding suicide and cessation of treatment** 1983.

Law Reform Commission of Saskatchewan **Proposals for an advance health care directives act** December 1991.

Law Reform Commission of Western Australia **Report on medical treatment for the dying** 1991.

Leenen, H J J "The definition of euthanasia" 1984 **Med Law** 333.

Leenen, H J J "Supreme Court's decisions on euthanasia in the Netherlands" 1986 **Med Law** 349.

Leenen, H J J "Dying with dignity: developments in the field of euthanasia in the Netherlands" 1989 **Med Law** 517.

Leinbach, R M "Euthanasia attitudes of older persons" 1993 **Research on Aging** 433.

Leonard-Taitz, J "Euthanasia, the right to die and the law in South Africa" 1992 **Med Law** 597.

Lowe, N & Juss, S "Medical treatment - pragmatism and the search for principle" 1993 **Modern Law Review** 865.

Lupton, M L "**Clarke v Hurst NO, Brain NO & Attorney-General, Natal**" 1992 **SACJ** 342.

Manitoba Law Reform Commission **Report on self-determination in health care (living wills and health care proxies)** Report No 74 1991.

Mason, J K & McCall Smith, R A **Law and medical ethics** 3rd ed London Butterworths 1991.

Moor, S "Euthanasia in relation to newborn babies - a comparative study of the legal and ethical issues: Part I 1996 **Med Law** 295.

Moor, S "Euthanasia in relation to newborn babies - a comparative study of the legal and ethical issues : Part II 1996 **Med Law** 537.

Nadasen, S "' Suffer the little children .....' - euthanasia and the best interests of the child" 1997 **THRHR** 124.

Nel, J P "Regs vrae rondom die geneeskundige behandeling van ernstig gestremde pasgeborenes" 1998 **THRHR** 73 and 1998 **THRHR** 252.

Newfoundland Law Reform Commission **Advance health care directives and attorneys for**

**health care** Discussion Paper No 6 1992.

Ngwenya, C "Health care decision making and the competent minor: the limits of self-determination" 1996 **Acta Juridica** 132.

Plachta, M "The right to die in Canadian legislation, case law and legal doctrine" 1994 **Med Law** 639.

Plomer, A "Review: Ronald Dworkin Life's dominium: an argument about abortion and euthanasia" 1996 **The Modern Law Review** 479.

Pozgar, G D **Legal aspects of health care administration** 4th ed Maryland Aspen Publishers 1990.

Roberts, S E "When not to prolong life" 1990 **The Law Quarterly Review** 218.

Rougé, D Telmon, N, Albarède, J-L & Arbus, L "Questions raised by artificial prolongation of life of the aged patient" 1994 **Med Law** 269.

SAVES Southern Australia **Fact Sheet 21**.

Scott, H "Assisted suicide and the South African constitutional order" 1998 **Responsa Meridiana** 1.

Senate Legal and Constitutional Legislation Committee **Consideration of legislation referred to the Committee: Euthanasia Laws Bill 1996** March 1997.

Snyder, R D "End of life decisions at the beginning of life" 1996 **Med Law** 283.

South African Law Commission **Report on enduring powers of attorney and the appointment**



**of curators for mentally incapacitated persons** October 1988.

South African Law Commission **Euthanasia and the artificial preservation of life** Working Paper 53 March 1994.

South African Law Commission **Euthanasia and the artificial preservation of life** Discussion Paper 71 April 1997.

Stern, K "Competence to refuse life sustaining medical treatment" 1994 **The Law Quarterly Review** 541.

Strauss, S A **Doctor, patient and the law** 3rd edition Pretoria J L van Schaik Publishers 1991.

Strauss, S A "Toestemming deur 'n jeugdige" 1964 **THRHR** 116.

Strauss, S A "Bodily injury and the defence of consent" 1964 **SALJ** 179.

Strauss, S A "Onvrywillige genadedood: 'n belangrike Transvaalse beslissing" 1969 **THRHR** 385.

Trindade, F A "Disclosure of risks in proposed medical treatment" 1993 **The Law Quarterly Review** 352.

Van den Heever, P "The patient's right to know: informed consent in South African medical law" 1995 **De Rebus** 53.

Van der Merwe, N J & Olivier, P J J **Die onregmatige daad in die Suid-Afrikaanse reg** 6th ed Pretoria Van der Walt and Son 1989.

Van der Wal, G & Dillmann, R J M "Euthanasia in the Netherlands" 1994 **British Medical Journal** 1346.

Van Oosten, F F W "Aandadigheid aan selfmoord in die Suid-Afrikaanse reg" 1985 **TSAR** 189.

Van Oosten, F F W "**Castell v De Greef** and the doctrine of informed consent: medical paternalism ousted in favour of patient autonomy" 1995 **De Jure** 164.

Van Oosten, F F W "Patients rights: a status report on the Republic of South Africa" **Law in Motion** International Encyclopedia of Laws World Conference 989.(to be published).

Weinfeld, J "Active voluntary euthanasia - should it be legalised?" 1985 **Med Law** 101.

## TABLE OF CASES

### SOUTH AFRICA

- Bernstein v Bester** 1996 (4) BCLR 449 (CC).
- Brink v Kitshoff NO** 1996 (6) BCLR 752 (CC) 769.
- Calitz Calitz** 1939 AD 56.
- Castell v De Greeff** 1994 (4) SA 408.
- Clarke v Hurst NO and others** 1992 4 SA 630 (D).
- Esterhuizen v Administrator, Transvaal** 1957 3 SA 710 (T).
- Ex parte Die Minister van Justisie: In re S v Grotjohn** 1970 2 SA 355 (A).
- Gardener v Whitaker** 1994 5 BCLR 19(E) 36.
- Lange v Lange** 1945 AD 332.
- R v Davidow** 1955 WLD unreported.
- R v Makali** 1950 1 SA 340 (N).
- R v McCoy** 1953 2 SA 4 (SR).
- R v Nbakwa** 1956 2 SA 557 (SR).
- R v Peverett** 1940 AD 213.
- S v De Bellocq** 1975 3 SA 538 (T).
- S v Gordon** 1962 4 SA 727 (N).
- S v Hartmann** 1975 3 SA 532 (C).
- S v Hibbert** 1979 4 SA 717 (D).
- S v Makwanyane** 1995 (2) SACR 1 (CC) 94.
- S v Marengo** 1990 WLD unreported.
- S v McBride** 1979 4 SA 313 (W).
- S v Smorenburg** 1992 CPD unreported.
- S v Williams** 1986 4 SA 1188 (A).
- Soobramoney v Minister of Health (Kwazulu- Natal)** 1997 BCLR (12) 1696 (CC).
- Van Rooyen v Werner** (1892) SC 425.

**USA**

**Compassion in Dying v State of Washington** 79 F3d 790 (9th Cir 1996).

**Cruzan v Director Missouri Department of Health** (1990) 497 US 261; 111 L Ed 2d 224; 110 S Ct 2841.

**In re Claire Conroy** 98 NJ 321; 486 A 2d 1209 (NJ 1985).

**In re Hilda M Peter** 108 NJ 365; 529 A 2d 419 (NJ 1987).

**In re Nancy Ellen Jobes** 108 NJ 394; 529 A 2d 434 (NJ 1987).

**In re Quinlan** 81 NJ 10; 355 A 2d 647 (NJ 1976).

**John F Kennedy Memorial Hospital Inc v Bludworth** 452 So 2d 921 (Fla 1984).

**Quill v Vacco** 80 F 3d 716 (2d Cir 1996).

**Schloendorff v Society of New York Hospital** 211 NY 125, 105 NE 92.

**Washington v Glucksberg** 117 S Ct 2302 (1997).

**UNITED KINGDOM**

**Airedale NHS Trust v Bland** [1993] 1 All ER 821.

**Bolam v Friern Hospital Management Committee** [1957] 2 All ER 118; [1957] 1 WLR 582.

**Gillick v West Norfolk and Wisbeck Area Health Authority and another** [1985] 3 All ER 402.

**F v West Berkshire Health Authority** [1989] 2 All ER 545, [1990] 2 AC 1.

**Frenchay Healthcare NHS Trust v S** [1994] 2 All ER 403 (CA).

**In re B (a minor) (wardship: sterilization)** [1987] 2 All ER 206; [1988] AC 199.

**In re B (a minor) (wardship: medical treatment)** [1990] 3 All ER 927; [1981] 1 WLR 1421.

**In re C (a minor)(wardship: medical treatment)** [1989] 3 WLR 240.

**In re J (a minor)** [1990] 3 All ER 930.

**In re R** [1991] 4 All ER 177.

**In re S (adult: Refusal of treatment)** [1992] 3 WLR 806.

**In re T(adult): Refusal of treatment** [1992] 4 All ER 649; [1992] 3 WLR 782.

**In re W** [1993] Fam Court 64.

(xxxix)

**Sidaway v Bethlehem Royal Hospital Governors** [1985] 1 All ER 643.

## **CANADA**

**Rodriguez v British Columbia (Attorney General)** (1993) 107 DLR 4th 342.

**Re Rodriguez & Attorney-General of British Columbia** (1994) 85 CCC (3rd) 15 (SCC).

## **CHAPTER 1**

### **INTRODUCTION**

#### **A) Origin of the investigation**

1.1 The South African Voluntary Euthanasia Society (SAVES), which has since changed its name to SAVES The Living Will Society, suggested in a letter to the Commission, dated 14 October 1991, that the Commission should consider legislation regarding a document known as a "Living Will". This proposal was subsequently substantiated in a memorandum dated 27 December 1991, which contained more detailed information about the Society and its objectives as well as references to applicable overseas legislation, articles and newspaper reports.

1.2 On 27 January 1992, at a meeting of the Working Committee, the Commission approved the proposal submitted by SAVES as a research project. However, it was decided that issues relating to the termination of life should, for the sake of completeness, also be investigated under the heading "Euthanasia and the artificial preservation of life".

#### **B) Scope of the investigation**

1.3 In the initial stages of the investigation the Commission concerned itself only with instances of cessation of treatment as well as with the question regarding the legality of the Living Will. As a result of the developments in regard to active euthanasia in other countries, most notably in the Netherlands, Northern Australia and certain states of the USA as well as enquiries by respondents in this regard, the Commission however decided to address the question relating to end of life decisions in its entirety. The investigation was therefore broadened to include the question of active euthanasia.

1.4 From the start it was clear that the subject under discussion readily lends itself to theorisation and moralising. However, the Commission's research has indicated that it is especially in this field that a sober and practical approach will be most fruitful.<sup>2</sup>

1.5 Research also showed that the subject under discussion lends itself to confusion with regard to the terminology used. An analysis of the situation brought the Commission to the conclusion that there are basically three categories within which the preservation of life and questions relating to actions that hasten death should be discussed, namely:

- (a) the artificial preservation of life after clinical death has set in;
- (b) the preservation of life where the patient is competent to make decisions; and
- (c) the preservation of life where the patient is incompetent to make decisions.

Terminology and definitions used, are discussed below.<sup>3</sup>

### C) **Exposition of the problem**

1.6 The advances made in medical science and in the application of medical technology have resulted in patients living longer. For many patients this signifies a welcome prolongation of meaningful life, but for others the result is a poor quality of life which inevitably raises the question whether treatment is a benefit or a burden.

1.7 Having created a situation in which lives are routinely saved, transformed or prolonged by medical intervention, we can hardly pretend that the process of dying, and that alone, must be 'left to nature'.<sup>4</sup> Simplistic aphorisms, which might have had more general truth fifty years ago

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<sup>2</sup>An excellent example of such an approach is found in the **Report of the Select Committee on medical ethics** of the British House of Lords, published on 31 January 1994 (hereinafter referred to as "**Report of the Select Committee**").

<sup>3</sup>Para 2.1 on 18.

<sup>4</sup>See Kuhse, H "'No' to the intention/foresight distinction in medical end-of-life decisions" (Paper presented at the 11th World Congress on Medicine and Law held at Sun City July 28 -

such as "while there is life there's hope" or "killing is killing" are inadequate to address the present state of medical expertise which is capable of keeping 'alive' irreparably sick or damaged patients who in the recent past would not have survived at all.<sup>5</sup>

1.8 Worldwide, increased importance is furthermore being attached to patient autonomy. The need has therefore arisen to consider the protection of a patient's right to refuse medical treatment and to receive assistance, should he or she so require, in ending his or her life. This is also important in cases where the patient has strong views regarding his or her treatment and is concerned that he or she may in future be incapable of communicating his or her wishes to the doctor. In this regard the so-called living will may be relevant.

1.9 Since matters concerning the treatment of terminally ill people are at present being dealt with on a fairly **ad hoc** basis, there is some degree of uncertainty in the minds of the general public and medical personnel about the legal position of terminally ill and dying people. Doctors and families want to act in the best interests of patients, but are unsure about the scope and content of the obligation to care. It was felt that this uncertainty may lead to unnecessary tension and conflict within the treatment team; between the team and the next of kin of a patient; and amongst family members themselves. Such conflict and tension when people need to make difficult emotional and moral decisions are not to the advantage of anyone, least of all the patient.<sup>6</sup>

1.10 Doctors are furthermore afraid of being exposed to civil claims, criminal prosecution and professional censure should they withhold life support systems or prescribe drugs which may inadvertently or otherwise shorten the patient's life even if they are merely complying with the

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Aug 1 1996) as well as her reference to Van der Maas, PJ, Van Delden, JJM, Pijnenborg, L and Looman, CWN "Euthanasia and other medical decisions concerning the end of life" **Lancet** 14 September 1991 at 338: Death is no longer the natural event it once was. Rather, most patients die in institutional settings, as the result of a medical end of life decision. Nearly 40 % of all deaths and 54% of all non-acute deaths are the result of a medical end of life decision - the foregoing of life-sustaining treatment, the administration of potentially life-shortening pain- and symptom control and of euthanasia.

<sup>5</sup>Voluntary Euthanasia Society, England.

<sup>6</sup>Alfred Allan, Department of Psychiatry, University of Stellenbosch.



wishes of the patient. Consequently patients are suffering and the court has to be approached at great cost to decide the question of whether a patient should be allowed to die.

#### **D) Consultation process**

1.11 In accordance with the Commission's policy to consult as widely as possible, every effort was made throughout the investigation to publicise the investigation and to elicit response from interested persons and organisations as well as from members of the public.

1.12 In 1994 the Commission published a Working Paper entitled "Euthanasia and the artificial preservation of life".<sup>7</sup> Working Paper 53 contained an exposition of the present state of our law regarding the circumstances in which actions that could indirectly end a person's life may be justified; the role that the wishes of the patient should play in this regard and what conduct would be acceptable in cases where no instructions or requests have been received from the patient. The paper included an investigation of similar systems in other jurisdictions and preliminary proposals on ways in which the abovementioned problems could be dealt with in this country. The draft bill contained in the paper elicited a live and varied response. Written comment was furthermore received from 60 persons and institutions.<sup>8</sup>

1.13 On 22 June 1994 the Commission held a workshop which was attended by 80 persons, including experts in the fields of medicine, law, religion and ethics. This was followed up by a second smaller workshop held on 18 October 1996.

1.14 During the course of 1996 the magazines *You* and *Huisgenoot* invited their readers to contact the Project Leader in connection with their personal experiences and opinions regarding the cessation of life of family members or themselves. Close to a hundred letters were received by the Project Leader.

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<sup>7</sup>South African Law Commission **Euthanasia and the artificial preservation of life** Working Paper 53 March 1994 (hereinafter referred to as "**Working Paper 53**").

<sup>8</sup>A list of respondents is enclosed as Annexure A.

1.15 In the light of the great interest displayed by the public in this investigation and the evident need for more comprehensive discussion of the whole problem of euthanasia and the artificial preservation of life the Commission published a second Discussion Paper for general information and comment.<sup>9</sup> Since the question of euthanasia had at that stage never been put before the South African public in its entirety, this working paper set out to state all issues regarding end of life decisions objectively and neutrally without proposing specific measures.

1.16 In addition to the issues discussed in the first working paper, the aim of this Discussion Paper was to investigate further whether and in what circumstances actions that could directly end a person's life may be justified. A distinction was made between cases where clinical death had set in, cases where the terminally-ill person had contractual capacity and cases where the terminally-ill person lacked contractual capacity. For the purposes of focussing attention on the various problem areas and to evoke discussion and debate, a draft bill was enclosed in the paper for comment. For purposes of easy reference the Bill, hereinafter referred to as the Discussion Paper Bill is set out hereunder:

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<sup>9</sup>South African Law Commission **Euthanasia and the artificial preservation of life** Discussion Paper 71 April 1997(hereinafter referred to as "Discussion Paper 71").

**BILL**

*To regulate end of life decisions and to provide for matters incidental thereto.*

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*To be introduced by the Minister of Justice*

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*BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:*

***Definitions***

*1. (1) In this Act, unless the context otherwise indicates-*

- (i) 'competent witness' means a person of the age of 18 years or over who at the time he witnesses the directive or power of attorney is not incompetent to give evidence in a court of law and for whom the death of the maker of the directive or power of attorney holds no financial benefit;*
- (ii) 'court' means a provincial or local division of the High Court of South Africa within whose jurisdiction the matter falls;*
- (iii) 'life-sustaining medical treatment' includes the maintenance of artificial feeding;*
- (iv) 'medical practitioner' means a medical practitioner registered as such in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);*

- (v) *'palliative care' means treatment and care of a terminally ill patient, not with a view to cure the patient, but rather to relieve suffering and maintain personal hygiene;*
- (vi) *'terminal illness' means an illness, injury or other physical or mental condition which-*
  - (a) *will inevitably result in the death of the patient concerned within a relatively short time and which is causing the patient extreme suffering; or*
  - (b) *is causing the patient to be in a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.*

### ***Conduct of a medical practitioner in the event of clinical death***

*2. (1) For the purposes of this Act, a person is considered to be dead when two medical practitioners agree and confirm in writing that a person is clinically dead according to the following criteria for determining death, namely -*

- (a) *the irreversible absence of spontaneous respiratory and circulatory functions; or*
- (b) *the persistent clinical absence of brain-stem function.*

*(2) In the event of a person being considered to be dead according to the provisions of subsection (1), the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of treatment.*

### ***Mentally competent person may refuse treatment***

*3. (1) Every person above the age of 18 years and of sound mind is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.*

(2) *Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in subsection (1) is, that such a person's refusal is based on the free and carefully considered exercising of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.*

***Conduct of medical practitioner in relieving distress***

4. (1) *Should it be clear to a medical practitioner responsible for the treatment of a patient that the patient is suffering from a terminal illness and that such a patient's pain and distress cannot satisfactorily be alleviated by ordinary palliative treatment, he or she may, in accordance with responsible medical practice-*

(a) *with the object to provide relief of severe pain and distress; and*

(b) *with no intention to kill*

*increase the dosage of medication (whether analgesics or sedatives) to be given to the patient, even if the secondary effect of this action may be to shorten the life of the patient.*

(2) *No medical practitioner shall treat a patient as contemplated in subsection (1) unless the condition of the patient concerned has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition in view of his or her expertise with regard to the illness with which he or she is affected and on account of his examination of the patient concerned.*

(3) (a) *A medical practitioner who treats a patient as contemplated in subsection (1) shall record in writing his findings regarding the condition of the patient and his conduct in treating the patient.*

(b) *A medical practitioner as contemplated in subsection (2) shall record in writing his findings regarding the condition of the patient concerned.*

***Cessation of life***

*5.(1) Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall not give effect to the request unless he or she is convinced that-*

- (a) the patient is suffering from a terminal illness;*
- (b) the patient is subject to extreme suffering;*
- (c) the patient is over the age of 18 years and mentally competent;*
- (d) the patient has been adequately informed as to the terminal illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;*
- (e) the request of the patient is based on an informed and well considered decision;*
- (f) the patient has had the opportunity to re-evaluate his or her request, but that he or she has persisted; and*
- (g) euthanasia is the only way for the patient to be released from his or her suffering.*

*(2) No medical practitioner to whom the request to make an end to a patient's suffering is addressed as contemplated in subsection (1), shall give effect to such a request, even though he or she may be convinced of the facts as stated in that subsection, unless he or she has conferred*

*with an independent medical practitioner who is knowledgeable with regard to the terminal illness from which the patient is suffering and who has personally checked the patient's medical history and examined the patient and who has confirmed the facts as contemplated in subsection (1)(a), (b) and (g).*

*(3) A medical practitioner who gives effect to a request as contemplated in sub-section (1), shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner with whom he or she has conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).*

*(4) The termination of a patient's life on his or her request in order to release him or her from suffering may not be effected by any person other than a medical practitioner.*

*(5) A medical practitioner who gives effect to a patient's request to be released from suffering as contemplated in this section shall not suffer any civil, criminal or disciplinary accountability with regard to such an act provided that all due procedural measures have been complied with.*

*(6) No medical practitioner is obliged to give effect to a patient's request to assist with the termination of the patient's life.*

***Directives as to the treatment of a terminally ill person***

**6. (1)** *Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive declaring that if he or she should ever suffer from a terminal illness and would as a result be unable to make or communicate decisions concerning his or her medical treatment or its cessation, any medical treatment which he or she may receive should be discontinued and that only palliative care should be administered.*

*(2) A person as contemplated in subsection (1) shall be competent to entrust any decision-*

*making regarding the treatment as contemplated in that subsection or the cessation of such treatment to a competent agent by way of a written power of attorney, and such power of attorney shall take effect and remain in force if the principal becomes terminally ill and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof.*

*(3) A directive contemplated in subsection (1) and a power of attorney contemplated in subsection (2) and any amendment thereof, shall be signed by the person giving the directive or power of attorney in the presence of two competent witnesses who shall sign the document in the presence of the said person and in each other's presence.*

*(4) When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) or (2) regarding his medical treatment or the cessation thereof have been issued, the decision-making regarding such treatment or the cessation thereof shall, barring any court order or the provisions of any other Act, vest in such guardian or curator.*

### ***Conduct in compliance with directives by or on behalf of terminally ill persons***

*7. (1) No medical practitioner shall give effect to a directive regarding the refusal or cessation of medical treatment or the administering of palliative care which may contribute to the hastening of a patient's death, unless-*

*(a) the medical practitioner is satisfied that the patient concerned is suffering from a terminal illness and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof; and*

*(b) the condition of the patient concerned, as contemplated in paragraph (a), has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional*



*opinion on the patient's condition in view of his or her expertise with regard to the illness with which the patient is afflicted and his or her examination of the patient concerned.*

(2) *Before a medical practitioner gives effect to a directive as contemplated in subsection (1) he shall satisfy himself, in so far as this is reasonably possible, of the authenticity of the directive and of the competency of the person issuing the directive.*

(3) *Before giving effect to a directive as contemplated in subsection (1), a medical practitioner shall inform the interested relatives and family members of the patient of his findings, that of the other medical practitioner contemplated in paragraph (b) of subsection 1, and of the existence and content of the directive of the patient concerned.*

(4) *If a medical practitioner is uncertain as regard to the authenticity of the directive or its legality, he shall treat the patient concerned in accordance with the provisions set out in section 8 below.*

(5) (a) *A medical practitioner who gives effect to a directive as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and his conduct giving effect to the directive.*

(b) *A medical practitioner as contemplated in paragraph (c) of subsection (1) shall record in writing his findings regarding the condition of the patient concerned.*

(6) *A directive concerning the refusal or cessation of medical treatment as contemplated in subsection (1) and (2) shall not be invalid and the withholding or cessation of medical treatment in accordance with such a directive, shall, in so far as it is performed in accordance with this Act, not be unlawful even though performance of the directive might bring about the hastening of the moment of death of the patient concerned.*

***Conduct of a medical practitioner in the absence of a directive***

*8. (1) If the chief medical practitioner of a hospital, clinic or similar institution where a patient is being cared for is of the opinion that the patient is in a state of terminal illness as contemplated in this Act and for this reason unable to make or communicate decisions concerning his or her medical treatment or its cessation, and his opinion is confirmed in writing by at least one other medical practitioner who has not treated the person concerned as a patient, but who has examined him and who is competent to submit a professional opinion regarding the patient's condition on account of his expertise regarding the illness of the patient concerned, the first-mentioned medical practitioner may, in the absence of any directive as contemplated in section 6(1) and (2) or a court order as contemplated in section 9, grant written authorisation for the cessation of all further life-sustaining medical treatment and the administering of palliative care only.*

*(2) A medical practitioner as contemplated in section (1) shall not act as contemplated in subsection (1) if such conduct would be contrary to the wishes of the family members or close family of the patient, unless authorised thereto by a court order.*

*(3) A medical practitioner as contemplated in section (1) shall record in writing his findings regarding the patient's condition and any steps taken by him in respect thereof.*

*(4) The cessation of medical treatment as contemplated in subsection (1) shall not be unlawful merely because it contributes to causing the patient's death.*

***Powers of the court***

***Option 1:***

*9. (1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may if satisfied that a patient is in a state of terminal illness and for this*

*reason unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, order the cessation of medical treatment.*

*(2) A court shall not make an order as contemplated in subsection (1) without the close family having been given the opportunity to be heard by the court.*

*(3) A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who are knowledgeable with regard to the patient's condition and who has treated the patient personally or has checked his or her medical history and has personally examined the patient.*

*(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act.*

**Option 2:**

**10.** *(1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may if satisfied that a patient is in a state of terminal illness and for this reason unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, issue an order for the performance of any medical procedure which would have the effect of terminating the patient's life.*

*(2) A court shall not make an order as contemplated in subsection (1) without the close family of the patient having been given the opportunity to be heard by the court.*

*(3) A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who are knowledgeable with regard to the patient's condition and who have treated the patient personally or have checked his or her medical history and have personally examined*

*the patient.*

*(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act.*

***Interpretation***

*11. The provisions of this Act shall not be interpreted as though a medical practitioner is obliged to do anything that would be in conflict with his conscience or any ethical code to which he feels himself bound.*

***Short title***

***Option 1:***

*12. This Act shall be called the Rights of the Terminally Ill Act 1997.*

***Option 2:***

*12. This Act shall be called the End of Life Decisions Act 1997.*

1.17 Four hundred and three discussion papers were distributed to identified interested persons and bodies, including the various religious denominations, medical institutions, law societies, bar councils, registrars of the Supreme Court, the Appellate Division, foreign law reform agencies and non-governmental organisations representing the public at large. The availability of the discussion paper was also publicised through a notice in the Government Gazette and by way of a media statement circulated to the public media. A substantial number of publications, radio and

television programmes<sup>10</sup> covered the investigation and drew attention to the fact that the public could comment on the Commission's proposals.<sup>11</sup> Representatives of the Commission also participated in discussion groups, a telephone conference and various meetings<sup>12</sup>. A copy of the Discussion Paper was also available on the Commission's Internet site. A further 258 copies of the Discussion paper were sent out upon telephonic and written requests by interested parties following the release of the media statements.

1.18 One hundred and eighty-four respondents acted on the Commission's invitation and

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<sup>10</sup>Monitor, RSG; Janine Lazarus Show Radio 702; Talk at Will, SAFM; News insets: Radio 702, SAFM, RSG; 5FM; Radio seSotho, Bloemfontein; Radio Highveld; SABC Radio News; Punt Radio; Cape Talk; Two Way Street, SABC2; Carte Blanche, M Net; Felicia Mabuza-Suttle Show.

<sup>11</sup>As far as the Commission could ascertain the following articles appeared in the press in anticipation and response to the paper being published : "Report backs the right to die" Sunday Times April 13, 1997; "SA dokters erken hul pas genadedood toe" Die Beeld 28 November 1996, "Law Commission report on euthanasia released" The Star 18 April 1997; "SA debates a new law" Readers Digest, Aug 97; Woza Internet: today/news, April 11, 1997; "The Right to Die-Should you have the choice" Sunday Tribune Feb 25, 1996; "First steps to legal euthanasia" Electronic Mail & Guardian, April 11, 1997; "SA confronts 'death on demand' Electronic Mail & Guardian Feb 25, 1997; "So when are you legally declared dead?" The Saturday Paper (Natal) 27 July 1996; "And now for death on demand" Mail & Guardian Feb 21-27 1997; "Genadedood"editorial Die Beeld 15 April 1997; "Draft bill looks at eight aspects of the road to ending a life" The Star April 18 1997; " Law Commission report on euthanasia released" The Star April 18, 1997; "Genadedood lok reaksie van baie" Die Beeld 27 May 1997; "Religious bodies united in condemnation of 'termination'" The Leader 25 April 1997; "Regsekerheid oor genadedood lyk moontlik" Die Beeld, 10 April 1997; "SA Law Commission looks to revamp euthanasia laws" Business Day April 11 1997; "Euthanasia laws are probed" The Citizen 11 April 1997; "Way opened for death on demand" Mail & Guardian 11-17 April 1997; "Euthanasia" editorial The Citizen 14 April 1997; "SA dalk eerste om gendadedood te wettig" Naweek-Beeld 12 April 1997; "Gendadedood: bydraes ingewag" Naweek-Beeld 12 April 1997; "Doctors for Life oppose euthanasia" The Citizen 15 April 1997; "Euthanasia legislation among the most liberal in the world" Pretoria News June 25 1997; "Prokureurs oor genadedood" Die Beeld 3 Julie 1997; "Euthanasia law to be explored" The Star June 27 1997; "Euthanasia impasse" Pretoria News 2 July 1997; "Lawyers differ on euthanasia" The Citizen 2 July 1997; "Gendadedood: mens moet nie God speel" Die Kerkbode 18 April 1997; "Genadedood: nog reaksie ingewag" Die Beeld 27 Junie 1997; "Houdings teenoor genadedood aan't verander: regs kommissie wag menings in" Die Beeld 2 Julie 1997; "Legal clarity on euthanasia needed: SA to get 'right to die' law" The Cape Times 27 June 1997.

<sup>12</sup>See eg SA Council of Churches workshop; Catholic Church The Right to Live Campaign, telephone conference on Sunday 29 June 1997; University of the North Pharmaceutical Society workshop.

submitted written comment in respect of Discussion Paper 71. A list of names of respondents is enclosed as Annexure B to this report. It was especially the question in respect of the possible decriminalisation of active euthanasia that drew most comment. Submissions ranged from passionate calls for the legalisation of euthanasia to outright condemnation of any act associated therewith.

1.19 The submissions received, the discussions that followed, the points raised at the two workshops, the participation of the general public, all assisted the Commission in its task. All points of criticism and suggestions for improvement were duly considered. We take this opportunity to thank all who responded to the Working Paper and Discussion Paper as well as the Commission's other requests for submissions.

1.20 Throughout this report the position set out in Discussion Paper 71 in regard to the different issues will be stated,<sup>13</sup> followed by a discussion of the submissions received in each case and in conclusion, the recommendation of the Commission.

## **E) Need for legislation**

1.21 A question that was discussed throughout the investigation was whether there was in fact a need for legislation in this area or whether uncertainty in this field could not be addressed more adequately by the education of medical personnel, health care professionals and the public at large.

1.22 There were commentators who argued that the law was an inappropriate instrument for the sensitive decision making needed in situations at the end of life and that additional education was preferable to additional legislation.<sup>14</sup> This was however a minority opinion.

1.23 The majority of respondents who addressed this issue recommended formal legislation on

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<sup>13</sup>Information has been updated where possible.

<sup>14</sup>See eg. Hospice Association of South Africa; Africa Christian Action; The Christian Lawyers Association.

end of life issues to remove legal uncertainty for doctors, patients and family.<sup>15</sup> Commentators however differed in so far as the content of the legislation was concerned.

1.24 Some respondents supported legislation that would reaffirm the current prohibition on intentional killing, whether by act or omission, and that would clarify the distinction between medical treatment and basic care.<sup>16</sup>

1.25 On the other hand there was also support for public-policy regulation of end-of-life decisions which would remove and decriminalise actions that respondents felt should not be crimes but should be seen to be both merciful and respectful of autonomy.<sup>17</sup>

1.26 It was argued that should such legislation be consistent with the new Constitution<sup>18</sup> and its entrenched Bill of Rights, it would bring a measure of legal certainty. This would be reassuring to patients, their next of kin and the medical personnel in whose care terminally ill and dying patients are. It would furthermore provide a basis for those who counsel the elderly, terminally ill and dying when they enter a hospital or nursing home.<sup>19</sup>

1.27 Respondents contended that it was very difficult for medical personnel to raise matters such as for example advance directives with patients in the absence of legislation which governs them. They feared that it may sound as though they were suggesting something illegal since the directives are not formally governed by law. It was also difficult for medical practitioners as non-lawyers to explain the relevant legal position to patients in the absence of hard and fast rules.<sup>20</sup>

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<sup>15</sup>See eg SA Nursing Council; Department of Health; Christian Medical Fellowship of SA; Mandisa Sonqishe, Cancer Association; Voluntary Euthanasia Society, London; Dr Willem Landman; Prof JG Swart, Faculty of Medicine, UP; Alfred Allan; National Primary Health Care Network(hereinafter referred to as "NPHCN").

<sup>16</sup>Christian Medical Fellowship of SA.

<sup>17</sup>Dr Willem Landman.

<sup>18</sup>Constitution of the Republic of South Africa 108 of 1996.

<sup>19</sup>Alfred Allan.

<sup>20</sup>Alfred Allan.

1.28 Respondents furthermore strongly supported the idea that legislation could be used to include strict safeguards that would protect both the patient and the health care professional in any given situation.<sup>21</sup> There was general agreement that legislation should include a conscientious clause.<sup>22</sup>

1.29 It was however emphasized that although changing the legal framework would be an important step in expanding people's rights to die with dignity, this development would have a hollow ring unless substantial efforts were made to inform and educate patients and providers and to make available the necessary support to implement these changes. Respondents emphasised the fact that strategies had to be implemented to inform individuals, families, and health care providers about their rights, responsibilities and choices. The implementation of these proposals would include advice regarding the mechanisms for redress should an individual or family member feel that his or her rights have been violated.<sup>23</sup>

**1.30 The Commission considered all the arguments stated above carefully. The Commission agrees with the viewpoint that legislation in this field would enhance the treatment of terminally ill and dying patients. It is therefore recommended that formal legislation on all end of life issues should be implemented.**

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<sup>21</sup>Director General, Department of Health (hereinafter referred to as "Department of Health").

<sup>22</sup>Alfred Allan.

<sup>23</sup>NPPHCN.



## CHAPTER 2

### TERMINOLOGY AND DEFINITIONS

2.1 In Discussion Paper 71 the following terms were defined in sec 1 of the proposed bill: "competent witness", "court", "life-sustaining medical treatment", "medical practitioner", "palliative care" and "terminal illness".<sup>24</sup>

2.2 Respondents were in general in agreement with the way in which the terminology used in the document was defined.<sup>25</sup> There were however a few instances where commentators disagreed in principle with the proposals made and there was also some criticism on points of detail. The following submissions were made:

*"competent witness" (sec 1 (i))*

2.3 It was suggested that the word "financial" as in "financial benefit" should be deleted in the definition of "competent witness".<sup>26</sup> **The Commission agrees with this submission.**

*"life-sustaining medical treatment" (sec 1(iii))*

2.4 Submissions received indicated that there are some respondents who disagree with the idea that artificial feeding and hydration<sup>27</sup> should be regarded as a form of medical treatment and should therefore be included in the definition of "life-sustaining medical treatment". Some

<sup>24</sup>See para 1.16 on 5 above.

<sup>25</sup>See eg Prof KRL Huddle, Head of the Department of Medicine, Chris Hani Baragwanath Hospital and University of Witwatersrand.

<sup>26</sup>Mr HJ Barker, an attorney.

<sup>27</sup>The Commission did not include hydration in its definition.

respondents furthermore asked for greater recognition of the ethical distinction between ordinary and extraordinary means of sustaining human life. However, the opposite view was also argued convincingly. See the full discussion in Chapter 5.<sup>28</sup>

**2.5 After due consideration of these proposals and also taking into account the judgement held in this regard in South Africa<sup>29</sup> as well as in other jurisdictions<sup>30</sup> the Commission's decision is not to amend sec 1(iii).**

*"Palliative care" (Sec 1 (v))*

2.6 The Commission received a proposal to insert the words "physical, emotional and psychosocial" before the word "suffering" in section 1(v).<sup>31</sup>

**2.7 Since this proposal is in accordance with the essence of palliative care as understood by the Commission, the section is amended accordingly.**

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<sup>28</sup>For a discussion of the various views see Chapter 5 para 5.97 and further below: Cessation of treatment of the incompetent patient.

<sup>29</sup>**Clarke v Hurst NO** ao 1992 4 SA 630 (D).

<sup>30</sup>**Airedale NHS Trust v Bland** [1993] 1 All ER 821; **Cruzan v Director Missouri Department of Health** (1990) 497 US 261; 111 L Ed 2d 224; 110 S Ct 2841.

<sup>31</sup>Ethics Committee, Medical School, University of the Witwatersrand (hereinafter referred to as "Ethics Committee"; SAVES The Living Will Society (hereinafter referred to as "Living Will Society").

*"family members"*

2.8 A definition of the term "family members" should be included <sup>32</sup> in sec 1 to avoid possible dispute concerning the precise meaning of this term.

**2.9 The Commission agrees to the inclusion of a definition of "family members".**

*"terminal illness" (sec 1(vi))*

2.10 The definition that drew most comment was that of "terminal illness". The following submissions were made:

(a) It was stated that the definition of terminal illness opens itself to indiscriminate interpretation. Words such as "mental condition",<sup>33</sup> "meaningful existence",<sup>34</sup> "extreme suffering"<sup>35</sup> and "irreversible state"<sup>36</sup> lend themselves to a stretched meaning and differences of opinion and needed to be clarified.<sup>37</sup>

(b) Objection was furthermore raised on ethical grounds to the notion of "meaningful existence" since it was argued that the mere fact of life is in itself sufficient to constitute meaningful existence. Anything beyond this is dependent on whose criteria one uses, and is thus arbitrary and open to abuse.<sup>38</sup>

<sup>32</sup>Judge JJ Kriek, Judge President, Northern Cape Division.

<sup>33</sup>Doctors for Life.

<sup>34</sup>Doctors for Life.

<sup>35</sup>Anglican Church; African Christian Church.

<sup>36</sup>The Critical Care Society of Southern Africa argued that critically ill patients, who have reached a stage of medical futility may neither be in extreme suffering nor in an irreversible vegetative state, but that their mental state may range from confusion to coma.

<sup>37</sup>Cancer Association (National Office).

<sup>38</sup>South African Catholic Bishops Conference Parliamentary Liaison Office (hereinafter referred to as "SACBC"); (Fr) Hyacinth Ennis; African Christian Action; The Christian Lawyers Association.

(c) Given the fact that people sometimes recover from illness against all expectations, the view was rejected that the definition of "terminal illness" should include "a persistent and irreversible vegetative condition". Respondents felt that such patients may be aware of their surroundings, but unable to react to them. To withdraw nutrients from such patients could expose them to unimaginable mental anguish.<sup>39</sup>

(d) It was furthermore felt that the phrase "a relatively short time" is too vague.<sup>40</sup> To reduce uncertainty, it should be replaced by "within six months"<sup>41</sup> which is the more common meaning.<sup>42</sup> Respondents acknowledged that it could be argued that specifying a time period would not really be helpful because medicine is an imprecise science and, at best, prognosis is an educated guess. Nevertheless, it was felt that death within a relatively short time is a far more elastic, open-ended notion than death within six months, the latter being more likely to rule out extremes that are either too short (such as a week) or too long (such as a year), and thus harder to justify ethically.<sup>43</sup>

**2.11 In considering these proposals the Commission holds that since the diagnosis of the patient's condition is a question of fact and lies within the discretion of the medical practitioner involved, the Commission does not seek to impose unnecessary restrictions in this regard. The principles embodied in this clause are furthermore that of respect for the personal autonomy and dignity of the patient balanced with accepted medical practice. The Commission is satisfied that the clause gives effect to those objectives.**

*"Intractable and unbearable illness"*

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<sup>39</sup>United Christian Action.

<sup>40</sup>Doctors for Life; Anglican Church; Dr Willem Landman; South Australian Voluntary Euthanasia Society; Office of the Chief Rabbi.

<sup>41</sup>Dr Willem Landman.

<sup>42</sup>South Australian Voluntary Euthanasia Society.

<sup>43</sup>Dr Willem Landman.

2.12 The following definition was recommended in addition to the current definition of terminal illness:

"Intractable and unbearable illness " means a bodily disorder that -

- (a) cannot be cured or successfully palliated; and
- (b) causes such severe suffering that death is preferable to continued life.<sup>44</sup>

2.13 The reasoning behind this proposal is that there are many people whose lives are filled with unrelenting and unbearable suffering although they are not terminally ill. Those who may warrant euthanasia may therefore also include persons who are months or years away from dying and for whom palliative care does not provide adequate relief.<sup>45</sup> Given that the same rationale of respect for autonomy which supports such options for those suffering from terminal illnesses applies equally to these cases, it would be arbitrary to permit these options only to those whose death was relatively close and deny it to those suffering chronic and degenerative conditions including multiple sclerosis, amyotrophic lateral sclerosis, motor-neurone disease and quadriplegia.<sup>46</sup> This aspect was reiterated in many submissions, especially from individuals who recounted their personal suffering.<sup>47</sup>

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<sup>44</sup>Submission from Prof Solly Benatar and various members of the UCT Bio-ethics Centre: David Benatar, Raymond Abratt, Lesley Henly, Mark Mason, Lance Michell, Eleanor Nash, Augustine Shutte and JP de V vn Niekerk (hereinafter referred to as "Professor S Benatar et al").

<sup>45</sup>Dr Selma Browde; See also Peter Buckland, Executive Director, Hospice Witwatersrand as reported in The Star 18 April 1997 who said it was a misconception that terminally ill people wanted euthanasia. "Good palliative medicine as Hospice provides, obviates the need for euthanasia. It is victims of diseases for which there are no cure and no likelihood of immediate death who ask for active intervention" he said.

<sup>46</sup>See eg. Solly Benatar et al.

<sup>47</sup>Rhona Foyn; Ruth Schmid; See also Leenen HJJ & Legemaate J "Sterwensfase geen vereiste voor eutanasia" (1993) 68 **Nederlandse Juriste-Med** 755 as referred to in Labuschagne JMT "Aktiewe eutanasia en professionele hulpverlening by selfdoding van n psigiatriese pasient" **SALJ** 1995 229(hereafter referred to as Labuschagne **SALJ** 1995) where it is stated that active euthanasia is available where the patient is not terminally ill. See however submission of the Office of the Chief Rabbi for a contrary view.

2.14 The inclusion of this definition was supported by another commentator<sup>48</sup> who felt however that it would be better to do away with the qualification "bodily" in order to exclude an unduly narrow understanding of a disorder. Although all disorders have some bodily or physiological foundation, we tend to think of disorders as either physiological or psychological. Secondly, if suffering is conceived as an emotional response to more than minimal pain or distress, then suffering can be either physical or mental (or both). To furthermore ensure that the definition of "intractable and unbearable illness" would also cover dementing illnesses, such as Alzheimer's disease, which is neither terminal nor painful it was proposed that the term "physical or mental suffering" should be used.

2.15 In a contrary view it was however stated that terminally ill patients are the only patients that should qualify for active voluntary euthanasia.<sup>49</sup>

**2.16 After carefully considering this very controversial aspect, the Commission comes to the conclusion that should active euthanasia be legalised there would be no reason to withhold this option from persons with intractable illness as opposed to those with terminal illness. On the contrary, it would be a better reflection of the situation as experienced by patients in practice. The Commission did however emphasise the fact that, in order to prevent abuse, active euthanasia would only be available to competent persons who suffer from intractable and unbearable illness. These and other requirements will however be discussed in Chapters 3 and 4.**

2.17 It is therefore recommended that the section on definitions in the proposed Bill should read as follows:<sup>50</sup>

### *Definitions*

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<sup>48</sup>Dr Willem Landman.

<sup>49</sup>Prof Geoffrey Falkson.

<sup>50</sup>For a discussion of the inclusion of a definition of "nurse" see para 4.50 below.

1. (1) In this Act, unless the context otherwise indicates-

**'competent witness'** means a person of the age of 18 years or over who at the time he witnesses the directive or power of attorney is not incompetent to give evidence in a court of law and for whom the death of the maker of the directive or power of attorney holds no benefit;

**'court'** means a provincial or local division of the High Court of South Africa within whose jurisdiction the matter falls;

**'family member'** in relation to any person, means that person's spouse, parent, child, brother or sister;

**'intractable and unbearable illness'** means an illness, injury or other physical or mental condition, but excluding a terminal illness, that-

- (a) offers no reasonable prospect of being cured; and
- (b) causes severe physical or mental suffering of a nature and degree not reasonable to be endured.

**'lawyer'** means an attorney as defined in section 1 of the Attorney's Act, 1979 (Act 53 of 1979) and an advocate as defined in section 1 of the Admission of Advocates Act, 1964 (Act 74 of 1964);

**'life-sustaining medical treatment'** includes the maintenance of artificial feeding;

**'medical practitioner'** means a medical practitioner registered as such in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);

**'nurse'** means a nurse registered as such in terms of the Nursing Act 50 of 1978 and

*authorised as a prescriber in terms of section 31(14)(b) of the proposed [South African Medicines and Medical Devices Regulatory Authority Bill]<sup>51</sup>;*

*'palliative care' means treatment and care of a terminally ill patient with the object of relieving physical, emotional and psycho-social suffering and of maintaining personal hygiene;*

*'spouse' includes a person with whom one lives as if they were married or with whom one habitually cohabits;*

*'terminal illness' means an illness, injury or other physical or mental condition that-*

- (a) in reasonable medical judgement, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering;*

*or*

- (b) causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.*

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<sup>51</sup>Editorial note: Now Act 132 of 1998 assented to 11 December 1998, date of commencement to be proclaimed.



## CHAPTER 3

### THE ARTIFICIAL PRESERVATION OF LIFE WHERE THE PATIENT IS CLINICALLY DEAD

#### a) Position as set out in Discussion paper 71

3.1 In Discussion paper 71 the first critical question identified was whether, and if so, under what circumstances, the medical practitioner would be entitled to disconnect the life-sustaining system of a person who was being kept 'alive' by a heart lung-machine or ventilator.

3.2 In order to answer this question it was deemed necessary to determine precisely when it is that death sets in. Readers were referred to the fact that people, especially moralists and persons with strong religious beliefs, often speculate in a metaphysical way about the concepts of "life" and "death". Quite often qualities are attributed to the concept of "life" that gives it an esoteric meaning, for example that life should be equated with a decent existence or one associated with consciousness, and on this basis conclusions are then drawn. It was however emphasized that the jurist must inevitably follow a more sober, certain and accordingly more clinical approach - just like the medical scientist.

3.3 Over the years the views of medical scientists in regard to the question as to precisely when it is that death sets in have differed<sup>52</sup>. However, since 1980 there has been broad

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<sup>52</sup>Strauss, S A **Doctor, patient and the law** 3rd ed Pretoria J L van Schaik Publishers 1991 321(hereinafter referred to as "Strauss **Doctor, patient and the law**"); Benatar, S R "Dying and 'euthanasia'" 1992 **SA Medical Journal** 35; with the first heart-transplant operation, Professor Chris Barnard and his team used the following test: the absence of heart activity for five minutes, measured by an electrocardiograph, the absence of spontaneous respiration and the absence of reflexes(Barnard, CN "A human cardiac transplant: an interim report of a successful operation performed at Groote Schuur Hospital, Cape Town" 1967 **SA Medical Journal** 1271); The Society of Neurosurgeons of South Africa commented that at the time of this transplant the concepts of brainstem death had not been crystallised as they exist today.

agreement by the medical profession that brain death equals death<sup>53</sup> ie that irrespective of whether other criteria apply, death definitely sets in when the brainstem ceases to function.

3.4 However, the criteria for diagnosis and the existence of legal definitions of brain death still vary between countries. The definition of brain death in the United States of America for instance requires "... the confirmed death of the whole brain as indicated by clinical tests and a flat waveform on the electro-encephalogram". In the United Kingdom the position is different: "...the definition requires clinical evidence confirming death of the brainstem which supports vital organs such as the heart and lungs".<sup>54</sup>

3.5 From a legal point of view, the so-called moment of death is, in the absence of a statutory or common-law definition, a still unresolved issue. In fact, the existing statutory and common-law sources on the matter reveal approaches which are to some extent inconsistent.<sup>55</sup>

3.6 Although the legislator had the opportunity to prescribe a test, it chose not to do so. The now repealed **Anatomical Donations and Post Mortem Examinations Act**<sup>56</sup> contained no criteria for the establishment of death. Section 3(2) of this Act *inter alia* stipulated that for purposes of tissue-removal the death of a person had to be established by at least two medical practitioners, one of whom shall have been practising for at least five years after the date on which he was registered as a medical practitioner. Establishment of the death of a person with the object of tissue removal in terms of this Act was therefore left entirely in the hands of the doctors. This approach has also been followed in the current **Human Tissue Act**.<sup>57</sup>

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<sup>53</sup>See **Report of the Select Committee** Appendix 5 at 70 for an outline of developments regarding medical science in this field.

<sup>54</sup>**Report of the Select Committee** Appendix 5 at 70.

<sup>55</sup>Van Oosten, FFW "Patient rights: a status report on the Republic of South Africa" in **Law in Motion**, International Encyclopedia of Laws World Conference 989(to be published) (hereinafter referred to as "Van Oosten Status Report") footnote 216 at 1022.

<sup>56</sup>Act 24 of 1970. This Act was repealed by the **Human Tissue Act** 65 of 1983. See further De Klerk, A "Transplantation of human tissue and organs in South African law" 1992 **TRW** 112.

<sup>57</sup>Act 65 of 1983.

3.7 In so far as case law is concerned, the position has not been cleared up either. In **S v Williams**<sup>58</sup> the accused shot the deceased in the neck with the result that his jugular vein and carotid artery were severed. Medical help was summoned quickly and the patient, who had lost a great deal of blood and was unconscious, was connected to a respirator. The jugular vein and carotid artery were ligatured. After one day it was found that according to medical evidence the left side of the brain was dead and a day later no brain activity could be discerned. The brain stem was also dead. He was, however, kept 'alive' by artificial respiration for forty-eight hours, after which the respirator was disconnected on the instructions of the neurosurgeon, after consultation with two other neurosurgeons. Ten minutes later no heartbeat could be found.

3.8 The question was whether the accused had in fact caused the death of the deceased. The trial court regarded the moment of death as being of cardinal importance. Accordingly it found that death set in with the death of the brain stem, in other words at the moment when brain activity (including activity of the brain stem) ceased.

3.9 On appeal it was submitted that the trial court had incorrectly held that a person is legally dead when death of the brainstem occurs, even though the person's heartbeat and respiration have not yet ceased. According to this submission the accused was still alive when the respirator was disconnected and it was therefore the disconnection of the respirator that caused his death.

3.10 The Appellate Division did not consider it necessary to decide whether the medical approach concerning the moment of death, as reflected in the trial court's verdict, should be accepted in law as the moment of death. The Appellate Division dealt with this question on the basis of what was described as probably the traditional public policy on this question, namely that death occurs with the cessation of a person's respiration and heartbeat.<sup>59</sup> With respect, the mere question as to the existence in a patient of respiration and heartbeat cannot be a complete description of a clinical test for death. Many people experience cardiac arrest and respiratory

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<sup>58</sup>1986 4 SA 1188 (A).

<sup>59</sup>Supra at 1194 E-F.

failure for a few seconds or minutes after which normal functions are resumed. The traditional test referred to **independent** respiratory and circulatory functions.

3.11 Legal commentators have argued that brainstem death should be accepted and recognised as a legal criterion of death.<sup>60</sup> The Commission however decided that it was unnecessary for present purposes to choose or to justify one or the other of these tests. It is enough to accept that death occurs with irreversible cessation of spontaneous respiratory and circulatory functions or with irreversible brainstem-death. Whether one or the other has occurred is a question of fact and depends on clinical proof.

3.12 The problem, as explained in Discussion Paper 71, was that quite often a person who is already dead according to the above-mentioned tests is kept 'alive' artificially<sup>61</sup> by a ventilator, that is to say, he or she is ventilated and the circulatory functions are kept going. If it could however be proved that brainstem death has occurred, such a person would, in the opinion of the Commission, already be legally dead. Alternatively, if no apparatus is available to prove brainstem death, the Commission agreed with the opinion of Dorfling:<sup>62</sup>

A person will be considered dead if in the announced opinion of a physician based on

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<sup>60</sup> Van Oosten **Status Report** 1024 : The recognition and acceptance of brainstem death as a legal criterion for death would:

- (a) remove brainstem dead patients from the realm of euthanasia and thus, narrow the scope of the euthanasia problem in respect of terminal patients to instances of patients in a vegetative state or terminal patients in a conscious state who are connected to life-support measures or who receive life-supporting medication and;
- (b) accord with medical practice in instances of
  - (i) the transplanting of vital organs and;
  - (ii) the replacing of brainstem dead patients with patients with a prospect of recovery on respirators or ventilators in intensive care units where the demand for respirators or ventilators is greater than the supply.

<sup>61</sup>The Society of Neurosurgeons of South Africa drew attention to the fact that there is no "life" to be maintained after clinical death - one can at most, maintain functions of certain organ(s) in a brainstem dead patient.

<sup>62</sup>Dörfling, D F "**Genadedood**" in die strafreg - 'n regsfilosofiese en regsvergelykende perspektief (Unpublished thesis submitted in partial fulfilment of the degree Magister Legum) Faculty of Law Rand Afrikaans University 1991 at 157 (hereinafter referred to as "Dörfling").

ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

3.13 The Commission therefore contends that according to the present legal rules the medical practitioner would be entitled to disconnect the life-sustaining system of a person if it could be proved that the person was clinically dead according to the abovementioned tests, but was being kept 'alive' by a heart-lung machine or ventilator. There is no rule in our law which requires any person to artificially bestow certain signs of life on a person who is already dead. The respiration and heartbeat that seemingly exist are artificial and do not represent life. To disconnect the life-sustaining system would therefore not be to cause death.

3.14 In **S v Williams**<sup>63</sup> the Appellate Division came to the same conclusion. The court held that the disconnection of the respirator could not be seen as the act that caused death, but that it was merely the termination of a fruitless attempt to save the person's life. This is not what killed him. It is the action of the accused that caused his death.

3.15 The disconnection of the respirator in the case currently under discussion is therefore not an action which can be described as mercy killing or euthanasia.

3.16 The Commission concluded that it follows logically that where the medical practitioner responsible for the treatment of the patient concerned is convinced that the patient is clinically dead according to any of the tests described above, the disconnection of the respirator will neither be unlawful for the purposes of criminal law nor for the purposes of private law.

#### **b) Discussion of submissions received**

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<sup>63</sup>Supra.

3.17 Respondents who commented on this issue seem to agree with the Commission's view<sup>64</sup>. The opinion was expressed that one should not be obliged to use medical means that are merely death-delaying, preventing an irreversible dying process from following its natural course.<sup>65</sup> It would furthermore be morally irresponsible to use available resources (both personal and material) to continue the treatment of such patients.<sup>66</sup> Respondents furthermore supported the idea that treatment of a brain dead person should be continued in order to enable transplants to take place.<sup>67</sup> Caution was however expressed that the medical practitioner should at all times work in agreement with the family and a multi-disciplinary team.<sup>68</sup>

3.18 In so far as the formalisation of the position in legislation is concerned, different views were expressed. Respondents expressing the minority view commented as follows:

- i) The present law seems to be functioning very satisfactorily as understood by transplant surgeons and any further elaboration would be unnecessary.<sup>69</sup> Experience has shown that the law is easily explained to relatives and any difficulty is due to an emotional acceptance of the situation, not any legal problem.
- ii) It would seem sufficient to provide for extra-legal education in order to avoid confusion.<sup>70</sup> It is difficult to see how codifying the common law as it presently exists will enhance certainty.<sup>71</sup>

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<sup>64</sup>See eg Islamic Medical Association of South Africa; Christian Lawyers Association; Society of Neuro-surgeons of South Africa; Mpumalanga Provincial Government; Critical Care Society of South Africa; Society of Advocates Natal.

<sup>65</sup>MLavies; Rev Justin Swanson who does not regard brain death as true death, but rather as a step in the irreversible process of dying, followed by death in the short term.

<sup>66</sup>Southern African Anglican Theological Commission (Cape Town); Final Exit-Zimbabwe.

<sup>67</sup>EMD Pope.

<sup>68</sup>Mandisa Sonqishe, Cancer Association; Barbara Steenkamp: Free State and Northern Cape region, CANSA; MASA.

<sup>69</sup>Dr T Germond et al.; Society of Neurosurgeons of South Africa.

<sup>70</sup>Rev Justin Swanson; Christian Lawyers Association.

<sup>71</sup>Society of Advocates of Natal; Hospital Association of South Africa.

- iii) The present legal position should not be formalised in legislation. An Expert Committee should be commissioned and authorised to make recommendations to the Minister of Health on possible amendments of the present legal rules applied to determine "brain death".<sup>72</sup>

3.19 The majority of commentators however supported the view that the position should be formalised in legislation. The following specific statements were made:

- i) Legislation as proposed would be useful in clarifying the situation for both doctors and the families of patients.<sup>73</sup>
- ii) Although it may be true that ideally the problem should be addressed by educating people, death is such a taboo in many communities that people are not interested in education of this nature while their loved ones are healthy. When they find themselves in a position where a loved one is brain dead they are so emotional that it is very difficult to provide the necessary education for them.<sup>74</sup>
- iii) Extra-legal education should be provided to patients, families and doctors in addition to the legislation to promote understanding and knowledge of these rights. It should be a mandatory requirement for the training of medical practitioners.
- iv) Mechanisms should be established to review the decisions of the medical practitioners and to obtain redress should these discretionary powers be abused.<sup>75</sup>

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<sup>72</sup>Department of Health.

<sup>73</sup>See eg MASA; Southern African Anglican Theological Commission (Cape Town ); SA National Consumer Union; Prof JG Swart; Prof Geoffrey Falkson, Professor and Head: Dept of Medical Oncology, University of Pretoria; Prof FFW Van Oosten; United Christian Action; SACBC; Prof KRL Huddle.

<sup>74</sup>Alfred Allan.

<sup>75</sup>Lawyers for Human Rights: Aids and Human Rights Programme (hereinafter referred to as " Lawyers for Human Rights"); NCCPHN.

c) **Recommendation of the Commission**

**3.20 The Commission recommends that the present legal position regarding brain dead patients should be formalised in law as follows:**

*Conduct of a medical practitioner in the event of clinical death*

2. (1) *For the purposes of this Act, a person is considered to be dead when two medical practitioners agree and confirm in writing that a person is clinically dead according to the following criteria for determining death, namely -*
  - (a) *the irreversible absence of spontaneous respiratory and circulatory functions; or*
  - (b) *the persistent clinical absence of brainstem function.*
- (2) *Should a person be considered to be dead according to the provisions of subsection (1), the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of treatment.*



## CHAPTER 4

### CASES WHERE THE PATIENT IS COMPETENT TO MAKE DECISIONS

4.1 This chapter deals with those instances where the patient is in possession of all his or her faculties, and therefore legally and mentally competent to make certain requests of the medical practitioner which, if acceded to, would amount to the hastening of the death of the patient concerned. In Discussion Paper 71 the question was discussed whether agreement to such requests would be lawful or unlawful and if any legal reform was necessary.

4.2 However, before this problem was dealt with, clarity was sought with regard to the terms "legal competency" and "mental competency".

4.3 In general a person will be regarded as legally competent if he or she has the ability to enter into a legal transaction and therefore take part in commerce and law. The essence of the term "legal competency" lies in the fact that a person should be able to understand the nature and implications of the legal transaction concerned. He or she should understand its nature and implications and consent to the transaction while he or she is not being influenced by mental illness or any other factor that could seriously impair his or her capacity to understand the nature and consequences of the action.<sup>76</sup>

4.4 The situation sketched in 4.1 deals not only with the competence, in general, to conclude a legal transaction, but it deals specifically with the legal act which is known as **consent to injury**.

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<sup>76</sup>**Lange v Lange** 1945 AD 332.

A prerequisite for the validity of this consent is that the consenting person should be mentally competent. This means that persons under twenty-one years of age and who do not therefore have unlimited contractual capacity in the eyes of the law, may still be mentally competent to consent to injury. As it is the bodily integrity of a person that is at issue here, the writers agree that for this kind of consent the cooperation of a minor's parent or guardian is not a prerequisite, as long as it is certain that the minor is mentally competent.<sup>77</sup>

4.5 Whether the consenting person is mentally competent or not is a question of fact on which it is unnecessary now to dwell.

4.6 A prerequisite for valid consent to injury is that the consent has to be voluntary consent<sup>78</sup> and that the consenting person needs to have full knowledge of the extent of his or her rights and of the nature of the injury.<sup>79</sup>

4.7 A further requirement is that the consent to injury is considered valid only if it is not **contra bonos mores**. In our law it is for instance accepted that a person cannot consent to serious bodily mutilation.<sup>80</sup> This requirement should however be approached with caution as consent to serious bodily mutilation is not in all cases considered **contra bonos mores**. Say, for

<sup>77</sup>Strauss, S A "Toestemming deur 'n jeugdige" 1964 **THRHR** 116 at 123; Van der Merwe, N J en Olivier, P J J **Die onregmatige daad in die Suid-Afrikaanse reg** 6th edition Pretoria Van der Walt & Son 1989 at 91-92.

<sup>78</sup>**R v McCoy** 1953 2 SA 4 (SR).

<sup>79</sup>**Esterhuizen v Administrator, Transvaal** 1957 3 SA 710 (T). See also Van den Heever, P "The patient's right to know: informed consent in South African medical law" 1995 **De Rebus** 53; Van Oosten, F F W " **Castell v De Greef** and the doctrine of informed consent: medical paternalism ousted in favour of patient autonomy" 1995 **De Jure** 164; Earle, M "Informed consent': is there room for the reasonable patient in South African law?" 1995 **SALJ** 629; Deyer, L "Redelike dokter versus redelike pasient" 1995 **THRHR** 532; Burrows, R "Removal of life support in intensive care units" 1994 **Med Law** 489; Stern, K "Competence to refuse life-sustaining medical treatment" 1994 **Law Quarterly Review** 541; See also **Castell v De Greef** 1994 4 SA 408 for the court's interpretation of informed consent, which included knowledge and awareness of the nature and extent of the harm; appreciation and understanding of such harm; and comprehensive consent to the harm.

<sup>80</sup>**R v McCoy** supra.

instance, that in light of medical considerations it is found that the amputation of a leg is inevitable. The patient's consent to the amputation, that is to say the serious bodily mutilation, would certainly not be seen as invalid.<sup>81</sup>

4.8 The need for informed consent was also stressed in submissions received.<sup>82</sup> Respondents felt that the onus was on the doctor to ensure that the patient is fully informed of the disease, the treatment, palliation and implications of refusing life-sustaining treatment. The importance of receiving the information from a person sharing the same first language as the patient was also stressed.<sup>83</sup>

4.9 The consent of a mentally competent patient can be relevant in the following situations:

**(A) Cessation of the life-sustaining medical treatment of the competent person**

**a) Position as set out in Discussion paper 71**

4.10 The case under discussion here is that of a mentally competent patient who is suffering from a disorder and for whom no effective medical treatment may exist. One thinks here of a patient with terminal cancer, Aids sufferers and persons with chronic and untreatable diseases, for instance motor-neuron disease and others. Generally these patients' lives are prolonged, in comparison with the natural condition, by for example intravenous or nasogastric feeding, the administering of antibiotics to avoid or fight secondary infections and the administering of oxygen when necessary.

4.11 It can happen that such a patient may find the situation unbearable as a result of pain and

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<sup>81</sup>See also Strauss, S A "Bodily injury and the defence of consent" 1964 **SALJ** 179 at 332.

<sup>82</sup>Prof L Schlebusch, Head of Department of Medically Applied Psychology, University of Natal.

<sup>83</sup>National Office: Cancer Association of South Africa; See also para 4.197 on page 120 for a discussion on possible safeguards.

suffering or because of the indignity of the situation. He or she then requests the cessation of the life-prolonging treatment but with the continuation of palliative care.

4.12 Palliative care can be described as medical intervention not intended to cure but to alleviate the suffering, including the emotional suffering, of the patient. It is concerned with the quality of life when, in the course of an illness, death becomes inevitable.<sup>84</sup> With palliative care some patients can be kept physically comfortable until the moment of death. However, such a state of affairs may not be emotionally or psychologically acceptable to such patients.

4.13 The question is therefore: suppose a patient who has the necessary mental capacity and who realises the nature, extent and consequences of a request for the cessation of life-sustaining treatment, still persists in his or her request: will compliance with that request be **contra bonos mores** or should effect be given to it?

4.14 In English law the rule is acknowledged that an adult patient who has the necessary mental capacity and who has been fully informed of the consequences of his or her decision, has the right to refuse any treatment, even if such refusal would hasten death.<sup>85</sup> The House of Lords' "**Report of the Select Committee on medical ethics**"<sup>86</sup> states that a patient who is mentally competent and fully informed of the consequences may refuse any form of medical treatment. Reference is made to two court judgements.<sup>87</sup>

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<sup>84</sup>Browde, S "There would be little need for euthanasia if doctors understood how to deliver a 'good death'" **The Sunday Independent** 8 December 1996.

<sup>85</sup>See also the American case of **Schloendorff v Society of New York Hospital** 211 NY 125, 105 NE 92 where it was held: 'Every human being of adult years and sound mind has a right to determine what shall be done with his or her own body...'

<sup>86</sup>Op cit, par 41.

<sup>87</sup>In the case **Sidaway v Bethlehem Royal Hospital Governors** [1985] 1 All ER 643 Lord Scarman said that "... a doctor who operates without the consent of the patient is... guilty of the civil wrong of trespass to the person; he is also guilty of the criminal offence of assault". From this it follows that a patient who has the necessary mental capacity may refuse medical treatment and that no medical treatment may be forced on such a person against his or her will. In **In re T (Adult: Refusal of treatment)**[1992] 3 WLR 782 the Court of Appeal again affirmed this right of the patient.

4.15 The same report<sup>88</sup> recalls that the British Department of Health has positively acknowledged this right. Their contribution in this regard reads as follows:

A patient who has the necessary mental capacity and has been properly informed of the nature of his condition and the implications of the treatment proposed is entitled to accept or decline that treatment as he sees fit.... The patient's right to self-determination regarding the treatment he will accept is paramount. The BMA (British Medical Association) said 'ultimately the individual's right to self determination decides whether or not treatment can be given... the decisions of a competent patient regarding non-treatment must be respected.

4.16 The report further states that the medical practitioner has to tread carefully with regard to the question whether consent has been given in a specific case. The report states that the British Alzheimer's Disease Society led evidence to the effect that practitioners often assume that patients are behaving irrationally and are thus incapable of giving informed consent. The British Department of Health recommends that should a medical practitioner have any doubt as to whether valid consent has been given, a second medical opinion on that question should be sought and the matter should further be discussed with other members of the health care team and with the patient's relatives and friends who could cast light on whether the decision was in keeping with the patient's previous wishes.<sup>89</sup>

4.17 The report also states that a too-ready acceptance of the validity of the patient's wishes may cause a problem. The medical practitioner has to be very careful to make sure that the patient's request is not influenced by an undiagnosed depressive illness which, if successfully treated, might affect his or her attitude.<sup>90</sup>

4.18 The report also refers to the fact that a great deal of dissatisfaction exists with regard to the judgment of the High Court in the case of **In re S (Adult: Refusal of treatment)**<sup>91</sup> in which

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<sup>88</sup>**Report of the Select Committee** par 42 and further.

<sup>89</sup>Op cit par 44.

<sup>90</sup>Op cit par 45.

<sup>91</sup>[1992] 3 WLR 806.

the court forced the woman in question, against her wishes, to have a Caesarean section performed. The woman refused the operation on religious grounds, although she had been advised that both she and the fetus would die without it. The court forced her to undergo the operation and she survived, but the child didn't. Apparently the case was heard as a matter of urgency and the judgement given on short notice. A number of witnesses expressed their dissatisfaction with this judgment.<sup>92</sup>

4.19 In the case of children, the position in English law is that parents or competent guardians can consent to the treatment of the child if it is in his or her best interest.<sup>93</sup> Under the **Family Law Reform Act** of 1969 minors aged sixteen and seventeen are presumed to be competent to consent to treatment unless there is a reason to suppose that they are not. Even children under the age of sixteen may consent to treatment if they have "sufficient understanding and intelligence.... to understand fully what is proposed".<sup>94</sup>

4.20 However, it is important to note that the right of minors to refuse consent has not been upheld by the courts. In two cases the courts have given consent for treatment of competent minors who had refused treatment.<sup>95</sup>

4.21 South African law does not differ substantially from English law in so far as consent to cessation of treatment is concerned. In our opinion it is clear that the right to refuse medical treatment where the patient has the necessary mental capacity is also acknowledged in our law. It would also be a prerequisite here for the patient to be informed fully with regard to the consequences of his or her refusal, to understand the nature of the consequences and to give the

<sup>92</sup>**Report of the Select Committee** para 46.

<sup>93</sup>See also Roberts, S E "When not to prolong life" 1990 **The Law Quarterly Review** 218 for a discussion of **In re C (a minor) (wardship: medical treatment)** [1989] 3 WLR 240 and **In re B (a minor) (wardship: medical treatment)** [1981] 1 WLR 1421. See further Lowe, N & Juss, S "Medical treatment - pragmatism and the search for principle" 1993 **Modern Law Review** 865 (hereinafter referred to as "Lowe and Juss"); Eekelaar, J "White coats or flak jackets? Doctors, children and the courts - again" 1993 **The Law Quarterly Review** 182.

<sup>94</sup>**Gillick v West Norfolk and Wisbeck Area Health Authority and another** [1985] 3 All ER 402.

<sup>95</sup>**In re R** [1991] 4 All ER 177 and **In re W** [1993] Fam Court 64.

instructions for the life-prolonging treatment to be discontinued. It would seem that the legal position is that our courts would acknowledge the medical practitioner's obligation to comply with such a request and that, in doing so, he or she would not act unlawfully, either according to criminal law or in terms of private law, even if such an action would have the effect of hastening death.

4.22 In the case of **Castell v De Greeff**<sup>96</sup> the unambiguous recognition and acceptance of the right of the patient, who need not be terminal, to refuse a life-saving medical intervention was emphasised. This is an explicit rejection of medical paternalism and an endorsement of patient autonomy as a fundamental right.

4.23 In so far as minors are concerned the Child Care Act 74 of 1983 states that a child over the age of 14 years may consent to medical treatment, without the assistance of his or her guardian.<sup>97</sup> Whether a minor over the age of 14 years may also refuse consent to treatment has not been settled yet.<sup>98</sup>

4.24 Some South African medical practitioners, however, still seem to be under the misconception that it is their duty to prolong life at all cost, notwithstanding the quality thereof. They may influence the patient, his or her family and next of kin to continue with the life-prolonging treatment.<sup>99</sup> Every patient is of course free to discharge his or her medical practitioner and to appoint another practitioner in his or her place, but indications are that very few patients have the perseverance to follow this route.

<sup>96</sup>Supra 408; Van Oosten 1995 **De Jure** 164.

<sup>97</sup>Sec 39(4) of the Child Care Act provides that:

'Notwithstanding any rule of law to the contrary

- a) any person over the age of 18 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon himself; and
- b) any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical procedure on himself or his child.'

<sup>98</sup>See discussion below para 4.30 on 47.

<sup>99</sup>See eg the submission of Pro-Life stating that the doctor is morally obliged to encourage the patient to undergo treatment that is ordinary, non-burdensome, non-heroic in order to preserve or restore health or to ameliorate complications and effects of illness and disease.

**b) Discussion of submissions received**

4.25 With reference to the submissions received by the Commission and the discussions during the workshops held on 22 June 1994 and 18 October 1996, it seems that commentators support the view that a medical practitioner would in general be acting legally should he or she comply with the request of a mentally competent patient for the discontinuance of life-prolonging treatment and the provision of palliative care only.<sup>100</sup> It was argued that patients should have the right to protection of bodily and psychological integrity<sup>101</sup> and that a doctor who wilfully disregards this right to self-determination could be regarded as bridging professional conduct.<sup>102</sup> This would be the case notwithstanding the fact that such actions may hasten the death of the person.

4.26 There were however comments from respondents who qualified their approval to the extent that they felt:

- i) Refusal of life-sustaining medical treatment should be restricted to cases of those who are terminally ill.<sup>103</sup>
- ii) The treatment refused should be extra-ordinary or over-zealous treatment ie treatment that is very uncertain, painful or expensive,<sup>104</sup> also burdensome, dangerous, extraordinary or disproportionate to the expected outcome.<sup>105</sup> Ordinary treatment should be continued.

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<sup>100</sup>Lawyers for Human Rights: Aids and Human Rights Programme; R Higgs; Dr HJC du Plessis, Head ICU 1Mil; United Christian Action; Mpumalanga Provincial Government; Society of Advocates of Natal.

<sup>101</sup>NPPHCN.

<sup>102</sup>Department of Health.

<sup>103</sup>Southern African Anglican Theological Commission (Cape Town group); Rev Justin Swanson.

<sup>104</sup>Rev Justin Swanson.

<sup>105</sup>The Right to Live Campaign, Natal.



4.27 In so far as the question is concerned whether the position should be formally regulated in legislation the following submissions were received:

- i) The minority view was that it is not necessary to formalise the position in legislation since the law is clear: a medical practitioner may not perform any procedure or treat any person without informed consent. Medical practitioners should be educated so that they are aware that they may not perform any procedure or treat any patients without informed consent.<sup>106</sup>
- ii) The majority of commentators held views contrary to the opinion expressed above. They argued that it seems necessary, for the sake of caution, but also in order to remove any uncertainty, to confirm by way of legislation the right of the mentally competent patient to refuse life-sustaining treatment.<sup>107</sup> This would afford guidance to medical care providers, family members and society at large.<sup>108</sup>

4.28 Two major proposals were received regarding the content of the section concerned:

- i) Firstly it was proposed that consideration should be given to lowering the age requirements with regard to consent to refuse medical treatment.<sup>109</sup> Since a child over the age of 14 years may consent to medical treatment without the assistance of his or her guardian, it stands to reason that he or she may also refuse

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<sup>106</sup>See eg Dr Elizabeth Murray, Senior Radiation Oncologist, Groote Schuur Hospital; Hospital Association of South Africa.

<sup>107</sup>See eg Prof JG Swart, Faculty of Medicine, UP; Department of Health; Prof Geoffrey Falkson ; Lawyers for Human Rights; Alfred Allan.

<sup>108</sup>Department of Health.

<sup>109</sup>Prof Geoffrey Falkson; Lawyers for Human Rights; Alfred Allan; Hospital Association of South Africa; Society of Advocates of Natal referred to the fact that the position of children under the age of 18 years is no longer clear in the South African law.

treatment.<sup>110</sup> In today's world children are more mature and better informed than in the past. To deny children of, for example 16 years, the power to make their own decisions on health care could be seen as curtailing their human and constitutional rights.<sup>111</sup> The impact of HIV on the youth should furthermore be considered.<sup>112</sup> With older children and adolescents chronological age becomes a less accurate indicator of mental competence. South African abortion law, for example, recognises the mental competence of minors to make serious medical decisions by requiring consent for abortion only from the pregnant woman, who is defined as "any female person of any age".<sup>113</sup> Moreover, the issue of children's competence is currently under review in South Africa. The South African Law Commission in its review of the Child Care Act and addressing the issue of informed consent by children to medical treatment or surgical intervention, asks whether the arbitrary (legal) age limits set in this regard are morally appropriate. Informed consent would depend on an individual's level of mental development, or mental maturity, and this may be greatly influenced by prolonged experience of repeated hospitalisation, treatment for terminal illness, and suffering. Some argue persuasively that minors with, for example, end-stage renal disease or terminal cancer and who have the required cognitive and emotional wherewithal, should have the right to refuse life-sustaining treatment. Mercy, respect for personal autonomy, fairness and consistency should all play a role. Legislation would require additional procedural safeguards, addressing such issues as the competent minor's presumptive decision making capacity; respect of parents' or guardian's

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<sup>110</sup>Lawyers for Human Rights; See also Ngwenya C "Health care decision-making and the competent minor: the limits of self-determination" 1996 **Acta Juridica** 132 (hereinafter referred to as "Ngwenya"): "...logically the competence to say 'yes' is co-existent with the competence to say 'no'. Indeed to confer on minors meeting the statutory criteria something less than a right to veto, would be to render s 39(4) nugatory."

<sup>111</sup>SA Nursing Council.

<sup>112</sup>The latest antenatal statistics show that of the women between 15-19 years of age who participated in the survey, 12.8% were infected with HIV. This means that a large proportion of children below the age of 18 years are infected with HIV and may develop full-blown AIDS within their teenage-years; Many babies are furthermore born infected with the HIV-virus.

<sup>113</sup>**Choice on Termination of Pregnancy Act 92 of 1996.**

authority by involving them intimately in all deliberations throughout the decision-making process and requiring their consent; written certification by a psychiatrist, registered clinical psychologist or social worker, personally familiar with the circumstances of the particular patient; and the power of the courts to grant minors' wishes against those of their parents in highly exceptional and compelling circumstances.<sup>114</sup> Minors are of course under the decision-making authority of their parents and parents are presumed to do what is in the best interest of their children. Therefore, some balance needs to be maintained between the decision-making authority of the parents and the decision-making ability of minors by recognising some joint-decision making process, and taking account of the minor's particular vulnerability.<sup>115</sup>

- ii) Secondly, it was proposed that a clause should be added dealing with ways of communicating with persons who are handicapped in communication<sup>116</sup> or where language is an obstacle.<sup>117</sup> Patients may try to communicate by means other than verbal. People with aphasia from a stroke may for instance be able to indicate that they do not wish further treatment including a feeding tube. It was noted that too often, especially in frail care units, people of advanced age are maintained on treatment which may be sustaining life but are causing extreme discomfort to the patient. Since no one attempts to communicate with the patient, he or she may be kept in an intolerable situation not of his or her own choosing for months or even years.<sup>118</sup> Care should furthermore be taken that a person is addressed by someone sharing his or her first language.<sup>119</sup>

**c) Recommendation of the Commission**

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<sup>114</sup>Dr Willem Landman.

<sup>115</sup>Dr Willem Landman.

<sup>116</sup>The Living Will Society.

<sup>117</sup>Prof KRL Huddle.

<sup>118</sup>Living Will Society; Dr Selma Browde; Ethics Committee.

<sup>119</sup>For a further discussion see para 4.197 below.

**4.29** After due consideration of the arguments set out above the Commission confirms the view set out in Discussion paper 71 and referred to above that although it might be possible in specific circumstances to encourage patients to continue with treatment, it would be impossible to compel a mentally competent patient to accept treatment against his or her wishes, especially where the patient is not terminally ill.

**4.30** In Discussion Paper 71 the Commission acknowledged the fact that mental competency is a question of fact and that minors could therefore in principle give or refuse consent to treatment as long as it is certain that they are mentally competent.<sup>120</sup> However, it seemed prudent to restrict the right to refuse treatment in the proposed Bill to persons of 18 years and older<sup>121</sup> as a safety measure since refusal of treatment could be to the detriment of the patient. The Commission agreed with the view<sup>122</sup> that there is a rational distinction to be made between giving consent and withholding it. This is based on the assumption that a doctor will act in the best interests of his patient. Hence if the doctor believes that a particular treatment is necessary for a patient, it is perfectly rational for the law to facilitate this as easily as possible and allow the child to give a valid consent. It would also protect the child against unreasonable parents. In contrast, it is surely right for the law to be reluctant to allow a child to veto treatment designed for his or her benefit particularly if a refusal would lead to the child's death or permanent damage.

**4.31** However, the arguments in favour of a lowering of the age limit have been convincing and the Commission has taken note of the fact that it has become accepted

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<sup>120</sup>See para 4.4 above.

<sup>121</sup>See Sec 28(3) of the Constitution where a child is defined as a person under the age of 18 years old.

<sup>122</sup>Set out in Lowe & Juss on 871.

practice for minors to make all sorts of medical decisions that is acknowledged by the law.<sup>123</sup>

The parent-child relationship has been shifting away from protecting parental rights as intrinsic rights towards protecting the best interests of the minor, including recognition, where appropriate, of the minor's autonomy.<sup>124</sup> However, the Commission is still of the opinion that unlike the position of an adult who is *compos mentis*, respect for self-determination is and should not be treated as an overriding value. This is because there are other competing values to be weighed, in particular the legitimate authority of the parent or guardian to decide for the minor and the protection of a conception of what is in the best interests<sup>125</sup> of the minor.<sup>126</sup> The Commission has therefore decided to lower the age limit to 14 years of age provided that such a minor is assisted in his or her decision making by his or her parents or guardian. It should also be remembered that the Supreme Court's authority as upper guardian, is wider than that of both the powers of the parent and the minor.<sup>127</sup>

**4.32** The Commission has furthermore included two additional clauses (see clauses 3(3) and (4) hereunder) dealing with persons handicapped in communication or with persons who do not understand a specific language.

4.33 The Commission recommends the legislative enactment to read as follows:

*Mentally competent person may refuse treatment*

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<sup>123</sup>Dr Willem Landman; Art 12(1) of the United Nations Convention on the Rights of the Child provides that:

'State parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'

<sup>124</sup>Ngwenya on 141 and the references made therein.

<sup>125</sup>Sec 28(2) of the Constitution provides" 'A child's interests are of paramount importance in every matter concerning the child'.

<sup>126</sup>Ngwenya on 134.

<sup>127</sup>See **Van Rooyen v Werner** (1892) SC 425 at 428, per De Villiers CJ and **Calitz v Calitz** 1939 AD 56 at 63 per Tindall JA as referred to by Ngwenya on 145.

3. (1) *Every person -*

- (a) *above the age of 18 years and of sound mind, or*
- (b) *above the age of 14 years, of sound mind and assisted by his or her parents or guardian,*

*is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.*

(2) *Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in subsection (1) is, that such a person's refusal is based on the free and considered exercise of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.*

(3) *Care should be taken when taking a decision as to the competency of a person, that an individual who is not able to express him or herself verbally or adequately, should not be classified as incompetent unless expert attempts have been made to communicate with that person whose responses may be by means other than verbal.*

(4) *Where a medical practitioner as contemplated in subsection (2) does not share or understand the first language of the patient, an interpreter fluent in the language used by the patient must be present in order to facilitate discussion when decisions regarding the treatment of the patient are made.*

**B) Double effect**

**a) Position as set out in Discussion Paper 71**

4.34 A further complication that was brought to the attention of the Commission, and which

was also discussed in the abovementioned Report of the British House of Lords<sup>128</sup> with regard to the cases now being discussed, is the so-called double effect. It is true that patients often request the discontinuance of life-prolonging treatment in circumstances as set out above and that medical practitioners comply with this request. The request is furthermore for the provision of palliative care only, which includes the administering of painkilling drugs.

4.35 A guideline for behaviour by a medical practitioner in respect of a terminally ill patient who is enduring pain is to be found in the World Medical Association's Declaration of Venice of October 1983. The declaration affirms the doctor's duty to heal and, if possible, to relieve suffering. Furthermore, the following rules are set out:<sup>129</sup>

The physician may relieve suffering of a terminally ill patient by withholding treatment with the consent of the patient or his immediate family if unable to express his will. Withholding of treatment does not free the physician from his obligation to assist the dying person and give him the necessary medicaments to mitigate the terminal phase of his illness.

4.36 The effect of large dosages of a painkiller is, however, that it may hasten death. It is apparently the position in our medical practice, as in England, that medical practitioners fail to supply sufficient painkillers to ensure effective relief of pain for the patient, as they are afraid that they may be criminally prosecuted on account of the fact that such large dosages of painkillers may hasten death and that they may therefore be held criminally liable.

4.37 Authority exists in our law to the effect that the hastening of a person's death, if it was done unlawfully and with the necessary intention, would constitute murder.<sup>130</sup> It can also be argued that the medical practitioner, even though he may have had a pure motive, had **dolus eventualis** under those circumstances.

4.38 Professor Strauss<sup>131</sup> nevertheless feels that administering drugs to a terminally ill patient

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<sup>128</sup>Op cit par 242 and further.

<sup>129</sup>Declaration of Venice, October 1983 15.

<sup>130</sup>**R v Makali** 1950 1 SA 340 (N) at 344.

<sup>131</sup>Strauss **Doctor, patient and the law** 345.

would be lawful, even if it has the secondary effect of hastening death, if the doctor acted in good faith and used the normal drugs in reasonable quantities with the object of relieving pain and without the intention of causing death.

4.39 Professor Strauss refers to a paper by Professor H J J Leenen from Amsterdam in which, amongst other things, he said:<sup>132</sup>

The administration of the pain-alleviating method can be qualified as an act with double effect. It must not be defined according to its side-effect, the unavoidable shortening of life, but according to its aim, which is to combat the pain of which the patient is suffering. Many medical acts and drugs have side-effects, but nobody will define them from the viewpoint of these side-effects. The same is true for pain-killing.

4.40 This is also the position as set out in the Report of the British House of Lords where it was stated that it was common practice and unexceptional for doctors to prescribe sufficient drugs to control the pain of a patient adequately even though a probable consequence may be the shortening of the patient's life.<sup>133</sup> The report rejected the charge of medical hypocrisy in that the so-called double effect was being used as a cloak for what in effect amounted to widespread euthanasia. They did however acknowledge the fact that the doctor's intention, and the evaluation of the pain and distress suffered by the patient, are of crucial significance in judging the double effect. They referred to the fact that juries in England are however asked every day to assess intention in all sorts of cases and could also do so in respect of double effect if in a particular case there was any reason to suspect that the doctor's prime intention was to kill the patient rather than to relieve suffering.<sup>134</sup>

#### **b) Discussion of submissions received**

4.41 From the submissions received it was clear that there is overwhelming support for the

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<sup>132</sup>As quoted by Strauss **Doctor, patient and the law** 346, since published as "The definition of euthanasia" 1984 **Med Law** 333.

<sup>133</sup>**Report of the Select Committee**, par 73, 20.

<sup>134</sup>Op cit, par 243, 50.



principle that doctors should be able to administer treatment to prevent pain even if the secondary effect of the painkillers may be the shortening of life.<sup>135</sup>

4.42 The Commission was inter alia referred to Paragraph 2279 of the Catechism of the Catholic Church, Rome 1992 that states:

Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such, it should be encouraged.<sup>136</sup>

4.43 Reference was also made to the Department of Health's proposed guidelines on Pharmaceutical Pain Control for Terminal Ill patients which states that in accordance with the best practices in palliation it is accepted practice to increase pharmaceuticals for pain control to the limit of the pain being controlled, irrespective of the consequences or dosage.<sup>137</sup>

4.44 Reiterating the views expressed above, the explicit divorcing of palliative care from legal liability, even if it hastens death, but provided that it is given in accordance with responsible medical practice, was praised as making good sense from a practical perspective. This would be especially helpful given the current tendency to undermanage pain. It is also consistent with recent observations made by some Judges of the United States Supreme Court.<sup>138</sup>

4.45 One commentator remarked that medical evidence suggests that when individuals receive

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<sup>135</sup>See eg. Phil Harrison; Dr HJC du Plessis; Prof KRL Huddle; Rev Justin Swanson; (Fr) Hyacinth Ennis; NPPHCN; SA National Consumer Union; M Lavies; Lawyers for Human Rights; Methodist Church; ACDP; SA Nursing Council; Department of Health; Dr Willem Landman; Archbishop of Cape Town, Anglican Church; Alfred Allan; The Christian Lawyers Association; Hospital Association of South Africa; Society of Neurosurgeons of South Africa (who felt however that legislation was unnecessary).

<sup>136</sup>SACBC.

<sup>137</sup>Department of Health.

<sup>138</sup>Dr Willem Landman; **Washington v Glucksberg** 117 S. Ct. 2302 (1997).

adequate emotional support and pain relief for their symptoms, the desire to terminate their lives greatly diminishes.<sup>139</sup> It is however important that the patient should be fully informed of possible consequences of the dosage.<sup>140</sup>

4.46 In a minority view it was contended that the principle of double-effect could open the door to all kinds of abuses which will be difficult to detect, prove or control.<sup>141</sup>

4.47 Commentators also referred to the fact that the linkage of pain management with the doctrine of double effect may be problematic from a philosophical perspective as reliance on such a mental construct calls into question the intrinsic moral validity of the distinction between pain management which relies on double effect, and euthanasia.<sup>142</sup>

4.48 In this respect the question of the doctor's intent drew much comment. It was stressed that the procedure must be safeguarded by the provision that there is no intention on the part of the physician to kill the patient.<sup>143</sup> While the effect is ultimately the same as euthanasia, the intention and way of dealing with people is vastly different. It was contended that palliative care fosters respect for life<sup>144</sup> and people are not treated as objects, whereas with euthanasia, people become obstacles to be "removed" as quickly and as quietly as possible.<sup>145</sup> Respondents agree that ethically the intention of the doctor administering the drugs is of prime importance, and that if the doctor's intention is to mitigate pain and suffering, he or she is acting rightly even though such action may hasten the patient's death. It was furthermore emphasised that a doctor should never be obliged to act in a certain way if such action is contrary to his or her religious or moral

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<sup>139</sup>NCCPHN.

<sup>140</sup>Methodist Church; Hospital Association of South Africa.

<sup>141</sup>A Rogers; R Higgins ; See Rev Justin Swanson who referred to the fact that doctors could use painkilling drugs as a form of active euthanasia. If a patient is kept permanently unconscious by sedatives, for example, then it is an easy step to ending the patient's life by increasing the dose, rather than, as many see it, allowing the patient to go on living uselessly.

<sup>142</sup>Dr Willem Landman.

<sup>143</sup>Methodist Church.

<sup>144</sup>ACDP.

<sup>145</sup>Phil Harrison.

convictions.<sup>146</sup>

4.49 Three concerns were raised on points of detail. They came from commentators who are in favour of the acceptance of the principle of double-effect as part of responsible medical practice:

- i) The first concern was the use of the words *ordinary* palliative treatment and *responsible* medical practice. It was submitted that palliative treatment or care for chronic pain in cancer cannot be described as *ordinary* palliative treatment and that the word "ordinary" should be deleted. Compared with other pain regimens, it requires a different approach to the administration of analgesia which few doctors have been taught, are prescribing or practising adequately.<sup>147</sup> The words "ordinary palliative treatment" may be interpreted by the doctor untrained in palliative care as the treatment he would ordinarily give, and would be what palliative care doctors would consider sub-optimal treatment. There is no such thing as "ordinary" palliative treatment. Palliative care is specific.<sup>148</sup> The second word that is likely to lead to problems is the word "responsible". Many doctors might regard responsible medical practice as minimal doses of analgesics and would feel that there is a limit to what they may give if they are to be regarded as "responsible medical practitioners". Thus they may not increase analgesia sufficiently as and when needed according to *competent* medical practice in palliative care.<sup>149</sup> It was felt that this clause as it is presently worded could lead to increased suffering rather than the reverse which is the intended effect of this clause.<sup>150</sup>
- ii) The second concern raised was the practicability of the need for confirmation by a second medical practitioner of the patient's condition and level of pain before

<sup>146</sup>Archbishop of Cape Town, Anglican Church.

<sup>147</sup>Cancer Association: National Office.

<sup>148</sup>Dr Selma Browde; The Living Will Society; Ethics Committee.

<sup>149</sup>National Office: Cancer Association.

<sup>150</sup>Dr Selma Browde; The Living Will Society; Ethics Committee.

increasing or prescription of appropriate palliation. It was felt that clause 4(2) and 4(3)(b) should be deleted.<sup>151</sup> Reasons given were as follows:

- aa) A provision that two medical practitioners should issue a certificate as is done in clause 4(2) may be impractical in certain rural areas.<sup>152</sup>
  - bb) Clause 4(2) may in certain circumstances lead to unnecessary caution on the part of medical practitioners, suffering of patients and delays. Virtually all, if not all, medication has side-effects. Any medication can potentially shorten the life of a patient. Say for example a doctor wishes to sedate a seriously ill person prior to transporting him from a farm to a hospital. However, because it is foreseeable that one of the secondary effects of the medication may be to shorten the life of the patient, the practitioner may feel obliged to obtain a second opinion. Although doctors may in certain circumstances use the doctrine of emergency to justify his or her decision, it places the doctor in the unenviable position where he may withhold treatment which would be humane in the circumstances, because he is uncertain about the legal position.<sup>153</sup>
  - ccc) The medical practitioner increasing the dosage of medication should be following the National Cancer Control Programme (NCCP) and WHO guidelines<sup>154</sup> in which case a second opinion is unnecessary.
- iii) The third concern raised was that since the patient may find him or herself in a

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<sup>151</sup>National Office: Cancer Association of SA; Living Will Society; Alfred Allan; Dr Elizabeth Murray, Senior Radiation Oncologist, Groote Schuur; Prof KRL Huddle; Critical Care Society of South Africa; Society of Advocates of Natal; Society of Neurosurgeons of South Africa (who was however against legislating this issue).

<sup>152</sup>Alfred Allan; Dr Elizabeth Murray, who is against any legislation dealing with these issues; the Critical Care Society.

<sup>153</sup>Alfred Allan; Critical Care Society of South Africa.

<sup>154</sup>National Office: Cancer Association.

rural area or primary health care situation, the legislation of the role of the Primary Health Care Nurse in prescribing analgesia in the absence of the doctor needs clarification.<sup>155</sup> Support was expressed for the expansion of home-based care to develop the capacity of community health workers to provide hospice and palliative care.<sup>156</sup> It was further stated that these services must be provided at primary health care facilities with support from secondary and tertiary levels<sup>157</sup> Patients who rely on home based care should also be provided for. They may be in need of increased palliative care, but are not being attended to by a medical practitioner. Issues that need to be dealt with include the question as to what drugs may be prescribed in terms of the Essential Drugs List and who may prescribe the drugs.<sup>158</sup>

c) **Recommendation of the Commission**

**4.50 The Commission agrees with the view<sup>159</sup> that more emphasis is needed in South Africa on pain management, medical care, spiritual care and social services. Currently, too few health workers are oriented to view end of life care as important. All people who are terminally ill, irrespective of their financial situation, should have access to palliative care services. Since for many persons in this country palliative care will in all likelihood be the only available and affordable treatment, the Commission supports the idea that access to and availability of palliative care in South Africa should be improved. The Commission endorses the proposal that the availability of palliative care in South Africa be thoroughly examined with a view to expanding the provision of such care and support the suggestion made for the development of policies or regulations by the Minister of Health**

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<sup>155</sup>National Office: Cancer Association.

<sup>156</sup>NPPHCN.

<sup>157</sup>NPPHCN.

<sup>158</sup>Lawyers for Human Rights.

<sup>159</sup>NPPHCN; Dr Selma Browde; MASA; The Living Will Society ; National Office: Cancer Association.

with regard to the increased provision of palliative care.

**4.51** In this context the Commission agrees with the proposals made and views expressed regarding the deletion of the words "ordinary" and "responsible" in sec 4(1) as well as the deletion of sections 4(2) and 4(3)(b).

**4.52** In so far as the issue of the primary health care nurse's responsibility in regard to palliative care in a primary health care situation is concerned the Commission notes that a new Bill<sup>160</sup> dealing inter alia with the control, selling and prescription of medicine, is presently (November 1998) being argued in Parliament. In terms of this proposed bill a nurse has been included in the definition of "authorised prescriber" in terms of the Act (sec 31 (17)(a)); he or she may possess any medicine or Scheduled substance for the purposes of administering it in accordance with his or her scope of practice( sec 31 (16) (c)) and no nurse may prescribe such medicine or substance unless that nurse has been authorised to do so within the scope of that nurse 's practice by that nurse's professional council(sec 31 (14)(b)).

**4.53** In ordinary circumstances the nurse in a primary care setting will therefore work within the palliative care referral protocol<sup>161</sup> received from the hospital or institution from which the patient has been discharged. It is however envisaged that a specific nurse may be authorised by his or her professional body, in areas where there are no medical practitioners, to prescribe Scheduled substances in accordance with his or her scope of practice to patients in distress. The proposed National Cancer Control Programme furthermore provides that oral morphine should, in line with the Essential Drugs programme, be available at all primary care service sites.

**4.54** Taking into account the recent developments referred to above and in order to make

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<sup>160</sup>South African Medicines and Medical Devices Regulatory Authority Bill [B114-98] tabled by the Department of Health. (Editorial note: Act 132 of 1998 was assented to on 11 December 1998, date of commencement to be proclaimed)

<sup>161</sup>As set out in the proposed National Cancer Control Programme, October 1998.

provision for the position of terminally ill patients in rural areas who do not have access to medical practitioners the Commission has decided to amend sec 4 to widen its scope to include registered nurses who have been authorised by their professional body as "authorised prescribers".

4.55 Legislative enactment of this principle should read as follows:

*Conduct of a medical practitioner in relieving distress*

4. (1) *Should it be clear to a medical practitioner or a nurse responsible for the treatment of a patient who has been diagnosed by a medical practitioner as suffering from a terminal illness that the dosage of medication that the patient is currently receiving is not adequately alleviating the patient's pain or distress, he or she shall -*

- (a) *with the object to provide relief of severe pain or distress; and*
- (b) *with no intention to kill*

*increase the dosage of medication (whether analgesics or sedatives) to be given to the patient until relief is obtained, even if the secondary effect of this action may be to shorten the life of the patient.*

(2) *A medical practitioner or nurse who treats a patient as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and his or her conduct in treating the patient, which record will be documented and filed in and become part of the medical record of the patient concerned.*

4.56 The next two cases to be discussed relate to the relatively small percentage of mentally competent patients who are terminally ill or can be identified as having an intractable and unbearable illness ie no effective curative medical treatment is available and palliative medical

skills are not adequate or acceptable.<sup>162</sup> These patients may be subject to unbearable pain or discomfort or emotional distress despite all the known techniques and not prepared to continue living under such circumstances.

**(C) Assisted suicide (ie the provision, but not the administration of a legal drug or injection)**

**a) Position as set out in Discussion Paper 71**

4.57 In the case of assisted suicide the patient does not only require, as has been set out in paragraph (A), discussed above, that life-prolonging medical treatment should be discontinued. He or she wants something more: the patient may for example request that lethal drugs be made available to take him or herself; or the patient may request to be supplied with a hypodermic needle containing a lethal drug in order to give him or herself an injection.

4.58 In our law the position is that the person who knowingly supplies a drug to a patient for use in a suicide is guilty of aiding and abetting a suicide and can accordingly be found guilty of murder. An example in point is that of **R v Peverett**.<sup>163</sup> In this case the accused, Peverett, concluded a suicide pact with his mistress, one Saunders. Peverett connected the exhaust pipe of the car with the interior of the car and the two of them sat in the car with the doors and windows closed while the engine was running. They were both later found in an unconscious state but survived the attempted suicide. Peverett was found guilty of the attempted murder of Saunders. Watermeyer JA held as follows:<sup>164</sup>

In the present case it is clear that the accused contemplated and expected that as a consequence of his acts Mrs. Saunders would breathe the poisoned gas and die. In the eye of the law, therefore, he intended to kill her, however little he may have desired her death.

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<sup>162</sup>Prof S Benatar et al; Dr Willem Landman; See also the discussion in this regard para 2.12 on 24 above.

<sup>163</sup>1940 AD 213.

<sup>164</sup>Supra at 219.



The Appeal Court confirmed the conviction of attempted murder.

4.59 In a decision by the then South Rhodesian court, **R v Nbakwa**,<sup>165</sup> the facts were that Nbakwa, a man who lived according to the traditions of his tribe, suspected and accused his mother of the death of his child. His mother then requested him to kill her. Nbakwa went to the hut where his mother was lying ill, tied a rope to a rafter in the hut and tied a noose in the other end. He then told her to hang herself. She asked him to lift her up and asked for something to stand on. He helped her to get up and then put a block of wood under the rope. He then looked on while she hanged herself by kicking away the block of wood. Nbakwa was acquitted on a charge of murder. The rationale of the judgement was that there was no chain of causation between Nbakwa's act and the subsequent death of the mother. She caused her own death. Beadle J stated as follows:<sup>166</sup>

The accused did not actually kill the deceased himself, but if his acts could be construed as an attempt to do so he could be legally convicted of attempted murder, since on an indictment for murder a verdict of attempted murder is a competent one. I will first consider, therefore, whether these particulars disclose on the part of the accused an attempt to murder the deceased. In my view the acts of the accused on this occasion do not go far enough to constitute an attempt; they go no further than what are commonly called acts of preparation. The accused provided a means for causing death and he persuaded the woman to kill herself, but the actual act which caused the death of the woman was the act of the woman herself. There was, to use a common legal expression, a **novus actus interveniens** between the actions of the accused and the death of the deceased which in my view broke the chain of causation between the act of the accused and the death of the deceased..... The direct cause of death was not the action of the accused. I come to the conclusion, therefore, that the accused's acts did not go far enough to constitute an attempt to murder; at most his acts went no further than acts of preparation.

4.60 In South Africa the school of thought in **R v Nbakwa**<sup>167</sup> was followed in **S v Gordon**.<sup>168</sup> Gordon and a girlfriend concluded a suicide pact. Gordon obtained some lethal drug and both took some of it. The girlfriend died, but Gordon lived. He was charged with murder. Henning J

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<sup>165</sup>1956 2 SA 557 (SR).

<sup>166</sup>Supra at 559 A-E.

<sup>167</sup>Supra.

<sup>168</sup>1962 4 SA 727 (N).

distinguished the said case from **R v Peverett**<sup>169</sup> as follows:<sup>170</sup>

Now it will be observed that in that case the accused completed every necessary act to bring about the death of himself and Mrs Saunders, the starting of the engine being the final act. In the present case it is an accepted fact that the deceased took the tablets herself and that was the final act which brought about her death.

4.61 Henning J found that Gordon was not guilty of the murder. He stated as follows:<sup>171</sup>

To my mind, the mere fact that he provided the tablets knowing that the deceased would take them and would probably die cannot be said to constitute, in law, the killing of the deceased. The cause of her death was her own voluntary and independent act in swallowing the tablets. He undoubtedly aided and abetted her to commit suicide, but that is not an offence. The fact that he intended her to die is indisputable, but his own acts calculated to bring that result about fall short of a killing or an attempted killing by him of the deceased. One might say that the accused, as it were, provided the deceased with a loaded pistol to enable her to shoot herself. She took the pistol, aimed it at herself and pulled the trigger. It is not a case of **qui facit per alium facit per se**.

4.62 When the matter came before the Appeal Court for the first time, in **Ex parte Die Minister van Justisie: In re S v Grotjohn**,<sup>172</sup> the court was of the opinion that the school of thought as stated in **Rv Nbakwa**<sup>173</sup> and **S v Gordon**<sup>174</sup> was not unqualifiedly correct. Chief Justice Steyn held as follows:<sup>175</sup>

Of 'n persoon wat 'n ander aanmoedig, help of in staat stel om selfmoord te pleeg, 'n misdaad begaan, sal afhang van die feite van die besondere geval. Met die oog op die gewysdes wat aanleiding tot die vroege gegee het, is dit egter nodig om op die voorgrond te stel dat die blote feit dat die laaste handeling die selfmoordenaar se eie, vrywillige, nie-misdadige handeling is, nie sonder meer meebring dat bedoelde persoon aan geen misdaad

<sup>169</sup>Supra.

<sup>170</sup>Op cit at 730 B-C.

<sup>171</sup>Op cit at 731 B-D.

<sup>172</sup>1970 2 SA 355 (A).

<sup>173</sup>Supra.

<sup>174</sup>Supra.

<sup>175</sup>Op cit at 365 H.

skuldig kan wees nie. Die antwoord op die tweede vraag hang eweseer van die feitelike omstandighede af. Na gelang daarvan kan die misdaad moord, poging tot moord of strafbare manslag wees.

4.63 The warning in **Ex parte Minister van Justisie : In re S v Grotjohn**<sup>176</sup> apparently brought new insight to the trial courts, as can be seen in **S v Hibbert**<sup>177</sup> where Hibbert handed his depressed wife a fire-arm after she had expressed the desire to commit suicide. He was convicted of murder after his wife used the fire-arm he had given her to commit suicide. Shearer J explained as follows:<sup>178</sup>

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

Hibbert was sentenced to four years' imprisonment all of which was conditionally suspended for five years.<sup>179</sup>

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<sup>176</sup>Supra.

<sup>177</sup>1979 4 SA 717 (D).

<sup>178</sup>Op cit at 722 E-H.

<sup>179</sup>See also Van Oosten, FFW "Aandadigheid aan selfmoord in die Suid-Afrikaanse reg" 1985 **TSAR** 189 at 194; Labuschagne, J M T "Dekriminalisasie van eutanasie" 1988 **THRHR** 167(hereinafter referred to as "Labuschagne 1988 **THRHR**") especially at 171-174; Hunt, T M A & Milton, J R L **South African criminal law and procedure Vol 2** 2nd edition Cape Town Juta 1982 at 369-371.

4.64 With the exception of certain states in the USA,<sup>180</sup> aiding, abetting and assisting suicide is generally punishable in the Western world.<sup>181</sup> According to section 2(a) of the **British Suicide Act**, 1961 aiding, abetting and assisting suicide is punishable with imprisonment of up to fourteen years.

4.65 Section 241 of the **Canadian Penal Code** reads as follows:

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.

4.66 In June 1995, the Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide presented its report entitled **Of life and death**.<sup>182</sup> In this report, a majority of the Committee recommended that the laws relating to assisted suicide and euthanasia remain intact. These members of the Committee considered that, in relation to voluntary euthanasia, adequate safeguards could never be established to ensure the consent of the patient is given freely and voluntarily. Some members felt that "the common good could be endangered" if the law was changed to accommodate the few cases where pain control is ineffective. These cases were not sufficient to justify legalising euthanasia because it could create serious risks for the most vulnerable and threaten the fundamental value of life in society.<sup>183</sup>

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<sup>180</sup>See discussion below para 4.72 on 65. See also discussion of the position in the Netherlands, para 4.69.

<sup>181</sup>See in general Hu, P "The acceptability of active euthanasia in China" 1993 **Med Law** 47; Bix, B "Physician assisted suicide and the United States Constitution" 1995 **Modern Law Review** 404.

<sup>182</sup>Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide **Of life and death**, June 1995.

<sup>183</sup>Canadian Senate Report 86 as quoted in Senate Legal and Constitutional Legislation Committee **Consideration of legislation referred to the Committee: Euthanasia Laws Bill 1996**, March 1997 on 95.

4.67 In the case **Re Rodriguez and Attorney-General of British Columbia**<sup>184</sup> a woman applied for a declaratory order to the effect that she could be assisted to die should her situation become unbearable. The appellant who was terminally ill was suffering from a progressive neuron disease which would have the effect that she would ultimately be unable to speak or move, although she would be mentally competent. The Canadian Supreme Court denied the application with a small majority of five against four.

4.68 In Australia the **Criminal Code** states that it is a crime to aid another in committing suicide. According to a report of the Law Reform Commission of Western Australia<sup>185</sup> it would, in that country, be a crime for a doctor to place poison in the hand of a patient knowing that it would cause his death. This would amount to aiding suicide.

4.69 Section 294 of the Dutch **Criminal Code** reads as follows:

[H]ij die opzetlijk een ander tot zelfmoord aanzet, hem daarbij behulpzaam is of hem de middelen daartoe verschaft, wordt, indien de zelfmoord volgt gestraft met gevangenisstraf van ten hoogste drie jaren of geld boete van de vierde kategorie.

4.70 This section should be read with section 293 of the Dutch **Criminal Code** that reads as follows:

Hij die een of ander op zijn uitdrukkelijk en ernstig verlangen van het leven berooft, wordt gestraft met gevangenisstraf van hoogstens twaalf jaren.

4.71 Notwithstanding the express prohibitions found in sections 293 and 294 of the Dutch Criminal Code, the criminal courts in the Netherlands have since 1973 shown an inclination in

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<sup>184</sup>(1994) 85 CCC (3rd) 15 (SCC).

<sup>185</sup>Law Reform Commission of Western Australia **Report on medical treatment for the dying** 1991 (hereinafter referred to as **Western Australia Report**).

suitable cases to accept necessity as a defence for contraventions of said sections.<sup>186</sup> The most notable recent example is that of the Chabot-case.<sup>187</sup>

4.72 In the November 1994 general election the voters in the US State of Oregon approved a ballot measure by a vote of 51 to 49 per cent that allows a restricted form of physician assisted suicide. The resulting act is called the **Death With Dignity Act**. This is the first time that a law has been enacted in the United States that permits physician-assisted suicide.<sup>188</sup>

4.73 The Act allows a terminally ill patient to obtain a doctor's prescription for a fatal drug dosage for the express purpose of ending his or her life. However, the Act does not allow the doctor to carry out the killing of the patient: the patient must self-administer the fatal drug. Specific requirements and safeguards are set out in the Bill.<sup>189</sup>

4.74 The validity of the Act has been challenged on various occasions. A preliminary injunction was granted by the Federal District Court in Oregon in 1994 that prevented the Act from being used. In 1995 the Court found that the Act was unconstitutional and a permanent injunction was granted. An appeal was lodged with the US Court of Appeals for the Ninth Circuit from the

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<sup>186</sup>See Griffiths, J "Assisted suicide in the Netherlands: the **Chabot** case" 1995 **Modern Law Review** 232; Griffiths, J "Assisted suicide in the Netherlands: postscript to **Chabot**" 1995 **Modern Law Review** 895; Keown, J "Physician assisted suicide and the Dutch Supreme Court" 1995 **The Law Quarterly Review** 394.

<sup>187</sup>See discussion on para 4.96 on 72 below.

<sup>188</sup>GAO **Patient Self-determination Act: providers offer information on advance directives but effectiveness uncertain** Report No HEHS-95-135 January 1995 (hereinafter referred to as "GAO report") states that 32 states have laws that explicitly criminalise assisted suicide and 11 criminalise through the common law, while in 7 states the law concerning assisted suicide is unclear. Although a few states have considered allowing assisted suicide there is no clear consensus on the issue.

<sup>189</sup>The regulations **inter alia** require that:

- (i) The patient must be diagnosed as having six months or less to live.
- (ii) There must be two oral and one written request.
- (iii) There must be a 15 day waiting period between the first and second request.
- (iv) A second physician's opinion must be obtained.
- (v) Counseling is required where, in the judgement of either physician, the patient has a mental disorder, or is suffering from impaired judgement as a result of depression.

decision of the District Court in this case. In 1997 the Court of Appeals dismissed the challenge to the Oregon law saying that the plaintiffs lacked standing to challenge it. Those challenging the law have said that they will appeal the decision and the Oregon Deputy Attorney General was reported as saying that the law "is likely to remain on hold throughout the next phase of the litigation".<sup>190</sup> Oregon recently released data on the first deaths under the controversial assisted suicide law, in effect since November 1997.<sup>191</sup>

4.75 In order to have a sensible discussion with regard to the legal position in the case under discussion, it is necessary to look at the fourth possible category of the cases under discussion, namely where the patient desires active euthanasia.

**(D) Voluntary active euthanasia**

**a) Position set out in Discussion Paper 71**

4.76 The example that is usually used to illustrate what is referred to as "voluntary active euthanasia" is that of a terminally ill person who requests the termination of his or her life as he or she is experiencing unbearable pain or suffering and where the doctor then administers a lethal injection.

**i) Present position in South Africa**

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<sup>190</sup>Washington Post 28 February 1997 as referred to in the Senate Legal Committee on 108.

<sup>191</sup>Oregon Health division quoted in the American Medical Association News on 9:  
 Patients receiving lethal prescriptions: 10  
 Average age: 71  
 Prescribing doctors: 9  
 Underlying illness: 9 had cancer, one heart disease  
 Time between filling prescription and death: ranged between same day to 16 days.  
 Average time from taking medication to death : 40 minutes  
 Two people died of their illnesses before taking the drugs.

4.77 In South Africa such an act would undoubtedly be unlawful and the person giving the assistance could be convicted of murder. In Discussion Paper 71 the following cases of active euthanasia (both voluntary and involuntary) were discussed:

**R v Davidow**<sup>192</sup>

4.78 The accused was charged with the murder of his mother, who was suffering from a terminal illness accompanied by severe pain. The accused did everything in his power to obtain the best possible medical treatment for his mother. Her condition was, however, incurable and was deteriorating. She was very depressed and expressed the wish to be relieved of her suffering. The accused was extremely concerned about his mother's condition. Finally he asked a friend to give his mother a lethal injection. The friend refused. Eventually the accused, who was in a state of emotional turmoil, shot and killed his mother in her hospital bed. The accused was eventually found not guilty since he was not accountable for his actions as a result of his emotional state during the perpetration of the deed. There was, however, no question as to the unlawfulness of the act.

**S v De Bellocq**<sup>193</sup>

4.79 The accused, a young married woman, gave birth to a premature baby. After a few weeks it appeared that the baby was suffering from a disease known as toxoplasmosis, was an idiot and would never be able to live a normal life. The accused was a medical student and realised the extent of the problem. On the spur of the moment she drowned the baby in the bath. She was eventually found guilty of murder. On account of the overwhelming extenuating circumstances, she was however sentenced in terms of section 349 of the old Criminal Procedure Act.<sup>194</sup> This

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<sup>192</sup>1955 WLD unreported.

<sup>193</sup>1975 3 SA 538 (T).

<sup>194</sup>Act 56 of 1955.



section provided that the accused could be discharged on her own recognisance provided that she would appear and be sentenced if called upon by the court.

**S v Hartmann**<sup>195</sup>

4.80 The elderly father of the accused, a medical practitioner, suffered from cancer. The accused had treated his father for a considerable period. The condition of the father deteriorated and he was on the point of death. Morphine was administered to ease the pain. Eventually the practitioner injected his father with a lethal dose of Pentothal, which immediately caused his death. The accused was convicted of murder. He was sentenced to one year's imprisonment. He was detained until the rising of the court and the balance of the sentence was suspended for one year. The Medical and Dental Council took disciplinary action by suspending him temporarily.

**S v McBride**<sup>196</sup>

4.81 The accused and his wife were under the impression that the wife suffered from cancer. Her health deteriorated. Their financial position, likewise, deteriorated. The accused decided to take his wife's life and then his own. He shot and killed his wife, but his own life was saved through the intervention of others. He was accused of murdering his wife but the charge was dismissed on the grounds of criminal incapacity.

**S v Marengo**<sup>197</sup>

4.82 The accused shot and killed her 81-year old father, who suffered from cancer. She pleaded guilty to a charge of murder and stated that she could no longer endure her father's suffering. She was convicted of murder and sentenced to three years' imprisonment suspended for five years.

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<sup>195</sup>1975 3 SA 532 (C).

<sup>196</sup>1979 4 SA 313 (W).

<sup>197</sup>1990 WLD unreported.

**S v Smorenburg**<sup>198</sup>

4.83 The accused was a nursing sister. She attempted on two occasions to end the lives of terminally ill patients by injecting them with insulin in order to end their suffering. She was found guilty of attempted murder on both counts and was sentenced to three months' imprisonment suspended in its entirety.

4.84 All of the above-mentioned cases deal with active euthanasia. In each case the accused actively contributed to the death of the deceased. In each case the motive for the act was to end the suffering or useless existence of the deceased. However, in no case could the act be regarded as lawful. The courts, at best, reflected the sense of justice of the community regarding the blameworthiness of the accused by imposing very light sentences.

4.85 The attitude of the South African judiciary reflects the Anglo-American view. In Britain, Australia and Canada and in most of the states of the USA active assistance in terminating life is unlawful and is regarded as murder. In the previously mentioned **Report of the Select Committee**<sup>199</sup> the position in Britain was again revisited, but the commissioners recommended that the legal position should not be amended.

ii) **Comparative law**

**\*The Netherlands**

4.86 We have already referred to the fact that in the Netherlands the courts have in suitable cases accepted the defence of necessity as a ground for justification.

4.87 An example of this can be found in the well-known Alkmaar case<sup>200</sup> in which the Dutch

<sup>198</sup>1992 CPD unreported.

<sup>199</sup>Op cit para 259-260.

<sup>200</sup>(NJ) (1985) No. 106, 451 as discussed by Leenen, H J J "Supreme Court's decisions on euthanasia in the Netherlands" 1986 **Medicine and Law** 349. See also Labuschagné 1995 **SALJ** 227.

Supreme Court held, on appeal, that a doctor, who had applied active euthanasia at the request of an elderly woman suffering from several painful diseases, had acted lawfully. The accused relied on the defence of **force majeure** as a result of medical necessity.

4.88 Section 40 of the Dutch Criminal Code states that when a person commits a crime as a result of "overmacht" he is not criminally liable. "Overmacht" takes two forms, namely psychological **force majeure** and necessity. Necessity is regarded here as a ground of justification (although, in the Netherlands, it can be used as a ground for the exclusion of culpability as well) and is found where two interests are weighed up against each other and the interest sacrificed weighs less than the interest protected. It is furthermore required that it should not be possible to attain the object aimed at in a less punishable manner.<sup>201</sup>

4.89 Necessity in this case therefore refers to the patient's unbearable situation which induces the doctor to disregard the law (for a so-called "higher good"). The question of whether necessity exists is answered according to responsible medical opinion measured against the existing standard of medical ethics.

4.90 In 1989 the criteria laid down by the criminal courts in the Netherlands to determine whether the defence of necessity applied in a given case were summarised as follows by Mrs Borst-Eilers,<sup>202</sup> Vice-President of the Health Council:

- (a) the request for euthanasia must come only from the patient and must be entirely free and voluntary;
- (b) it must be a well-considered, durable and persistent request;
- (c) the patient must be experiencing intolerable suffering with no prospect of improvement;

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<sup>201</sup>Dörfling 20.

<sup>202</sup>Borst-Eilers, E "The status of physician administered active euthanasia in the Netherlands" (paper delivered at the Second International Conference on health law and ethics, London, July 1989) as quoted by Keown, J "The law and practice of euthanasia in the Netherlands" 1992 **The Law Quarterly Review** 51(hereinafter referred to as "Keown") at 56.

- (d) euthanasia must be a last resort;
- (e) euthanasia must be performed by a physician;
- (f) the physician must consult with a second independent physician who has experience in this field.

4.91 In medical circles the Royal Dutch Medical Association (KNMG), to which 60 per cent of Dutch doctors belong, has played a significant role since 1973. In 1984 a report was published that led in 1988 to a publication entitled **Guidelines for Euthanasia**, setting out guidelines that closely correspond to the above criteria as developed by the courts over the years.

4.92 In November 1990 the Minister of Justice and the KNMG agreed that a doctor, after practising euthanasia, would have to submit a report to the "gemeentelijke lijkschouwer" (coroner), who would in turn inform the public prosecutor. The prosecutor would ask the police to investigate the matter only if the **Guidelines for Euthanasia** had not been complied with. The final decision whether to prosecute would be taken by the "Procureurs-Generaal", but in practice they simply approve the decision of the prosecutor.<sup>203</sup> In 1992, one thousand three hundred such reports were received.<sup>204</sup>

4.93 Because medical practice and court decisions were no longer in accordance with the spirit of the legislation and different courts applied different criteria, the Dutch Government decided in 1982 to establish a State Committee to investigate euthanasia. In 1985 the Committee recommended that sections 293 and 294 be amended in order to allow a doctor to apply euthanasia in specific instances. Because of the opposition of the Christian Democrats, the Bill was not passed, but in December 1987 a compromise was reached by the opposing parties.<sup>205</sup>

4.94 The compromise provided that sections 293 and 294 would remain unchanged, but that

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<sup>203</sup>Keown 60. In a subsequent submission received from Keown he indicated that the "Procureurs-Generaal" do, albeit infrequently, disagree with a decision of the local prosecutor.

<sup>204</sup>Ministry of Justice, the Netherlands **Newsletter** February 1993.

<sup>205</sup>Leenen, H J J "Dying with dignity: developments in the field of euthanasia in the Netherlands" 1989 **Med Law** 517 at 523.

the position in practice, as set out above, would be given legal foundation. In September 1991 the findings of an independent commission consisting of jurists and doctors led to the introduction of a proposed Bill<sup>206</sup> in this regard, which was accepted in the Second Chamber of Parliament but rejected in the First Chamber because provision was made for both voluntary and non-voluntary euthanasia (i.e. incompetent persons, for example comatose patients).<sup>207</sup>

4.95 The Bill was amended and stated that under no circumstances would the verifying of the doctor's actions be excluded. Even euthanasia at a patient's express request, practised according to the prescribed criteria, would therefore not automatically be exempted from punishment. It furthermore provided that as a rule non-voluntary euthanasia would be regarded as punishable.

4.96 In June 1994 the Dutch Supreme Court decided the **Chabot case**<sup>208</sup> in which acceptance was expressed of euthanasia for persons not suffering from any physical disease. The suffering of the 50-year old woman was psychological. She had a long history of suffering depression and when both her sons died she decided to commit suicide. She was referred to Dr Chabot by the Dutch Federation for Voluntary Euthanasia after she had contacted them for assistance. Dr Chabot diagnosed her as suffering from severe and intractable mental suffering and was of the opinion that her case satisfied the prescribed guidelines. He consulted a number of colleagues, but none of them examined her. He assisted her to commit suicide by prescribing a lethal dose of drugs and reported the case to the coroner. He was prosecuted under Art 294 of the Dutch Penal Code. The Supreme Court held that there was no reason in principle why the defence of necessity could not apply where a patient's suffering is purely psychological. However, for the defence to apply the patient must have been examined by an independent medical expert. Since this had not happened in this case, Dr Chabot was found guilty of an offence under Article 294.

4.97 In the Netherlands a nationwide survey<sup>209</sup> found that about one third of the persistent, explicit requests for euthanasia were agreed to. In the remaining two thirds, alternatives were

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<sup>206</sup>Wijziging van de Wet op de Lijkbezorging No 22572.

<sup>207</sup>**Telegraaf**, 12 May 1993.

<sup>208</sup>Netherlands Supreme Court 21 June 1994 [1994] Nederlandse Jurisprudentsie 656.

<sup>209</sup>**Report of the Select Committee** par 121.

found which made the patient's life bearable again, or the patient died naturally before any action was taken. Of all deaths in the Netherlands, 1,8 per cent (that is two thousand three hundred cases annually) were the result of voluntary euthanasia. There were a further four hundred cases (0,3 per cent of all deaths) of assisted suicide. According to the survey there was an increase in the number of cases of voluntary euthanasia. Of the doctors interviewed for the study, fifty-four per cent said that they had practised voluntary euthanasia or had assisted in a suicide; many said that they would be reluctant to do so again, and then only in the face of unbearable suffering and if there was no alternative.

4.98 In November 1997, the Dutch Cabinet introduced a proposal to Parliament that would change the procedure for dealing with end of life decisions in the Netherlands.<sup>210</sup> The principal changes would be to introduce separate procedures for dealing with euthanasia and assisted suicide on the one hand, and end of life decisions without specific request on the other. Euthanasia and assisted suicide will be dealt with by five regional committees, each composed of a doctor, a jurist and an ethicist. These committees will assess whether a doctor has acted with due medical care and would make a preliminary judgement in a given case. The committees will communicate their opinion to the general office of the Public Prosecutions Service. End of life decisions without a specific request will be handled by a separate national committee. The changes will not alter the formal status of euthanasia in Dutch Law.<sup>211</sup>

#### \* **Australia**

4.99 The development in the field of 'physician-assisted termination of life' in the legislature of the Northern Territory of Australia should furthermore be noted. The **Rights of the Terminally Ill Act** came into force on 1 July 1996. The Act made provision for active euthanasia at the request of a terminally ill patient. This Act drew worldwide attention,<sup>212</sup> both critical and

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<sup>210</sup>Joint Press Release of the Ministry of Justice and the Ministry of Health, Welfare and Sport dated 24/11/97.

<sup>211</sup>Chesterman, S "Last rights: euthanasia, the sanctity of life, and the law in the Netherlands and the Northern Territory of Australia" 1998 **International and Comparative Law Quarterly** 362 (hereinafter referred to as "Chesterman").

<sup>212</sup>"Renewed protest over Australia's euthanasia laws" **Pretoria News** 7 January 1997,7.

supportive. On 24 March 1997 the Act however became void as the Australian Federal Parliament voted by a narrow margin of thirty-eight votes to thirty-four to overturn it by passing the **Euthanasia Laws Bill 1996** (the Andrews' Private Members Bill). Since the Bill removed the Territory's power to make laws permitting euthanasia, the vote set the scene for continuing controversy over the rights of states and territories to make their own laws and the constitutional powers of the Commonwealth to veto these laws.<sup>213</sup> Although the Australian Medical Association welcomed this new development, it is being suggested that Parliament's will on the matter runs counter to the current views of most Australians.<sup>214</sup> Doctors from both sides of the euthanasia lobby are however united in their calling for better funding for and access to palliative care services.<sup>215</sup> Although the act has been overturned, it is, for the sake of completeness, of more than passing interest to refer briefly to its provisions.

4.100 The **Rights of the Terminally III Act** provided that a patient who, in the course of terminal illness, is experiencing pain, suffering or distress to an unacceptable extent, may request his or her medical practitioner for assistance in terminating his or her life.<sup>216</sup>

4.101 A medical practitioner who receives such a request from a patient may, subject to section 8, assist the patient to terminate his or her life if the medical practitioner is satisfied that the conditions of section 7 have been met. The medical practitioner may also deny the request for such assistance.<sup>217</sup>

4.102 Before turning to sections 7 and 8, some of the terminology used in sections 4 and 5 needs

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<sup>213</sup>**The Australian** March 26 1997,12; State legislation unlike territory legislation is unassailable.

<sup>214</sup>**Roy Morgan Gallup Research Report** 18 February 1997; **The Australian** March 26 1997,12;

<sup>215</sup>Comments made by Dr Robert Marr, national spokesperson for the Coalition for Voluntary Euthanasia, as reported in **The Sydney Morning Herald**, March 26, 1997 and Dr Keith Woollard, President of AMA, **Australian Medical Association media release** 25 March 1997.

<sup>216</sup>Section 4.

<sup>217</sup>Section 5.

clarification:

The Act defines "assist" to include the prescription of a substance and the giving of a substance to the patient for self-administration and the administration of the substance to the patient. The Act therefore covers both active voluntary euthanasia and assisted suicide.

"Terminal illness" is defined as an illness which, in reasonable medical judgment will, in the normal course and without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient.

4.103 We now return to the conditions laid down by section 7 under which a medical practitioner may render the aforesaid assistance. Section 7 reads as follows:

#### 7. CONDITIONS UNDER WHICH MEDICAL PRACTITIONER MAY ASSIST

(1). A medical practitioner may assist a patient to end his or her life only if all of the following conditions are met:

- (a) The patient has attained the age of 18 years;
- (b) The medical practitioner is satisfied, on reasonable grounds, that -
  - (i) The patient is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient;
  - (ii) In reasonable medical judgment, there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and
  - (iii) Any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object of allowing the patient to die a comfortable death;
- (c) Two other persons, neither of whom is a relative or employee of, or a member of the same medical practice as the first medical practitioner or each other -
  - (i) One of whom is a medical practitioner who holds prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering; and
  - (ii) The other, who is a qualified psychiatrist,

have examined the patient and have -



- (iii) In the case of the medical practitioner referred to in subparagraph (i), -

confirmed -

- (a) The first medical practitioner's opinion as to the existence and seriousness of the illness;
- (b) That the patient is likely to die as a result of the illness; and
- (c) The first medical practitioner's prognosis; and

- (iv) In the case of the qualified psychiatrist referred to in subparagraph (ii) -

that the patient is not suffering from a treatable clinical depression in respect of the illness;

- (d) The illness is causing the patient severe pain or suffering;
- (e) The medical practitioner has informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available to the patient;
- (f) After being informed as referred to in paragraph (e), the patient indicates to the medical practitioner that the patient has decided to end his or her life;
- (g) The medical practitioner is satisfied that the patient has considered the possible implications of the patient's decision to his or her family;
- (h) The medical practitioner is satisfied, on reasonable grounds, that the patient is of sound mind and that the patient's decision to end his or her life has been made freely, voluntarily and after due consideration;
- (i) The patient, or a person acting on the patient's behalf in accordance with section 9, has, not earlier than 7 days after the patient has indicated to his or her medical practitioner as referred to in paragraph (f), signed that part of the certificate of request required to be completed by or on behalf of the patient;
- (j) The medical practitioner has witnessed the patient's signature on the certificate of request or that of the person who signed on behalf of the patient, and has completed and signed the relevant declaration on the certificate;
- (k) The certificate of request has been signed in the presence of the patient and the first medical practitioner by another medical practitioner (who may be the medical practitioner referred to in paragraph (c)(i) or any other medical practitioner) after

that medical practitioner has discussed the case with the first medical practitioner and the patient and is satisfied, on reasonable grounds, that the certificate is in order, that the patient is of sound mind and the patient's decision to end his or her life has been made freely, voluntarily and after due consideration, and that the above conditions have been complied with;

- (l) Where, in accordance with subsection (4), an interpreter is required to be present at the signing of the certificate of request, the certificate of request has been signed by the interpreter confirming the patient's understanding of the request for assistance;
  - (m) The medical practitioner has no reason to believe that he or she, the countersigning medical practitioner or a close relative or associate of either of them, will gain a financial or other advantage (other than a reasonable payment for medical services) directly or indirectly as a result of the death of the patient;
  - (n) Not less than 48 hours has elapsed since the signing of the completed certificate of request;
  - (o) At no time before assisting the patient to end his or her life had the patient given to the medical practitioner an indication that it was no longer the patient's wish to end his or her life;
  - (p) The medical practitioner himself or herself provides the assistance and/or is and remains present while the assistance is given and until the death of the patient.
- (2) In assisting a patient under this Act a medical practitioner shall be guided by appropriate medical standards and such guidelines, if any, as are prescribed, and shall consider the appropriate pharmaceutical information about any substance reasonably available for use in the circumstances.
- (3) Where a patient's medical practitioner has no special qualifications in the field of palliative care, the information to be provided to the patient on the availability of palliative care shall be given by a medical practitioner (who may be the medical practitioner referred to in subsection (1)(c)(i) or any other medical practitioner) who has such special qualifications in the field of palliative care as are prescribed.
- (4) A medical practitioner shall not assist a patient under this Act where the medical practitioner or any other medical practitioner or qualified psychiatrist who is required under subsection (1) or (3) to communicate with the patient does not share the same first language as the patient, unless there is present at the time of that communication and at the time the certificate of request is signed by or on behalf of the patient, an interpreter who holds a prescribed professional qualification for interpreters in the first language of the patient.

4.104 Section 8 of the Act provides a further safeguard. It reads as follows:

## 8. PALLIATIVE CARE

(1) A medical practitioner shall not assist a patient under this Act if, in his or her opinion and after considering the advice of the medical practitioner referred to in section 7(1)(c)(i), there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient.

(2) Where a patient has requested assistance under this Act and has subsequently been provided with palliative care that brings about the remission of the patient's pain or suffering, the medical practitioner shall not, in pursuance of the patient's original request for assistance, assist the patient under this Act. If subsequently the palliative care ceases to alleviate the patient's pain and suffering to levels acceptable to the patient, the medical practitioner may continue to assist the patient under this Act only if the patient indicates to the medical practitioner the patient's wish to proceed in pursuance of the request.

4.105 Section 10 of the Act further provides that a patient may rescind a request for assistance under this Act at any time and in any manner. In such an event the medical practitioner concerned shall destroy the original certificate of request.

4.106 During the brief period of the Act's existence, four people ended their lives by medically assisted suicide. The Senate rejected an amendment to the Bill that would have allowed a further two terminally ill suffering patients which had completed the required procedures, to die in the manner and at the time of their choosing. A voluntary euthanasia Bill is slowly being debated in the South Australian Legislative Council<sup>218</sup>

### (iii) Assisted suicide v active euthanasia

4.107 In our discussion so far, a distinction has been made between cases of assisted suicide (par. (C)), and cases where the patient requires active assistance in ending his or her life and where the final act is performed by the person granting the request. (par. (D))

4.108 It is however important to establish whether any real distinction, whether moral or legal, can be drawn between the two sets of cases. Is it not true that in both cases the person to whom the request was directed, performed the act, and was the intention in both cases not to cause death? Although commentators agreed that there is no general intrinsic moral difference between

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<sup>218</sup>South Australian Voluntary Euthanasia Society.

the two (given informed consent by the patient, assistance by another, and the same outcome), they felt that one could however still argue that there is an important evidentiary difference between the two and that the distinction could therefore have some value in practice.<sup>219</sup> Assisted suicide is a better test of the voluntariness of the choice to die or of the patient's resolve to end his or her life.<sup>220</sup>

**4.109 The Commission however concludes that both cases presently under discussion are legally speaking versions of active euthanasia and should be dealt with accordingly.<sup>221</sup> Should legal reform be necessary, it would be imperative to state clearly that both instances should be determined in the way which will be decided upon. In the discussion hereunder these two cases will be referred to as active euthanasia. This distinguishes these cases from those discussed earlier in this report vis the cessation of medical treatment which is sometimes referred to as passive euthanasia. Care should be taken to keep in mind that we are still dealing with the question whether effect should be given to life-ending decisions by a mentally competent person.**

**iv) Arguments for and against the decriminalisation of active euthanasia**

4.110 The central question in the present case is therefore whether our community would consider a request for euthanasia as reasonable or unreasonable where the consent is given by a mentally competent person with full knowledge and understanding of the extent, nature and consequences of his or her consent.

4.111 Arguments for and against voluntary active euthanasia have often been debated and are generally known. In Discussion Paper 71 the Commission referred to the extensive summary of the argument against voluntary euthanasia found in the report of the British House of Lords of 1994 and quoted fully from the relevant section of the report as well as the justification for the

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<sup>219</sup>Prof S Benatar et al, Dr Willem Landman.

<sup>220</sup>Dr Willem Landman.

<sup>221</sup>Chesterman at 364; Scott, H "Assisted suicide and the South African constitutional order" 1998 **Responsa Meridiana** 1998 1(hereinafter referred to as "Scott") at 3.

decision taken by the committee.<sup>222</sup>

236. The right to refuse medical treatment is far removed from the right to request assistance in dying. We spent a long time considering the very strongly held and sincerely expressed views of those witnesses who advocated voluntary euthanasia. Many of us have had experience of relatives or friends whose dying days or weeks were less than peaceful or uplifting, or whose final stages of life were so disfigured that the loved one seemed already lost to us, or who were simply weary of life. Our thinking must inevitably be coloured by such experience. The accounts we received from individual members of the public about such experiences were particularly moving, as were the letters from those who themselves longed for the release of an early death. Our thinking must also be coloured by the wish of every individual for a peaceful and easy death, without prolonged suffering, and by a reluctance to contemplate the possibility of severe dementia or dependence. We gave much thought too to Professor Dworkin's opinion that, for those without religious belief, the individual is best able to decide what manner of death is fitting to the life which has been lived.

237. Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover, dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.

238. One reason for this conclusion is that we do not think it possible to set secure limits on voluntary euthanasia. Some witnesses told us that to legalise voluntary euthanasia was a discrete step which need have no other consequences. But as we said in our introduction, issues of life and death do not lend themselves to clear definition, and without that it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused. Moreover to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by

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<sup>222</sup>**Report of the Select Committee** par 236 and further as referred to in Discussion Paper 71 page 37; see also Kapp, M B "'Ageism' and the right to die litigation" 1994 **Med Law** 69; Rougé, D Telmon, N, Albarède, J-L & Arbus, L "Questions raised by artificial prolongation of life of the aged patient" 1994 **Med Law** 269.

inadvertence, or by the human tendency to test the limits of any regulation. These dangers are such that we believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address. Fear of what some witnesses referred to as a "slippery slope" could in itself be damaging.

239. We are also concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. We accept that, for the most part, a request resulting from such pressure or from remediable depressive illness would be identified as such by doctors and managed appropriately. Nevertheless we believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.

240. Some of those who advocated voluntary euthanasia did so because they feared that lives were being prolonged by aggressive medical treatment beyond the point at which the individual felt that continued life was no longer a benefit but a burden. But, in the light of the consensus which is steadily emerging over the circumstances in which life-prolonging treatment may be withdrawn or not initiated, we consider that such fears may increasingly be allayed. We welcome moves by the medical professional bodies to ensure more senior oversight of practice in casualty departments, as a step towards discouraging inappropriately aggressive treatment by less experienced practitioners.

241. Furthermore, there is good evidence that, through the outstanding achievements of those who work in the field of palliative care, the pain and distress of terminal illness can be adequately relieved in the vast majority of cases. Such care is available not only within hospices: thanks to the increasing dissemination of best practice by means of home-care teams and training for general practitioners, palliative care is becoming more widely available in the health service, in hospitals and in the community, although much remains to be done. With the necessary political will such care could be made available to all who could benefit from it. We strongly commend the development and growth of palliative care services.

242. In the small and diminishing number of cases in which pain and distress cannot be satisfactorily controlled, we are satisfied that the professional judgment of the health-care team can be exercised to enable increasing doses of medication (whether of analgesics or sedatives) to be given in order to provide relief, even if this shortens life. The adequate relief of pain and suffering in terminally ill patients depends on doctors being able to do all that is necessary and possible. In many cases this will mean the use of opiates or sedative drugs in increasing doses. In some cases patients may in consequence die sooner than they would otherwise have done but this is not in our view a reason for withholding treatment that would give relief, as long as the doctor acts in accordance with responsible medical practice with the objective of relieving pain or distress, and with no intention to kill.

243. Some witnesses suggested that the double effect of some therapeutic drugs when given in large doses was being used as a cloak for what in effect amounted to widespread euthanasia, and suggested that this implied medical hypocrisy. We reject that charge while

acknowledging that the doctor's intention, and evaluation of the pain and distress suffered by the patient, are of crucial significance in judging double effect. If the intention is the relief of severe pain or distress, and the treatment given is appropriate to that end, then the possible double effect should be no obstacle to such treatment being given. Some may suggest that intention is not readily ascertainable. But juries are asked every day to assess intention in all sorts of cases, and could do so in respect of double effect if in a particular instance there was any reason to suspect that the doctor's primary intention was to kill the patient rather than to relieve pain and suffering. They would no doubt consider the actions of the doctor, how they compared with usual medical practice directed towards the relief of pain and distress, and all the circumstances of the case. We have confidence in the ability of the medical profession to discern when the administration of drugs has been inappropriate or excessive. An additional safeguard is that increased emphasis on team work makes it improbable that doctors could deliberately and recklessly shorten the lives of their patients without their actions arousing suspicion.

244. We could add that the effects of opiates (the drugs most commonly involved in double effect) and of some other pain-relieving and sedative drugs are so uncertain that the outcome of a particular dose can never be predicted with total confidence. The body weight, metabolism, habituation and general condition of the individual patient all affect the response. There have been cases where an error in dispensing resulted in the administration of a dose which seemed likely to be lethal, yet the patient flourished. A doctor called to testify in the case of Dr Bodkin Adams asserted that a particular dose must certainly kill, only to be told that the patient had previously been given that dose and had survived. The primary effect (relief of pain and distress) can be predicted with reasonable confidence but there can be no certainty that the secondary effect (shortening of life) will result. Decisions about dosage are not easy, but the practice of medicine is all about the weighing of risks and benefits.

4.112 The British Government responded to the report of the House of Lords Select Committee in May 1994<sup>223</sup> supporting most of its recommendations. In the instances where it did not agree, the Government held more conservative views. The British Government has subsequently reiterated its opposition to changing the law in relation to euthanasia in written answers in Parliament in April 1995<sup>224</sup> and January 1996.<sup>225</sup>

4.113 In Discussion Paper 71 the arguments set out in the Select Committee Report were

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<sup>223</sup>**Cica N Euthanasia - the Australian law in an international context Part 2: active voluntary euthanasia** Research Paper 4 Department of the Parliamentary Library Australia 1996-97 (hereinafter referred to as "Cica 4").

<sup>224</sup>Following the passing of the **Death with Dignity Act** 1994 in Oregon.

<sup>225</sup>In response to a question regarding the Government stance towards the Law Commissions' **Report on Mental Incapacity** referred to below.

juxtaposed with those of Professor JMT Labuschagne of the University of Pretoria, an outspoken champion of the decriminalisation of voluntary euthanasia.<sup>226</sup> His arguments in favour of euthanasia were discussed as follows under the following headings:

1. Religious-moral arguments.

Labuschagne points out that the religious and moral objections to euthanasia are based on diverse religious and moral convictions. He identifies with the writer Williams who argues that religious arguments against euthanasia are in themselves not enough. People who do not share particular convictions should not be bound by them. A rule should therefore be necessary for the "worldly welfare of society generally" before it can lay claim to judicial status. He also holds that a deregulating process on a wide front is taking place in the criminal law.

Labuschagne discusses the religious-moral arguments in more depth under the following headings:

(a) God has allocated a specific time of death to every person

He says that it is sometimes argued that God in his Providence has allocated a specific time of death to every person and that man is not supposed to interfere with that. Labuschagne however holds that if this argument is to be taken seriously, the question can then be asked why lives are prolonged artificially by medicine. Medical science is inherently an interference with the processes of nature. He associates himself with the writer Fletcher<sup>227</sup> who indicated that things like sterilisation, artificial insemination and birth control "...are all medically discovered ways of fulfilling and protecting human values and hopes in spite of nature's failures and foolishnesses. Death control, like birth control, is a matter of human dignity."

(b) The prohibition against killing

Labuschagne mentions the fact that it is sometimes argued that euthanasia is incompatible with the

<sup>226</sup>Labuschagne 1988 **THRHR** 167. See also Weinfeld, J "Active voluntary euthanasia - should it be legalised" 1985 **Med Law** 101 at 108 and further.

<sup>227</sup>Op cit 168.



sixth commandment which forbids killing. He however points out that the killing of a person may be lawful in certain circumstances, for example when acting in self-defence. The question is therefore not simply whether a fellow human being has been killed, but rather whether the killing was justified. That is the question that has to be answered.

(c) Suffering has a purpose

The argument is sometimes used, according to Labuschagne, that man should suffer, as suffering has a divine purpose. According to him the opposite principle would be love for one's neighbour, which has as its purpose the lessening or the elimination of human suffering. He associates himself<sup>228</sup> with the writer Mathews where he says:

Nothing could be more distressing than to observe the general degeneration of a fine and firm character into something which we hardly recognize as our friend, as the result of physical causes and of the means adopted to assuage intolerable pain. It is contended that the endurance of suffering may be a means of grace and no Christian would deny this, but I would urge that, in the case of man whose existence is a continuous drugged dream, this cannot be alleged.

2. Diagnostic and prognostic mistakes.

According to Labuschagne a further argument against euthanasia is that doctors are bound to make diagnostic or prognostic mistakes and that people sometimes recover from illness against all expectation. However, Labuschagne notes that in the proposals for the decriminalisation of euthanasia it is almost without exception accepted that the opinion of only one expert medical practitioner will not suffice. It should be the unanimous decision of more than one medical practitioner, in other words a panel. The fact that mistakes will nevertheless still occur, cannot be denied. Mistakes are typical of the human phenomenon and are found everywhere. Only if man should succeed in obliterating himself, would human mistakes cease to happen. In such a case the need for euthanasia would however also cease. According to him the said argument therefore contributes nothing to the euthanasia debate.

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<sup>228</sup>Ibid.

### 3. No illness is incurable.

Labuschagne notes that it is sometimes argued that no illness is inherently incurable: as long as there is life, there is hope. It is argued that medical science may find a cure for a certain illness in future. Against this Labuschagne holds that a person should judge a situation as it stands. He associates himself with Mathews where he says:

We cannot regulate our conduct at all unless we assume that we must be guided by the knowledge we have. We take for granted that known causes will be followed by known effects in the overwhelming majority of cases. Any other assumption would strike at the roots of sanity.

### 4. The thin-end-of-the-wedge argument.

It is sometimes argued, according to Labuschagne, that voluntary euthanasia is only the thin end of the wedge and that it could diminish the value attached to life. Legalisation of voluntary euthanasia could open the door to abuse and even foul play. Labuschagne however refutes this argument by saying that it could also be applicable to any other human action. To use an analogy: freedom of speech should be forbidden as it could lead to slander. Nobody can take such an argument seriously.

### 5. Medical-ethical arguments.

According to Labuschagne the following subdivisions of this argument can be distinguished:

#### (a) The Oath of Hippocrates is violated

It is sometimes submitted that euthanasia is in conflict with the Oath of Hippocrates that doctors have to take before practising medicine. Labuschagne, however, asks the question whether it is meaningful to be bound to an oath that is more than two thousand years old. If so, the oath should be adapted. In any case, the Oath of Hippocrates should be interpreted progressively, as the duty of the medical practitioner is not only to cure illness, but also to eliminate suffering.

## (b) Trust in medical science is violated

According to Labuschagne, it is sometimes submitted that legalising euthanasia (especially active euthanasia) would violate the trust of the population in the medical practitioner and in medical science. It is alleged that patients would see medical practitioners as executioners and not as doctors. In answer to this argument Labuschagne notes that the patient's consent is a requirement in all cases and that mechanisms have been built into the euthanasia process to prevent abuse.

## (c) Euthanasia assists organ transplants

The argument is sometimes raised that the legitimisation of euthanasia will enable doctors to obtain prime human organs on order, so to speak. Although Labuschagné concedes that organ transplants might benefit should euthanasia be legitimised, he nevertheless argues that this should never be used as justification for euthanasia.<sup>229</sup>

## (d) The problem of consent

Labuschagne explains that the problem in this case is that the consent to euthanasia given by the patient while he is in pain, suffering and facing death, and accordingly in a state of anxiety and depression, may be questionable. Can it really be regarded as voluntary? There is a difference between the expression of a desire to die and a request to be killed. A British study showed that requests to be killed should not always be taken seriously as they are often intended as cries for help and attention. Although Labuschagne concedes that since factors such as pain, illness, drugs and a range of other circumstances may have an effect on a person's mental state, the patient should be evaluated throughout. There should be compulsory consultation between and supervision by experts. The doctor should inform his or her patient as to the diagnosis and prognosis of the illness. This should however only be done should the patient request the information. The information needn't be given all at once. Consent given after having obtained sufficient information is known as informed consent. According to Labuschagne, the concept of informed consent is based on the principles of human individuality, dignity and autonomy and

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<sup>229</sup>Op cit 189.

forms one of the fundamental tenets of euthanasia.

4.114 Labuschagne<sup>230</sup> is of the opinion that voluntary euthanasia should be legalised. He proposes legislation that would legalise cessation of treatment as well as active euthanasia and suggests the following criteria:

- (a) The patient must be suffering from a **terminal** illness;
- (b) the suffering must be subjectively **unbearable**;
- (c) the patient must **consent** to the cessation of treatment or administering of euthanasia;
- (d) the above-mentioned condition and facts must be **certified** by at least two medical practitioners.

4.115 Labuschagne is also of the opinion that it would be preferable, in order to eliminate any question of criminal liability, to approach the Supreme Court, if possible before performing the act of euthanasia, in order to obtain a declaratory order that all conditions have been met.

4.116 It is therefore clear that Labuschagne wants to control euthanasia and wants to make it permissible only in cases where the necessary certificate has been issued by at least two medical practitioners. It can be assumed that he also intends the act of euthanasia to be performed by a medical practitioner only. This does not however mean that non-medical euthanasia would always be inadmissible. The common law principles with regard to necessity would be applicable in appropriate cases to justify non-medical euthanasia. Labuschagne refers to two hypothetical examples in this regard:

- (a) The driver A of a motor vehicle is trapped in his burning car. He requests B to kill him as he does not want to burn to death. B takes his revolver and kills A.
- (b) C, a soldier, lies on the battlefield, seriously wounded. As the enemy draws nearer

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<sup>230</sup>Op cit 190.

he asks his friend D to kill him in order to escape a torturous death at the hands of the enemy. D kills him.

Labuschagne is of the opinion that neither B nor D is criminally liable. Both have acted in what is legally known as necessity.

4.117 Labuschagne finally states that his recommendations are based on respect for human dignity and compassion for fellow human beings who have been exposed to great suffering and affliction. The accent therefore falls on the sacredness of the quality of life rather than the sacredness of life per se. He associates himself with Fletcher:<sup>231</sup>

[I]t is harder morally to justify letting somebody die a slow and ugly death dehumanised than it is to justify helping to avoid it.

4.118 He also quotes from Dowling, evidently with approval:<sup>232</sup>

By the bed of an actual sufferer the proportions of the problem are seen quite differently. It becomes no longer a question of the sanctity of 'life' and the need to prolong suffering existing just as long as it is technically possible, but a case in which the compelling demands of compassion and dignity combine to impose merciful death as the only natural solution.

4.119 The Commission tried to state the argument for and against euthanasia with the necessary thoroughness. However, since the decision as to whether active voluntary euthanasia and assisted suicide should be allowed is one of policy the Commission requested guidance from its readers on this question.

#### **b) Discussion of submissions received:**

4.120 The Commission received a tremendous amount of feedback on this question. Submissions received came from a broad spectrum of the public including individuals and organisations from the medical, religious and legal fraternities as well as from ordinary members of the public.

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<sup>231</sup>Op cit 191.

<sup>232</sup>Op cit 191.

Respondents were divided almost equally in their response to this question. There were respondents who totally rejected the idea of active euthanasia.<sup>233</sup> Others gave their unequivocal or sometimes conditional support to this option.<sup>234</sup> It was also found that there were instances where persons in a specific organisation could not reach a unanimous decision and either sent in a majority report<sup>235</sup> or sent in submissions arguing both sides of the issue.<sup>236</sup> There were submissions that included published material and the Commission also received two petitions.<sup>237</sup>

4.121 The rationales to be discussed below formed the basis upon which most commentators expressed their views regarding the question whether a mentally competent patient suffering from a terminal or intractable and unbearable disease should be allowed to receive assistance in ending his or her life. The Commission received submissions stating both sides of each rationale and it is therefore related in the same way here. The rationales will first be discussed in principle and then tested against the rights enshrined in the Constitution. Finally attention will be given to the practical question whether it would be possible to have sufficient safeguards to prevent abuse if euthanasia could be accepted in principle.

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<sup>233</sup>See eg. Pro-life; The World Federation of Doctors who Respect Human Life; Human Life International South Africa; Dr T Germond; Rev Vivian Harris, Executive Secretary, Methodist Church; United Christian Action; Doctors for Life; ACDP ; Gerda Strauss, North West Region, CANSA; Prof JG Swart, Dr Elizabeth Murray; SA National Consumer Union; Islamic Medical Association of SA; Christian Medical Fellowship of SA; Christian Doctors in SA; Christian Lawyers Association; SA Medical and Dental Council; Hospice Association; SACBC Parliamentary Liaison Office; Covenant Life Church; SA Council of Churches; Free Church in SA; Gereformeerde Kerk in SA; Nederduits Gereformeerde Kerk; African Christian Action; Office of the Chief Rabbi; International Fellowship of Christian Churches.

<sup>234</sup>See eg. NPPCHN; Soroptomists; Department of Health; National Council of Women of South Africa; Dr Glenda Hicks, educational and counseling psychologist; Prof S Benatar et al; J Barker; Shirley Firth; JL Booysen; Karen & Tony Crossland; HJ Stockwell; Herman Vos; Dr DG Catton; S Myburgh; UM Lyle; DP Strydom; D Simpson et al; K Miesner.; SA Nursing Council; Society of Neurosurgeons of South Africa; National Association of People with Aids (hereinafter referred to as "NAPWA"); The Hospital Association; B Kali; D Moelendorf.

<sup>235</sup>See eg. Southern African Anglican Theological Commission (Cape Town).

<sup>236</sup>CANSA; MASA; National Council for People with Disabilities; Society of Advocates of Natal.

<sup>237</sup>81 persons signed in favour of active euthanasia; 210 persons signed against active euthanasia.

i) Religious and philosophical beliefs

aa) Arguments of commentators against active euthanasia

4.122 Many religious denominations and organisations as well as individual persons in South Africa recorded their opposition to euthanasia on religious grounds.<sup>238</sup> It was stated that according to the Bible God is the creator of life and therefore the only One who may give or take the life of a human being.<sup>239</sup> Similar passages are found in the Noble Qur'an affirming the fact that both life and death are in the control of Allah: "Say (O Muhammad): It is Allah Who gives you life, then causes you to die...".<sup>240</sup>

4.123 The Commission was specifically referred to the views of the Roman Catholic Church on the preservation of life (which also summarises the views expressed by many other denominations)

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<sup>238</sup>See eg The Right to Live Campaign, Kwazulu-Natal; National Council for Persons with Physical Disabilities; Christian Coalition; ACDP; Christian Medical Fellowship of SA; United Christian Action; Methodist Church; SACBC; Covenant Life Church; Ned Gereformeerde Kerk; Human Life International SA; Africa Christian Action; Office Of the Chief Rabbi; Free Church in SA; Die Administratiewe Buro van die Gereformeerde Kerke in SA; South African Council of Churches; Pro-Life; International Fellowship of Christian Churches; Christian Lawyers Association; Muslim Lawyers Association.

<sup>239</sup>Nederduits-Gereformeerde Kerk; F Lobinger, Bishop of the Aliwal Diocese; Herman Selolo; Solomon Tlou Moloto; Wilson N Makhwiting; John Mahlangu; T Pather; Rev Justin Swanson; Dr HJC du Plessis; Ian Thomson, Minister Presbyterian Church; J Murray; G Murray; Dr JV Larsen; R Higgins; HMJ van Rensburg; The Right to Live Campaign: Kwa Zulu Natal; Prof JG Swart; SP Nhlabathu; Y Potgieter; Rev J Swanson; Craig Brady.

<sup>240</sup>Qur'an 45:26 as referred to in Ebrahim, AFM "The Noble Qur'an on the end of Human Life" **al-'ilm** Vol 16, 1996.

as set out in the Catechism of the Catholic Church<sup>241</sup> and explained in six principles.<sup>242</sup> It was furthermore pointed out that Islamic Law equates active inducement of death to an act of murder<sup>243</sup> and that according to the South African Hindu Maha Sabha<sup>244</sup> Hindus would not opt for a voluntary death. Judaism espouses the principle that the Almighty gave each person a body

<sup>241</sup>An act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his creator. The error of judgement into which one can fall in good faith does not change the nature of the murderous act, which must always be forbidden and excluded. (Paragraph 2277).

<sup>242</sup>1) Mankind is created in the image and likeness of God. Therefore human life is an intrinsic good of the person. Human life is qualitative rather than quantitative and is not primarily a proportionate or utilitarian or negotiable good.

2) Do not directly kill the innocent. One may not do evil to achieve good. Indirect death may be tolerated but never directly willed. That is, it may be foreseen but not intended. Examples of indirect killing or killing of the guilty are civilians who become tolerable casualties in war when self-defence against aggression is employed, baby dies when a mother has her cancerous uterus removed and the criminal to be executed is not innocent.

Examples of direct killing of innocents which are forbidden are obliteration bombing or torturing of hostages (doing evil to force the good of surrender), active euthanasia, abortion, failing to give quite ordinary help to a victim.

3) Ordinary means to preserve life are morally obligatory while extraordinary means are not. Ordinary and extraordinary means will vary somewhat from culture to culture depending on resources.

4) Human life is valuable in itself, independently of cognitive-affective awareness, productivity and functional contributions. Quality of life is not quantifiable and is not the criterion for treatment. Treatment is based on whether it works as care not necessarily as cure.

5) Death, a result of sin, not proper to the being and not "natural" except in the colloquial use of the term must be resisted. Hence it is not technically a "right" or a result of a positive "dying process". Suicide and assisted suicide are therefore immoral.

6) Medication may be administered as palliative care to relieve suffering even though indirectly the patient's life may be shortened. Death is a side-effect not a directly-chosen one.

<sup>243</sup>Islamic Medical Association of SA; MY Abdul Karrim of the Imam Ahmed Raza Academy as quoted in a newspaper article in the The Leader 25 April 1997 supra.

<sup>244</sup>Taking a life is not in accordance with the concept of non-violence which is the Hindu way of life stated Raghbeer Kallideen of the Sabha in the abovementioned article. According to the belief of the larger section of the Hindu community, death and suffering are co-related to *karma* and the individual in turn is bound by *karma*. Interfering with the process would therefore not be advisable - for it is bound to have an adverse effect on the future *karma* (as does suicide).



and a soul for a given time and it is one's duty when the time comes to return both to the maker.<sup>245</sup> Bishop Lekganjane<sup>246</sup> stated that God, the Almighty, is the creator of everything that is in this world. He is also the creator of the intelligentsia. Medical practitioners will not be able to prolong or end life if it is not His will that it would happen.

4.124 The Commission was also referred to various scriptures in support of the opposition to active euthanasia<sup>247</sup> Respondents furthermore referred the Commission to two instances in the Bible where a form of euthanasia was practised.<sup>248</sup>

4.125 Concern was furthermore expressed that a person may be punished in the afterlife if he or she commits suicide or murder. Such a price would be too high to pay simply to end someone else's strictly temporary suffering (however acute it may be) either by killing them or assisting in their suicide.<sup>249</sup>

bb) Arguments of commentators in favour of active euthanasia

4.126 It was clear from the submissions received that the question regarding the role that religious belief should play in this issue could be addressed in various ways.

<sup>245</sup>Office of the Chief Rabbi.

<sup>246</sup>His Grace Bishop BE Lekganyane "Euthanasia/Prolongation of life by artificial means(the religious aspects)speech delivered at the workshop of the SA Law Commission 22 June 1994, para10.1, p7.

<sup>247</sup>Exodus 20:13: "Thou shalt not kill" was quoted many times; Other references include Gen 1:27; John 3:16; 1 Corinthians 6:19; I Joh 3:15; Kings 16:1-23; Joh 15:4-5; 2 Sam 1:1-16; 1 Sam 31:3-5; Jdgg 9:24; Jdg 9:54-57; Job 14:5; Pred 3:1-2; Gen 9:6; Ex 23:7: "Do not put an innocent or honest person to death, for I will not acquit the guilty".

<sup>248</sup>Both Saul (2 Sam 1:1-16) and Abimelek (Judges 9:54-57)died, after being mortally wounded, by requesting a third person to release them from their suffering and shame . The Amalekite who killed Saul was punished by King David but nothing is said about the weapon carrier who assisted Abimelek.

<sup>249</sup>Mabotja Gosher; R Higgins; CJG du Toit; Ceu Vieira; Y Potgieter; Samson MM Kenna; Christian Coalition.

4.127 The first identifiable response was that religion should play no role at all since religion is just another way of making a living and controlling people's lives <sup>250</sup> and that it amounts to emotional arguments which serve only to confuse issues in what is already a complex debate.<sup>251</sup>

4.128 The second view was that religiously inspired views opposing voluntary euthanasia had to be respected but that religious views held by some should not be allowed to compel others not holding such views to be bound by them. Tolerance was requested to provide rights to those persons who wish to avail themselves of those rights since it would have no effect on religious and other people who prefer not to utilise them.<sup>252</sup>

4.129 A third consideration referred to the growing sense that the new Constitution<sup>253</sup> with its justiciable Bill of Rights, and not sectional moral or religious convictions, should inform public debate and legal reform.<sup>254</sup> Although religious convictions should be respected, they should not be used as a yardstick for making decisions in this regard. The question whether assisted suicide and euthanasia are ethically or morally justifiable practices is separate from the question whether they should be legalised. The answer to the latter can be explored whatever the answer to the former.<sup>255</sup> The distinction between the morality of a practice and the morality of legalising it was emphasised. It was argued that the question of assisted suicide for example, is not one question, but two: (1) Is assisted suicide morally permissible? and (2) Ought assisted suicide to be legal? It is the second question that is the concern of the Law Commission and of those who wish to comment on the draft bill. An affirmative answer to the first question is not required in order to answer the second one affirmatively. In other words, even those who think assisted suicide is wrong, are not committed to thinking that it ought to be illegal.<sup>256</sup>

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<sup>250</sup>Peter Hamilton.

<sup>251</sup>Voluntary Euthanasia Society, England.

<sup>252</sup>See also discussion below.

<sup>253</sup>Constitution of the Republic of South Africa Act, 108 of 1996.

<sup>254</sup>Dr Willem Landman.

<sup>255</sup>Dr Willem Landman.

<sup>256</sup>Prof S Benatar et al; Scott on 2.

4.130 In the final instance there were respondents who argued the point from within the Christian perspective. It should be noted that the fact that they were Christians did not preclude many respondents from stating their support for active euthanasia under specific circumstances.<sup>257</sup>

4.131 In a comprehensive submission received for the Anglican Archbishop of Cape Town specific principles were suggested as guidelines in this question.<sup>258</sup> It was further stated that an action designed to bring to an end life which comes as a gift from God entails serious moral problems. It is therefore impossible to provide hard and fast rules which will be universally valid. It was felt that even the distinction between passive and active euthanasia is ethically dubious. It was contended that Christians, both patients and carers, must be guided by principles which express the values of the gospel and the teaching of the church. Specific recommendations

<sup>257</sup>See eg. J de Necker; PC de Vries.

<sup>258</sup>1)A Christian's ethical action is guided on the one hand by one's understanding of precepts deriving from the Old and New Testaments and on the other hand by the duty to show love, both to individuals and to society at large. The latter principle may authorise Christians to disregard a normally observed precept for the sake of displaying love.

2) The moral value of any action is determined largely by the intention of the agent.

3) All life is a gift from God and therefore ultimately belongs to God. It may not be disposed of *merely* at the wish either of oneself or of someone else.

4) Every human being, created in the image of God (Gen 9:6) is of infinite value. Consequently a higher or lower value cannot be attributed to some people because of their innate physical or racial characteristics.

5) Living human beings are single organisms in which there can be no dualism between soul and body. Death is not to be feared neither is life to be clung to at all costs. Indeed death is to be preferred to a renunciation and denial of faith in Christ, and sometimes ought to be chosen for the sake of the life of others.

6) The weak and infirm, the sick, the disabled and the dying deserve special care and attention.

7) Carers have a moral duty to eliminate or mitigate suffering, wherever possible, whether such suffering is physical, mental or emotional.

8) Medical doctors and professional nurses are especially obliged to preserve life, but not necessarily to prolong it by all available means.

9) The needs of society as a whole must be considered, so that regard must be paid to justice or equity in the distribution of available health care resources within the community.

10) The principle of love demands that everything possible be done to reduce the suffering and distress of terminally ill patients. Therefore life should not be artificially prolonged at the cost of continued suffering, or at the cost of consuming resources which could be used for the benefit of others.

regarding the Christian Attitude to Euthanasia were set out.<sup>259</sup>

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- <sup>259</sup>(a) Since life is a gift from God, Christians have a prima facie obligation not to take their own lives except when the giving of their life is to save others. A terminally ill patient may therefore ask for his or her death to be hastened in order to enable other patients to benefit from the available resources.
- (b) Medical doctors and professional nurses must at all times follow their conscience. In principle they may not take active steps to hasten death, though they should respect the patient's wish to have treatment discontinued unless they have reason to believe that such action would not be in the patient's interest. Their intention in any case must be to minimize suffering, not to hasten death.
- (c) Carers are obliged to eliminate or reduce unnecessary suffering. Therefore, when the life of a terminally ill patient can be prolonged only at the expense of additional or continued suffering, treatment may, or perhaps should, be discontinued. The intention in such cases is to reduce suffering, even though the result may be the patient's earlier death. In no case should patients be kept alive for the sake of the doctor's reputation.
- (d) Although a patient may not cause his or her own death, the decision to withhold treatment aimed to prolong life should be taken only with the consent of the patient, or in the case of incompetence, with the consent of the patient's next of kin. Common Law respects the autonomy of a patient to refuse to submit to a surgical operation, even though such surgery may lead to a prolongation of life. Similarly, a patient's autonomy must be respected when the patient requests the withdrawal of life-sustaining treatment, either in the course of a terminal illness or as expressed in a Living Will ("advance directive"), provided that the terms of the directive can be clearly interpreted.
- (e) Medical doctors and professional nurses must at all times follow their conscience. They may not take active steps to hasten death, though they should respect the patient's wish to have treatment discontinued unless they have reason to believe that such action would not be in the patient's interest. Their intention in any case must be to minimize suffering, not to hasten death.
- (f) An advance directive expressing a patient's desire not to be kept alive by artificial means when dying, should be respected by doctors, unless they conscientiously believe that treatment leading to a prolongation of life would be beneficial to the patient, and provided that the terms of the directive are clearly expressed.
- (g) In the case of patients existing in a vegetative state for a prolonged period serious consideration should be given to withdrawing life-supporting devices, since the likelihood of restoration to a reasonable life, or even to any form of life, is minimal. Each case needs to be considered on its merits, since examples of PVS patients regaining some form of consciousness after several years are not unknown. Even in such cases, however, consideration needs to be given to the quality of life of such patients. Patients who have been pronounced to be "brain dead" by two or more doctors should not receive life-sustaining treatment.
- (h) The financial expense of prolonging the life of a terminally ill patient, and especially of a PVS patient, should be considered in relation to the cost of providing health care to many other patients who may die if they do not receive

4.132 Finally it was argued that the guidelines and recommendations should be taken into account in coming to a conclusion. It was stated that the giving of a lethal injection to a terminally ill patient is prima facie ethically culpable and legally murder. Specific note was taken of the report of the British House of Lords Select Committee in stating that the prohibition of intentional killing "is the cornerstone of law and social relationships" and that "the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole". It was nevertheless contended that situations may exist in which the patient's suffering is so severe and the patient's desire for an early release so sincere that it would be right to accede to the patient's request for an early ending of his or her life. The sixth commandment does not prohibit killing. It prohibits murder and culpable homicide. Reference to it therefore begs the question in a discussion on the ethics of euthanasia.<sup>260</sup>

ii). Sanctity of life

4.133 Although this term may seem specifically religious, it is discussed separately since it is held to transcend religion. It encompasses but is not restricted to religious conviction. It holds that human life is created in the image of God and is, therefore, possessed of an intrinsic dignity which entitles it to protection from unjust attacks.<sup>261</sup> The principle can however also be articulated in

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appropriate treatment. The welfare of the community may well have to take precedence over the prolongation of life of a terminally ill patient if life can be prolongation only at great expense and the use of valuable resources, both material and personal, which could be better employed in the provision of better health care to the community at large.

- (i) Different ethical considerations may apply to babies born with gross abnormalities:
  - (a) In the case of those born with such abnormalities that they are unlikely to live for more than a few days or months, the above guide-lines should be observed.
  - (b) Other considerations apply to those born with severe abnormalities which do not necessarily lead to an early death. Each case must be considered on its own merits.

<sup>260</sup>Southern African Anglican Theological Commission (Cape Town).

<sup>261</sup>Keown, J "Restoring moral and intellectual shape to the law after Bland" 1997 **The Law Quarterly Review** 481 (hereinafter referred to as "Keown"); Christian Medical Fellowship of SA.

non-religious terms in which "inviolability" might be more apt than "sanctity". Indeed a prohibition on killing is central to the pre-Christian fount of Western medical ethics - the Hippocratic Oath - and many non-believers recognise the right of human beings not to be intentionally killed. It can also be phrased as "inviolability of human life" or respect for human life.<sup>262</sup>

aa) Arguments of commentators against active euthanasia

4.134 Opponents of euthanasia rely strongly on the principle of the "sanctity of life". Euthanasia is regarded as being incompatible with the reverence for the sacredness of life.<sup>263</sup>

4.135 Respondents argue that legalising euthanasia would require a complete change in the whole common law understanding of the prohibition of murder<sup>264</sup> since the principle of the sanctity of human life has been the bulwark in every civilisation against the arbitrary destruction of the weak and helpless.<sup>265</sup> In South Africa there is a desperate need of inculcating a reverence for life in our citizens.<sup>266</sup> It was said that our society is struggling to recover from social engineering. We shouldn't now fall into life-and death engineering.<sup>267</sup>

4.136 Human life would no longer be precious if its value is relative to its usefulness to society and to the convenience of those around it. By moving to legalise the killing of humans if their quality of life is deemed to be poor, South Africa would be eroding the value of human life. Arbitrary questions that will have to be answered would be how the quality of life will be defined and who will determine the quality of life of a specific individual.<sup>268</sup>

<sup>262</sup>Keown on 483.

<sup>263</sup>The Right to Live Campaign, Kwazulu Natal; Ian Thomson, Minister of Pine Town Presbyterian Church.

<sup>264</sup>(Fr) Hyacinth Ennis.

<sup>265</sup>Dr J V Larsen.

<sup>266</sup>SK Schonegevel.

<sup>267</sup>Ian Thomson.

<sup>268</sup>United Christian Action; ACDP.

4.137 It was stated that the only acceptable exceptions to the prohibition against killing are self-defence, both of the individual and the community (armed conflict) and the judicial execution of murderers.<sup>269</sup> These exceptions all have as their aim a positive good, either of one's own bodily well-being or the well-being of others, as in self-defence. The good gained or preserved must at least be equal to the good lost - the life of the assailant.<sup>270</sup>

bb) Arguments of commentators in favour of active euthanasia

4.138 Respondents noted that there appears to be no genuinely comprehensive concept of the "sanctity of life". Even those who invoke it as if it pre-empted further discussion, usually in the context of an avowed religious belief, do not in fact present a consistent front. The phrase "respect for life" may reflect the present day consensus on the matter more accurately than the absolutism of "sanctity of life"<sup>271</sup>

4.139 It has always proved hard to construct any absolute philosophical argument against a person's right to waive the right to his own life, except by reference to a personal God against whom one would be offending.<sup>272</sup> It is however the sacredness of the quality of life that should be accentuated, rather than the sacredness of life per se.<sup>273</sup> Life is sacred by virtue of its quality and not its quantity. As the philosopher, James Rachels observed, it is possible to be alive but have no life.

4.140 All the major religions find certain categories of killing justifiable (war, capital punishment etc.). If sanctity of life was the concern of world leaders, weapons of mass destruction should have been abolished long ago.<sup>274</sup>

<sup>269</sup>United Christian Action.

<sup>270</sup>Rev Justin Swanson.

<sup>271</sup>Voluntary Euthanasia Society, England.

<sup>272</sup>Voluntary Euthanasia Society, England.

<sup>273</sup>Prof Geoffrey Falkson.

<sup>274</sup>Freddie Mashego.

4.141 Much of the argument about the sanctity of human life appears to be based on sentimentality where we acquiesce in a social system where people die daily from starvation, malnutrition or a lack of basic medical resources; a system that allows, for example, advertisements enticing people to smoke to appear, where totally inadequate measures are applied to reduce the slaughter from road accidents, and where no account is taken of the economic cost of maintaining meaningless or unbearably tortured human life.<sup>275</sup>

iii) Dignity of the person

aa) Arguments of commentators against active euthanasia

4.142 As opposed to *dying* with dignity respondents argued a person can *live* with dignity right up to the end. It was contended that in this day and age voluntary euthanasia is unnecessary because alternative treatments exist. Good palliative care should do away with the need for active euthanasia in the vast majority of cases.<sup>276</sup> The Hospice Movement has proved itself in this regard.<sup>277</sup>

4.143 Meticulous research in palliative medicine has in recent years shown that virtually all unpleasant symptoms experienced during a terminal illness can be either relieved or substantially alleviated by techniques already available.<sup>278</sup> The need is to spread this message rather than to suggest that dying must inevitably be a frightening ordeal.<sup>279</sup> Since the suffering of terminal patients can largely be alleviated by proper treatment, the national effort should be focussed in this direction, which would then support (rather than destroy) the dignity of the human person, protect

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<sup>275</sup>HJ Barker.

<sup>276</sup>Prof KRL Huddle; Denise van Schalkwyk, Chief Social Worker, Groote Schuur Hospital.

<sup>277</sup>Winky van der Merwe.

<sup>278</sup>British Christian Medical Fellowship.

<sup>279</sup>Dr Janet Goodall, British physician.



(rather than attack) life; and promote (rather than negate) the value of humanity.<sup>280</sup>

4.144 Good palliative care education should be encouraged in order to offer adequate symptom control and so be able to manage patients appropriately without the need for active euthanasia. This needs to be combined with adequate funding for the development of palliative care services in South Africa.<sup>281</sup>

4.145 It was however acknowledged that there are many patients presently dying in homes and hospitals who are not benefiting from these advances. There are indeed many having sub-optimal care. This is usually because facilities do not exist in the immediate area or because local medical practitioners lack the training and skills necessary to manage terminally ill patients properly. The solution<sup>282</sup> to this is to make appropriate and effective care and training more widely available<sup>283</sup>, not to give doctors the easy option of euthanasia.<sup>284</sup>

4.146 It was however conceded that it is conceivable that there may be a few cases of severe suffering in which a patient may wish to end his or her life. This may happen in cases with, for example, a degenerative disease. If we are to respect the patient's integrity and desire to die with dignity, it is difficult to ignore the option of euthanasia or suicide for a person who believes that

<sup>280</sup>Right to Live Campaign, Kwazulu Natal.

<sup>281</sup>Hospice Association of Southern Africa.

<sup>282</sup>Prof KRL Huddle.

<sup>283</sup>1. Every possible pressure should be put on government to accept that terminal care as offered by the hospice movement is a legitimate and important part of standard medical care and that it should be as well funded as all secondary medical care.

2. Palliative and terminal care should be available to patients in their own homes and be part of the Primary Health care Programme of SA. Sisters trained in palliative medicine could provide a network of care to a population linked in with GP's, hospital outpatients department, in-patients services and hospices. Both the State and non-governmental organisations need to be modernised to provide this care in the community.

3. What SA needs is more hospices for the terminally ill, and I think private business should be encouraged to donate money for their upkeep. Instead of sponsoring sport so heavily, the cigarette companies should be supporting health-care.

<sup>284</sup>British Christian Medical Fellowship.

this is morally acceptable. However patient autonomy does not necessarily mean that there is a right to euthanasia. The dangers of legalising euthanasia far outweigh the possible relief of suffering in such cases even if euthanasia was to be regarded as morally acceptable.<sup>285</sup>

4.147 In this regard respondents referred to the fact that hard cases make bad law. Legislation of euthanasia is usually championed by those who have witnessed a loved one die in unpleasant circumstances, often without the benefits of optimal palliative care. Allowing difficult cases to create a precedent for legalised killing is the wrong response. These difficult cases should be evaluated in order to do better in future.<sup>286</sup> There is also the fear that once euthanasia is legalised, the vast majority of those whose lives are deliberately shortened will not fall into these "worthy" categories.<sup>287</sup>

4.148 It was also indicated that voluntary euthanasia denies patients the final stage of growth. It is often through facing hardship that human character and maturity develop most fully.<sup>288</sup> According to the teaching of the Catholic Church (Second Vatican Council) "it is in the face of death that the riddle of human existence becomes most acute".<sup>289</sup> It is the suffering endured which brings a person to salvation.<sup>290</sup>

4.149 Euthanasia legislation might furthermore reduce or even remove the incentive for further improvements in patient care. If euthanasia was legal there would be a disincentive to those working in palliative care, education and research to teach and find new ways to decrease suffering. Worldwide developments in palliative care, which are just beginning to develop could cease to progress.<sup>291</sup>

<sup>285</sup>Dr Elizabeth Murray.

<sup>286</sup>British Christian Medical Fellowship.

<sup>287</sup>United Christian Action.

<sup>288</sup>British Christian Medical Fellowship; Pieter Pretorius.

<sup>289</sup>The Right to Live Campaign, Kwazulu Natal.

<sup>290</sup>Christian Coalition.

<sup>291</sup>Hospice Association of Southern Africa; Christian Medical Fellowship of SA; British Christian Medical Fellowship.

4.150 According to a submission received<sup>292</sup> the European Association for Palliative Care recently registered its strong opposition to the legalisation of euthanasia.

bb) Arguments of commentators in favour of active euthanasia

4.151 The fact that a dying person is still a living person was emphasized. The dying process is therefore just another stage of life through which each person has to live. To die with dignity therefore means to live with dignity.<sup>293</sup> If you subscribe to a principle of life with dignity then this should naturally lead to an equal dignity in death. For many people with AIDS their deaths lack the dignity which they may have had in life.<sup>294</sup> Human dignity should be protected right up to the moment of death. The cruel and inhuman way in which some people have to die within our present legal system just in order to satisfy the abstract and compassionless legal rules according to which a person has to be kept alive at all costs cannot be defended in a country where the human rights of people are said to be protected.<sup>295</sup> It can be regarded as human abuse.<sup>296</sup> It is also increasingly being evaluated critically worldwide.<sup>297</sup>

4.152 The principle of respect for human dignity of people demands that the autonomy of terminally ill and dying patients should be respected, provided the rights of others are not violated.<sup>298</sup> The draft bill is fundamentally about balancing the rights of patients, providers and the

<sup>292</sup>British Christian Medical Fellowship.

<sup>293</sup>Labuschagne, JMT "Aktiewe eutanاسie: mediese prerogatief of strafregtelike verweer?" 1996 **SALJ** 411 (hereinafter referred to as "Labuschagne 1996 SALJ") at 413; See also Labuschagne JMT "Die reg om waardig te sterf, aktiewe eutanاسie en bystand tot selfdoding" 1995 **SAJC** 224 (hereinafter referred to as "Labuschagne 1995 SAJC") en Labuschagne, JMT "Beeindiging van mediese behandeling en toestemmingsonbekwames " 1995 **Obiter** 175.

<sup>294</sup>NAPWA.

<sup>295</sup>Labuschagne 1995 **SAJC**.

<sup>296</sup>Rhona Foyn.

<sup>297</sup>Labuschagne, 1995 **SAJC** 227 and his reference to CD Schaffer " Criminal liability for assisting suicide" 1986 **Columbia Law Review** 348 at 367-69; Cedric Biggs.

<sup>298</sup>Alfred Allan ; Valerie Knight.

State so that individuals can live the final days of their lives with dignity.<sup>299</sup>

4.153 The Commission received numerous letters from individual persons sometimes relating their own experiences of suffering,<sup>300</sup> strongly expressing the belief that a terminally ill patient should have the right to die with dignity and that it is inhumane to let a person suffer. Respondents related illnesses where patients suffer from both physical and mental illness (especially those conditions which affect the central nervous system) which gradually destroy the quality of life altogether and leave individuals so disabled that they become totally dependent on others to attend to every detail of daily life. Families are often unable to cope with or provide the nursing care required for such conditions and when these patients have to be admitted to institutions (whether state funded or private) they often become victims of abuse.<sup>301</sup> It was emphasised that should a person be forced to die in a manner that might be acceptable to others, but is inconsistent with the dying person's values, it would be an affront to that person's human dignity. People therefore need to play an active role in the very personal process of dying.<sup>302</sup>

4.154 Respondents stressed the fact that it would give patients comfort and greatly reduce their anxiety and fear if they could have the assurance that if their position became unbearable they could expect and rely on assistance from a medically qualified person who would be prepared to

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<sup>299</sup>NPPCHN.

<sup>300</sup>I Lederman ; Valerie Knight ; A O Leary ; Chris Taylor ; Herman Vos ; MJ Lowson; TA Mc Bean ; also persons who asked to remain anonymous.; See also Vorobiof whose Centre treats 120 cancer patients a day, who said he often comes into contact with people who do not wish to carry on suffering and in certain instances he has had his "back against the wall". "We do not think that by continuing suffering we are benefiting the patient." It was incorrect to think that legal reform would make euthanasia quicker and easier. "It will be the same as before, but in a legalised way" he said.

<sup>301</sup>D Joubert.

<sup>302</sup>NAPWA.

administer or supply them with the means of achieving active euthanasia.<sup>303</sup>

4.155 The Commission was furthermore referred to the rights to human dignity, freedom and security that are all enshrined in the Constitution Act 200 of 1993.<sup>304</sup> See below for a discussion of Constitutional issues.

4.156 The wonderful service provided by Hospice Association in treating terminally ill patients by relieving distress and allowing them to die with a certain amount of dignity was acknowledged. It was however noted that there are a small proportion of cases where even the best palliative care is inadequate to control pain or other physical distress.<sup>305</sup> It was furthermore stated that it is victims of diseases for which there are no cure and no likelihood of immediate death who ask for active intervention.<sup>306</sup>

4.157 It was felt that the fear that incentives for providing palliative care would be diminished if assisted suicide and active euthanasia were legalised, were unfounded. This was especially true since the draft bill guards against this by making it a condition for either of these practices that there should be no other way possible for the patient to be released from his or her suffering.

<sup>303</sup>Valerie Knight; D Joubert; Peter Hamilton; See furthermore as an eg. the submission from H Mason: "I have been living with spinal muscular atrophy for over 30 years. My body has deteriorated to the point where I am confined to a wheelchair, cannot use my arms much, have great pain daily, cannot swallow easily etc. These are my physical problems, but there are so many others, ranging from financial reliance on family, not being able to get medical aid from most companies, to the mental anguish of being a burden, and being trapped in a wasting body but having a very alert mind. The worst part of all is the knowledge that ahead lies only further suffering and deterioration for an illness with no cure. I need to know that when the time comes when I've had all I can take, I can ask my doctor to assist me to gently slip away - a death of dignity, a death wherein I can say goodbye to loved ones in an atmosphere I choose and not subject myself to years of anguish and debilitation - mentally and physically. I can receive no greater calming influence than knowing I can end it when ready, legally and gently, benefiting from a humane law wherein my right to die is as important as my right to live a life of quality."

<sup>304</sup>NPPCHN; Labuschagne 1996 **SALJ** at 413; Labuschagne JMT "Menseregte na die dood: opmerkinge oor lyk en grafskending" 1991 **De Jure** 141 in which it was explained that the dignity of a person may even transcend death.

<sup>305</sup>Voluntary Euthanasia Society, England.

<sup>306</sup>Peter Buckland, Executive Director Hospice Witwatersrand reported in **The Star** 18 April 1997.

Accordingly, if euthanasia or assisted suicide were practised without options for palliative care being made available to patients there would be a breach of the law. Enforcement of this law would provide incentives to preserve and enhance the options for palliative care.<sup>307</sup>

4.158 Commentators furthermore felt that there should be an obligation on the State in the case of an individual requesting termination of his or her life to provide specific palliative care consisting of maximum pain relief and counselling. In a situation where this care has been provided and the patient's wishes to terminate his or her life remained unchanged, there should be provision for the courts to accede to the request of a patient, particularly when supported by the physician responsible for the palliative care and close relatives.<sup>308</sup>

iv) Personal autonomy

aa) Arguments of commentators against active euthanasia

4.159 Autonomy is important. Everybody values the opportunity of living in a free society. However, autonomy of a person can never be absolute. It should be balanced against the interests of the State and of the family of the patient.<sup>309</sup>

4.160 There is acceptance of the fact that in a very small percentage of cases euthanasia may be a deliberate choice and may in fact reflect autonomy. However for the law to be changed to allow patient A to exercise his carefully deliberated "right" to be killed by a doctor, society would have to move away from a situation of absolute protection of all patients into an uncertain area of value judgement. This would inevitably lead to decisions which are arbitrary and inherently unjust. Patient A's request might be well thought through, but to permit it for one person, the Law would have to be changed and up to 99 cases of injustice might occur. Patient A's

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<sup>307</sup>Prof S Benatar et al.

<sup>308</sup>NPPCHN.

<sup>309</sup>ACDP; British Christian Medical Fellowship; Christian Medical Fellowship of SA; Islamic Medical Association of SA.

responsibility to society means he should forgo his "right" to euthanasia.<sup>310</sup>

4.161 Death affects the whole family, it is never limited to the terminally ill patient. It affects the emotions of all those linked to the person. For this reason the South African Law Commission must balance what it perceives to be the rights of the terminally ill against the rights of their family members. There may be guilt, anger or bitterness felt by those left behind.<sup>311</sup>

4.162 A person may, for deeply personal or other reasons, be led to believe that they can legitimately ask for death and obtain it from others. Although in these cases the guilt of the individual may be reduced or completely absent, nevertheless the error in judgement into which the conscience falls, perhaps in good faith, does not change the nature of the killing, which will always be in itself something to be rejected.<sup>312</sup>

4.163 Those who support euthanasia call for more patient autonomy, but in fact legalisation of euthanasia puts more power into the hands of doctors. They are given the right to decide on the mental competence of the patient, to decide whether the patient is suffering from a terminal illness and that there is no hope of effecting a cure or a restoration of life with quality. Patients are guided in their decision-making by information given by doctors. If a doctor suggests a certain course of action, it can be very hard for a patient to resist. The doctor may be unaware of new treatment, prognoses are notoriously difficult to predict and serious mistakes may be made.<sup>313</sup>

bb) Arguments of commentators in favour of active euthanasia

4.164 Right from childhood we are told to take responsibility for our own lives. Suddenly, when faced with death one way or another, we are told that we may not be responsible for our own passing. This is unacceptable.<sup>314</sup> In a world where birth control is an accepted and indeed

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<sup>310</sup>Christian Medical Fellowship of SA.

<sup>311</sup>British Christian Medical Fellowship; ACDP.

<sup>312</sup>The Right to Live Campaign, Kwazulu Natal.

<sup>313</sup>Dr James Paul; British Christian Medical Fellowship.

<sup>314</sup>M Lavies.

indispensable part of life, where individuals aspire to make their own choices about education, career, marriage and lifestyle, and the common parlance is not of fate and God's will but of the opportunities and personal responsibility, a quiescent attitude to life's ending seems less logical than it did to previous generations.<sup>315</sup>

4.165 A person should have the right to make deeply personal decisions concerning their bodies, including decisions regarding the manner and timing of death.<sup>316</sup> When a terminally ill patient finds it unacceptable to lead a compromised lifestyle and has expressed his or her wish not to prolong life, has taken steps to make his or her wishes known (eg a series of interviews with respected professionals or the courts of law) then he or she has the right to expect medical assistance to terminate his or her own life.<sup>317</sup>

4.166 The logic was questioned of saying that a woman has bodily integrity and therefore has the right to abort an unborn child but at the same time denying a suffering terminally ill person the right to die if he so wishes. It was felt that if a person has made peace with his God (which is his own business) he should be allowed to die.<sup>318</sup>

4.167 We trust that the ever increasing number of HIV positive people will be allowed the opportunity of making an informed choice around their end of life issues.<sup>319</sup> Where the provision of palliative care does not limit the pain and suffering endured by patients dying of AIDS or other terminal illnesses, these patients should, in principle, be given the right to end their lives by other means.<sup>320</sup>

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<sup>315</sup>The Voluntary Euthanasia Society, London; For more on 'the right to die' see Plachta, M "The right to die in Canadian legislation, case law and legal doctrine" 1994 **Med Law** 639; Leonard -Taitz, J "Euthanasia, the right to die and the law in South Africa" 1992 **Med Law** 597.

<sup>316</sup>NAPWA ; Association for People with Disabilities: Gauteng North (Dr Laetitia Botha ); Joyce Dangatye, Health sister; Nico Hagg; Cedric Biggs; Chris Taylor; CW du Plooy; ME Chomse.

<sup>317</sup>Eastern Province Association for the Care of Cerebral Palsy; Chris Taylor.

<sup>318</sup>Mrs JM de Villiers.

<sup>319</sup>NAPWA.

<sup>320</sup>Lawyers for Human Rights.



4.168 The pro-choice philosophy goes both ways and a doctor should have the freedom to decline performing euthanasia as much as he should be able to decline the performing of termination of pregnancy.<sup>321</sup>

4.169 The proposed legislation is enabling not prescriptive. No one is obliged to make use of it.<sup>322</sup> The main point to consider is the well-being of the person concerned and not the belief or moral doubts of third parties.<sup>323</sup>

v) Erosion of medical ethics and the doctor patient relationship

aa) Arguments of commentators against active euthanasia

4.170 Should euthanasia be legalised, the whole practice of medicine will be seriously compromised.<sup>324</sup> Public confidence in the medical profession will be undermined and it will have a negative effect on the relationship between a doctor and his patient.<sup>325</sup> Reasons given for this statement are as follows:

1. The certainty that the doctor will do everything to help the patient vanishes when euthanasia is allowed.<sup>326</sup>
2. Medical practitioners will be set in the role of executioner.<sup>327</sup>
3. If patients didn't trust their doctors many may choose to delay their attendance in the fear

<sup>321</sup>Nico Hagg.

<sup>322</sup>Heman Vos.

<sup>323</sup>Myrna Boehm.

<sup>324</sup>United Christian Action; Victims of Choice; The World Federation of Doctors Who Respect Human Life.

<sup>325</sup>Dr James Paul; Pro-Life; Prof KRL Huddle.

<sup>326</sup>Winky van der Merwe.

<sup>327</sup>Dr JV Larsen Regional Obstetrics, South -East Zululand.

they may have a terminal disease. Such delays will often have serious consequences for the patients concerned.<sup>328</sup>

4. The patients most affected by the erosion of the relationship are likely to be the unsophisticated and illiterate and it will thus be contributing further to their marginalisation.<sup>329</sup>
5. Medical practitioners' lives are already highly stressed. It will add impossible stress if they are also given the responsibility of deciding when to offer to kill one of their patients. Medical practitioners should not be asked to make unnecessary moral and legal decisions. It may also have a detrimental effect on the character of the healer who becomes, however rarely and with whatever good intentions, the killer.<sup>330</sup> It is considered to be unethical and improper to ask that any medical staff anywhere should be burdened with the possibilities more permissive legislation about euthanasia would open up.<sup>331</sup>
6. There is a great margin of error in medical work, a margin which is much wider in smaller peripheral hospitals with their more limited diagnostic facilities and staff shortages than is generally appreciated. The same argument which is used against the death sentence for criminals must be accepted in the care of the terminally ill: death is final, and diagnostic mistakes cannot be rectified.<sup>332</sup>

<sup>328</sup>Dr JV Larsen.

<sup>329</sup>Dr JV Larsen.

<sup>330</sup>Christian Medical Fellowship of SA.

<sup>331</sup>a) We have more information than ever before about terminal care and more resources than ever before for adequate symptom control. The Hospice Movement has made huge contributions to our everyday practice. It is senseless therefore to begin to discuss euthanasia in this generation when other more acceptable answers to the needs of suffering people are so much more readily available.

b) None of us who have been in practice for any length of time would presume to judge when a patient is really ready to die. We have no measure of the spiritual state of individuals, or of the work that might still be needed in their relationships. We also have no measure of the motives behind a request, either from the patient him or herself, or from relatives, to take a life. The darkest possible picture from the patient's point of view can be changed into something very bearable by quite small events or changes in circumstances. We also recognise that acceding to a request for euthanasia may deprive a patient of the opportunity to make decisions about his or her spiritual life which could have eternal consequences.

<sup>332</sup>Dr JV Larsen.

7. Although the conscience clause exists, permissive legislation might drive from certain specialities doctors who otherwise ought to be there.<sup>333</sup>
8. The question was asked whether there will be legislation to guard against discrimination towards doctors who refuse to participate in euthanasia.<sup>334</sup>
9. Although the Hippocratic Oath is of pre-Christian origin, the section concerning euthanasia is consistent with the position found in many religions. The oath puts euthanasia and abortion in the same category. It insists that even suggesting suicide is wrong and unethical. The Oath has safeguarded patients for two thousand years and should therefore not be discarded lightly.<sup>335</sup> When answering the question whether it is meaningful to bound to an oath that is more than two thousand years old one should note that clauses that oblige doctors to preserve human life are also found in more modern ethical codes such as the International Code of Medical Ethics as adopted by the World Medical Association at the 3<sup>rd</sup> World Medical Assembly, London, England in October 1949. The Statement of Marbella in 1992 furthermore confirmed that assisted suicide like euthanasia, is unethical and must be condemned by the medical profession.<sup>336</sup> Euthanasia laws if passed will therefore go against the ethical codes ratified by the majority of the world's medical associations less than five years ago.<sup>337</sup>
10. The elderly and chronically "sick" are especially vulnerable<sup>338</sup> since they frequently feel a burden to their families and a society which is cost-conscious and may be short of resources. They may feel undue pressure to ask for euthanasia so as not to be a burden.<sup>339</sup>

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<sup>333</sup>Christian Medical Fellowship of SA.

<sup>334</sup>Dr James Paul.

<sup>335</sup>United Christian Action; Pro-Life; (Fr) Hyacinth Ennis; HM Janse van Rensburg.

<sup>336</sup>British Christian Medical Fellowship referring to the International Code of Medical Ethics as adopted by the 3<sup>rd</sup> World Medical Assembly, London, England, October 1949; Handbook of Declarations, WMA, 1992, France.

<sup>337</sup>Dr James Paul.

<sup>338</sup>Office of the Chief Rabbi.

<sup>339</sup>Hospice Association of Southern Africa; Dr James Paul; R Higgins; Victims of Choice.

These patients need to know that they are valued and loved as they are.<sup>340</sup> They may furthermore be in a confused and distressed state. At present they can rely on the fact that their medical practitioners will do all they can to cure and to heal.

4.171 Hospice doctors and nurses clearly stated that they would not be prepared to participate in bringing about the death of any person in their care if legalised and would not permit Hospice premises to be used for this purpose.<sup>341</sup>

bb) Arguments of commentators in favour of active euthanasia

4.172 Medical practitioners should be permitted to assist a suicide or to practise euthanasia. In the context of a doctor-patient relationship of caring, these options can play an important role when no further treatment can cure or satisfactorily palliate the illness. Doctors should not be forced to abandon their patients at such times or to be instrumental in their ongoing suffering. Provided that they adhere to the appropriate safeguards, medical practitioners should be permitted to effect or facilitate a good death for those whose continued living is worse than death.<sup>342</sup>

4.173 In an opinion poll in Australia, in 1996, 76% answered yes to the question whether the doctor should be allowed to give a lethal dose<sup>343</sup> where a hopelessly ill patient, experiencing unbearable suffering, with absolutely no chance of recovering, asks for a lethal dose, so as not to wake again. The Royal College of General Practitioners in Australia carried out a survey amongst its members, who are doctors most likely to be caring for dying patients : 68% regarded voluntary euthanasia as an act of caring and 56% supported its legislation.<sup>344</sup>

<sup>340</sup>British Christian Medical Fellowship.

<sup>341</sup>Hospice Association of Southern Africa.

<sup>342</sup>Prof S Benatar et al.

<sup>343</sup>Opinion poll carried out by Roy Morgan Research Centre, Melbourne, Finding 2933, South Australian Voluntary Euthanasia Society, SAVES Fact Sheet No 21.

<sup>344</sup>Ian Wilson et al **General Practitioners and euthanasia** , Australian Family Physician 26,4: 399-401 April 1997 referred to in SAVES Fact Sheet 21.

4.174 Most of the personal submissions received from people who specifically referred to the fact that they are elderly people, noted that they were in favour of the spirit of the Bill<sup>345</sup> and of active euthanasia.<sup>346</sup> One of the respondents referred to a passage from Dante who wrote: "Io non mori, e non rimasi vivo" roughly translated " I did not die, but nothing in life exists for me."<sup>347</sup> Reference was made to the fact that they were not afraid to die, but very afraid of lingering and that they would like to die with dignity.<sup>348</sup>

4.175 One submission<sup>349</sup> referred the Commission to an enclosed news clipping from the Daily Telegraph in which it was reported that voluntary euthanasia has received overwhelming support from pensioners in a new survey, with 78% prepared to persuade someone to help them die.<sup>350</sup> Yours, the monthly British magazine for the retired found that 89% of two thousand five hundred readers who responded to a questionnaire, disagreed with current legislation making euthanasia illegal. A total of 92% thought doctors should be allowed to end the lives of the terminally ill who wanted to die.

vi)      Constitutionality

4.176 In Discussion Paper 71, the question was asked whether the legalisation of euthanasia would not be in conflict with the provisions of the Bill of Rights set out in the Constitution.<sup>351</sup> Section 2 of the Constitution states that the Constitution is the supreme law of the Republic, that any law or conduct inconsistent with it is invalid and that the obligations imposed by it must be

<sup>345</sup>HADCA (Howick and District Council for the care of the Aged).

<sup>346</sup>MEE Frauenstein ; Aletta MB le Roux; HJ Barker, J de Necker; Peter Hamilton; D Joubert; Johan Driessen; Valerie Knight.

<sup>347</sup>J de Necker.

<sup>348</sup>Eighty one year old suffering from Parkinsons disease asking for anonymity.

<sup>349</sup>Cedric Biggs.

<sup>350</sup>See also Leinbach, RM "Euthanasia attitude of older persons" 1993 (15) **Research on aging** 433-448: results from study indicated that age is not the most important predictor of euthanasia attitude.

<sup>351</sup>Act 108 of 1996.

fulfilled. Sections 11, 10, 12, 9, 14 and 36 may be relevant in this regard.<sup>352</sup>

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- <sup>352</sup>11. Everyone has the right to life.
10. Everyone has inherent dignity and the right to have their dignity respected and protected.
12. (1) Everyone has the right to freedom and security of the person, which includes the right -
- (a).....
- (e) not to be treated or punished in a cruel, inhuman or degrading way.
- (2) Everyone has the right to bodily and psychological integrity, which includes the right -
- a) .....
- b) to security in and control over their body; and
- c) not to be subjected to medical or scientific experiments without informed consent.
9. (1) Everyone is equal before the law and has the right to equal protection and benefit of the law.
- (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
- (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
- (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.
- (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.
14. Everyone has the right to privacy, which includes the right not to have-
- (a) their property or home searched;
- (b) their property searched;
- (c) their possessions seized; or
- (d) the privacy of their communications infringed.
36. (1) The rights in the Bill of Rights may be limited only in terms of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including-
- a) the nature of the right
- b) the importance of the purpose of the limitation;
- c) the nature and extent of the limitation;
- d) the relation between the limitation and its purpose; and
- e) less restrictive means to achieve the purpose
- (2) Except as provided in subsection (1) or in any other provision of the

4.177 The question in regard to the constitutionality of euthanasia legislation has not been answered in the Constitutional Court yet. In **S v Makwanyane**<sup>353</sup> Mahomed J remarked as follows regarding the interpretation of sec 9 (Interim Constitution):

"Does the 'right to life', within the meaning of s9, preclude the practitioner of scientific medicine from withdrawing the modern mechanisms which mechanically and artificially enable physical breathing in a terminal patient to continue, long beyond the point when the 'brain is dead' and beyond the point when a human being ceases to be 'human' although some unfocused claim to qualify as a 'being' is still retained? If not, can such a practitioner go beyond the point of passive withdrawal into the area of active intervention? When? Under what circumstances?"

4.178 Readers were asked to consider the contents of the rights referred to above, whether euthanasia would be a violation of these rights, what the effect of the limitation clause set out in sec 36 would be on these rights and how the rights should be weighed up against each other.

aa) Arguments of commentators against active euthanasia

4.179 In discussing the constitutionality of the possible decriminalisation of euthanasia, the majority of respondents who do not favour active euthanasia based their views on the right to life currently entrenched in section 11 of the Constitution. They stated that the fact that this right should be entrenched in the highest law of the country is proof positive of the value that our lawmakers have attributed to the sanctity of life and that it would make a mockery of this sanctity if those very lawmakers should actively seek to create exceptions.<sup>354</sup> If the death sentence for criminal offences of a capital nature is absolutely prohibited and not an option under any circumstances, the same should be true for euthanasia.<sup>355</sup>

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Constitution, no law may limit any right entrenched in the Bill of Rights.

<sup>353</sup>1995 (2) SACR 1 (CC) 94; See also Goolam, NMI "Euthanasia: reconciling culture and human rights" 1996 **Med Law** 529.

<sup>354</sup>United Christian Action ; The Right to Live Campaign, Kwazulu Natal ; Hugh Fowler ; Wilson N Makhwiting ; CJG du Toit ; Phil Harrison;. CJG du Toit; ACDP; PB Monareng; Victims of Choice; African Christian Action; The Christian Lawyers Association.

<sup>355</sup>Prof JG Swart; HMJ van Rensburg.

4.180 The fundamental question is whether a person may waive his right to life. In order to answer this, one must distinguish between the inalienability of a right and its inwaivability. John Locke stated that "one cannot waive one's right not to be killed, because life is a gift from God and people are in effect the property of God."<sup>356</sup>

4.181 In so far as any right can be limited, sec 36 inter alia states that a democratic state is based on human dignity, equality and freedom. Where euthanasia is practised there is no limitation of a right but the right is completely ignored. Life is brought to an end. The proposed legislation will therefore be a complete violation of the Constitution and accordingly **ab initio** null and void.<sup>357</sup>

4.182 In so far as rights are weighed against other rights it is clear that human dignity can only be an issue where the person is alive. Since the right to life is a completely encompassing right that includes other rights including the right to dignity it would be impossible to weigh the two rights against each other.<sup>358</sup>

bb) Arguments of commentators in favour of active euthanasia

4.183 The "inalienable right to life" entrenched in sec 11 of the Constitution has no substance unless it concedes that we own our lives and may make decisions about them (including the manner of our dying) provided only that we do not exercise that right so as to harm others or society. Legislation regarding euthanasia is therefore not contrary to the Constitution.<sup>359</sup>

4.184 Human life is more than a simple continuation of breathing. Its value is to be found in its potential to pursue human good, especially in relationship with others. A terminally ill patient

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<sup>356</sup>ACDP.

<sup>357</sup>Landdros FVA Von Reiche.

<sup>358</sup>Landdros FVA Von Reiche.

<sup>359</sup>Alfred Allan; See also the submission of the The Society of Advocates of Natal in which they argued that the Constitution is not an obstacle to the legislation, but that it is rather a policy decision that has to be taken.



"subject to extreme suffering" which cannot be alleviated may morally request to be helped to find a natural end to his or her life in death. A law which offers an option that is to be voluntarily chosen is consistent with an open and democratic society. Those who reject the option should not deny it to others.<sup>360</sup> The accent should be on the sacredness of the quality of life, rather than the sacredness of life per se.<sup>361</sup>

4.185 Moreover, on a technical point, the Constitution speaks of a right to life, but not of a duty to live. Given their conceptual logic, rights may be waived. If continued life is no longer in somebody's interest that person should be free to waive the right to life.<sup>362</sup> The right to life is not an unqualified obligation to continue living.

4.186 The draft bill is fundamentally about balancing the rights of patients, providers, and the State so that individuals can live the final days of their lives with dignity.<sup>363</sup> Whereas it could be argued that these practices violate the constitutional right to life, this right is not absolute and has

to be weighted against other constitutional rights, such as the right to freedom and security of a person and specifically the rights not to be deprived of control over the body.<sup>364</sup>

4.187 Other rights referred to by commentators, that are entrenched in the Constitution and against which the right to life could be weighed are:

- i) The principle of respect for human dignity of people, which is set out in section 10 of the Constitution and demands that the autonomy of terminally ill and dying patients

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<sup>360</sup>South Australian Voluntary Euthanasia Society.

<sup>361</sup>Prof Geoffrey Falkson.

<sup>362</sup>Prof S Benatar et al.

<sup>363</sup>NPPCHN.

<sup>364</sup>Prof S Benatar et al.

should be respected, provided the rights of others are not violated.<sup>365</sup> The patient can make a claim that his or her constitutional right to human dignity must be respected and therefore, that there is a legitimate basis to consider his or her request if the quality of life is severely compromised or if life-sustaining measures are continued.<sup>366</sup>

ii) Section 12(2)(b) of the Bill of Rights furthermore recognizes that every person has the right to bodily and psychological integrity which includes the right to security in and control over his or her body.<sup>367</sup>

iii) The right to equality in section 9 of the Constitution prohibits unfair discrimination by the state against anyone. Two arguments were related in this connection:

aa) Since discrimination is prohibited on the grounds of disability, it would constitute unfair discrimination against the physically disabled, were the law to exclude euthanasia and only allow assisted suicide or cessation of treatment. It would unfairly favour persons who could take their own lives or whose illnesses were such that cessation of treatment would cause their deaths. What is in effect being said is that persons who are suffering grievously can kill themselves but if they are so debilitated that they cannot do it themselves they are on their own.<sup>368</sup>

bb) In **Brink v Kitshoff NO**<sup>369</sup> it was confirmed that the grounds of discrimination

<sup>365</sup> Judge O'Regan in **S v Makwanyane** *ao supra* on 506: "The right to life, thus understood, incorporates the right to dignity. So the rights to human dignity and life are entwined. The right to life is more than existence - it is the right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there can be no dignity".

<sup>366</sup> Department of Health; Eddie Malulyck.

<sup>367</sup> NPPCHN; Society of Advocates of Natal.

<sup>368</sup> See **Quill v Vacco** 80 F 3d 716 (2 nd Cir 1996) in which judge Miner said it amounted to people in the same circumstances being treated unequally. He did not accept the argument that there was a difference between allowing nature to take its course and intentionally using artificial death-producing device (on 729) He said there was nothing "natural" about causing death by means other than the original illness or its complications.

<sup>369</sup> 1996(6)BCLR 752 (CC) 769.

are not a **numerus clausus**. Another question asked was if equality before the law also includes equal socio-moral stigmatization? In South African law a perpetrator of active euthanasia is guilty of the same crime, namely murder, as a person who tortures his victim to death. This is not the question in Dutch and German law. The question is mooted whether citizens have a human right not to be stigmatized with a crime which reflects disproportionately to the seriousness of their conduct.<sup>370</sup> The courts seem to give an extensive interpretation to the fundamental right enshrined in sec 10 of the Constitution by including the right to esteem and self-esteem.<sup>371</sup> This would have the effect that persons would be protected against unfair stigmatization. To find a person who performs euthanasia and a person who tortures another to death guilty of the same crime constitutes a human rights violation.

iv) The Commission was also referred to the right to privacy in sec 14 of the Constitution. In **Bernstein v Bester**<sup>372</sup> the Constitutional Court discussed this right. Judge Ackerman stated the following:<sup>373</sup>

"The scope of privacy has been closely related to the concept of identity and it has been stated that 'rights like the right to privacy, are not based on a notion of the unencumbered self, but on the notion of what is necessary to have one's own autonomous identity..... The truism that no right is to be considered absolute, implies that from the outset of interpretation each right is always already limited by every other right accruing to another citizen. In the context of privacy this would mean that it is only the inner sanctum of a person, such as his or her family life, sexual preference and home environment, which is shielded from erosion by conflicting rights of the community. This implies that community rights and the rights of fellow members place a corresponding obligation on a citizen, thereby shaping the abstract notion of individualism towards identifying a concrete member of civil society. Privacy is acknowledged in the truly personal realm, but as a person moves into communal relations and activities such as business and social interaction, the scope of personal space shrinks accordingly."

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<sup>370</sup>Labuschagne, JMT "Dodingsmisdade, sosio-morele stigmatisering en die menseregterlike grense van misdaadsistematiesing" 1995 **Obiter** 34.

<sup>371</sup>**Gardener v Whitaker** 1994 5 BCLR 19(E) 36.

<sup>372</sup>1996(4) BCLR 449 (CC).

<sup>373</sup>On 483-484.

4.188 It is therefore contended that this "inner sanctum" and "autonomous identity" should also include the right to choose not to live a life of unbearable pain.

4.189 In the USA the right to privacy includes personal decisions regarding marriage, reproduction, family relationships, childcare, contraception and abortion.<sup>374</sup> The Supreme Court is however not keen to allow the right to privacy to encroach on traditional moral values.<sup>375</sup> In **Quill v Vacco**<sup>376</sup> the federal court said the right to assisted suicide "cannot be considered so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed... (n)or can it be said.... that (it) is deeply rooted in the nation's traditions and history".<sup>377</sup> It is clear that fundamental freedoms will only be violated by the state if a serious state interest demands it and then only to the extent that it is really necessary.<sup>378</sup>

4.190 In conclusion respondents feel that a combination of the fundamental human rights referred to above guarantees individuals some degree of control over their bodies and decisions about life and death.<sup>379</sup>

4.191 A recent ruling by South Africa's Constitutional Court in the **Soobramoney case**<sup>380</sup> has the effect that the state would, in certain circumstances, be inconsistent if it denies a request for assisted suicide or euthanasia. The appellant, in the final stages of chronic renal failure, claimed

<sup>374</sup>**Carey v Population Services International** 431 US 678, 684-685, 97 S Ct 2010, 2015-2016, 52 L Ed 2d 675, 684-685 (1977) as referred to by Labuschagne, JMT "Menseregtelike status van die strafregtelike verbod op hulpverlening by selfdoding" unpublished.

<sup>375</sup>**Bowers v Hardwick** 478 US 186, 192, 106 S Ct 2841, 2844-2845, 92 L Ed 2d 144, 147 (1986) as referred to by Labuschagne supra.

<sup>376</sup>Supra on 724.

<sup>377</sup>See also Marzen, TJ, O'Dowd, MK, Crone, D & Balch, TJ "Suicide: a constitutional right?" (1985) 24 **Duquesne Law Review** 1 at 17--100 and 147 as referred to by JMT Labuschagne supra.

<sup>378</sup>**Reno v Flores** 507 US 292, 301-303, 113 S Ct 1439, 1447, 123 L Ed 2d 1, 18 (1993) as referred to in **Quill v Vacco** supra.

<sup>379</sup>NPPCHN.

<sup>380</sup>**Soobramoney v Minister of Health (Kwazulu-Natal)** 1997 BCLR (12) 1696 (CC).

that he was entitled to emergency dialysis, given the constitutional provision that no-one may be refused emergency medical treatment, and the constitutional right to life. The court ruled his application unsuccessful on the grounds that withholding of life-prolonging treatment, that is, rationing care, is compatible with a human rights approach, given scarce resources. Withholding dialysis, a scarce resource, given the extreme healthcare needed, led directly to the appellant's death. But hypothetically, if the State can legitimately withhold resources necessary for life, surely it would be inconsistent, as well as cruel, if the state were to deny the "condemned" man's request for assisted suicide or euthanasia so that he could die sooner and, perhaps with less suffering. How could the State sanction death when it is bad for the applicant, but deny it when it is a good, especially if the State has made death the only option?<sup>381</sup>

4.192 However, the question as to the violation of the human right does not end the investigation regarding the constitutionality of the legislation. The final question is if the inequality cannot be rationalised by a legitimate state interest. The onus is on the claimants. In the American decision **Compassion in Dying v State of Washington**<sup>382</sup> a federal court came to the conclusion that the state has a legitimate interest in the prohibition of assisted suicide. In **Quill v Vacco** the State argued that its interests lie in the protection of the lives of its citizens at all times and in all circumstances. Judge Miner (on 729-730) however replied as follows:

But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely the state's interest lessens as the potential for life diminishes. And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's right to define [his] own concept of existence, of meaning, of the universe and of the mystery of human life' when the patient seeks to have drugs prescribed to end life during the final stages of terminal illness?

4.193 That the state has certain interests in this matter is an accepted fact. These interests are however also relevant in the case of cessation of treatment. It is therefore really a question of priorities. The question to be asked is whether these interests should be given priority in a

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<sup>381</sup>Dr Willem Landman.

<sup>382</sup>79 F3d 790 (9th Cir 1996).

situation where a person is subjected to senseless suffering and a cruel dying process.<sup>383</sup>

4.194 Finally, the Commission invited comment on the question whether it would be possible to provide sufficient safeguards to prevent abuse should voluntary euthanasia and assisted suicide be included as acceptable end of life decisions.

vii) Safeguards

4.195 Chesterton<sup>384</sup> refers to the fact that ..."- it is, perhaps, a telling point that the arguments against euthanasia are increasingly addressed not to the protection of the sanctity of life but the difficulty of restricting its effects."<sup>385</sup>

4.196 There were two distinct viewpoints in this regard:

- i) Some respondents argued that due to the often complex nature of life and death situations and the multiplicity of possible circumstances and clinical situations, it is near impossible to create safeguards which could keep the practice of euthanasia in check. To contain and control and monitor this practice through the whole spectrum of clinics, rural hospitals, and institutions across the country would be extremely difficult.<sup>386</sup> They therefore supported the decision of the House of Lords Committee<sup>387</sup> which concluded that there should be no change to the legislation against euthanasia since it would be

<sup>383</sup>Prof JMT Labuschagne.

<sup>384</sup>Chesterman at 373.

<sup>385</sup>This is particularly true of governmental enquiries into euthanasia : see e.g **Report of the House of Lords Select Committee on Medical Ethics**, supra at para 237. It is also the position that was argued by the US Solicitor General in the Supreme Court case concerning the constitutionality of State Laws prohibiting assisted suicide: **Washington v Glucksberg** 117S.Ct 2302 (1997) ; Canadian Special Select Committee on euthanasia and assisted suicide **Of Life and Death**, June 1995 referred to above in para 4.66 on 63.

<sup>386</sup>Doctors for Life.

<sup>387</sup>Para 237.

impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation could not be abused.<sup>388</sup>

ii) In answer to the opinions expressed above it was however said that although it is the moral responsibility of proponents of the legislation to see that procedural safeguards would provide adequate protection for vulnerable patients, it is equally the moral responsibility of opponents to show that having no legislation is the best way to prevent abuse.<sup>389</sup> All human endeavour including the status quo, has the potential for abuse, and demanding near absolute guarantees diverts attention from the substantive deliberation about what the right thing is to do. Experience suggests that most people routinely draw clear lines between different but, in some respects, closely related practices, including justified and unjustified forms of killing (for example in the context of self-defence or war).

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4.197 Reasons set out for the above views were as follows:

aa) Arguments of commentators against active euthanasia

1. The major argument used to support the above contention that it would be impossible to construct and implement safeguards for the practice of active euthanasia was that life in the South African context does not support such legislation:

i) It was firstly argued that enough consideration was not given to the fact that South Africa is a multi-cultural society, speaking eleven languages with diverse

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<sup>388</sup>Dr James Paul; SA National Consumer Council; Dr Elizabeth Murray; Human Life International SA; United Christian Action; Rev Justin Swanson; Victims of Choice; Africa Christian Action.

<sup>389</sup>Battin, MP "Voluntary euthanasia and the risks of abuse: can we learn anything from the Netherlands" **Law, Medicine and Health Care** 20, 133-143 at 143 as referred to by Dr Willem Landman in his submission.

<sup>390</sup>Dr Willem Landman; See also his reference to Heintz, APM "Euthanasia: can be part of good terminal care" **BMJ** Vol 308 25 June 1994 where he states that "regulation is the only way to create sufficient safeguards against its misuse".

indigenous populations and traditional communities.<sup>391</sup> Many of the traditions and customs of the black South African population do not support interventions like euthanasia or physician assisted suicide.<sup>392</sup> It has to be accepted that, given the fuller sense of community and family, different notions of respect and care for the elderly and sickly, as well as alternative values informing notions of disease and death in traditional communities, there would be very limited demand for assisted suicide and euthanasia among traditional people.<sup>393</sup> Some might see the legalization of assisted suicide and euthanasia as an imposition of Western values on people with different cultural belief systems.<sup>394</sup> It will therefore cater only for the parochial needs of a minority of South Africans.<sup>395</sup>

- ii) Secondly, many South Africans have educational deficits which would impact upon their ability to understand the true meaning and implications of a legal right to assisted suicide and euthanasia. The problem is essentially policing the proposed legislation of euthanasia in cases of the most marginalised and vulnerable persons in our society.<sup>396</sup> The proposals, as they are at the moment, leave the door open for abuse by the overworked and unscrupulous in anything but optimal Western situations, who would be able to act within the formal ambit of the law to administer euthanasia even in the absence of an informed decision by the patient. The implications of this law are twofold: in the first instance it may lead to abuse as suggested above. On the other hand the practical difficulties to obtain an informed decision from the terminal patient with whom he or she does not have an ideal doctor-patient relationship, may cause medical practitioners to be unwilling to administer euthanasia to certain, invariably traditionally disadvantaged patients.

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<sup>391</sup>Human Life International SA.

<sup>392</sup>Department of Health.

<sup>393</sup>Dr Willem Landman.

<sup>394</sup>Mac Farlane 1997 on 182 as referred to by Dr Willem Landman in his submission; Victor Southwell.

<sup>395</sup>Victor Southwell (South African lawyer studying in Michigan).

<sup>396</sup>Victims of Choice.



Such a state of affairs would deprive a significant sector of euthanasia as treatment option in terminal illness and would violate the constitutional guarantee to equality before the law in terms of the Constitution, 108 of 1996.<sup>397</sup>

- iii) Thirdly, South Africans have hugely differential access to scarce healthcare resources. Resources would be required to exercise a legal right to assisted suicide and euthanasia, but the reality is that the vast majority of patients in rural areas would not have routine access to a physician and would therefore be unable to choose these forms of assistance in dying. Very few people can claim the benefit of a personal relationship with a physician who has intimate knowledge of the patient's medical history, the assumption of a "doctor-patient" relationship as a basis for any proposed legislation on euthanasia is dubious.<sup>398</sup> The Department of Health has endorsed nurses as the front-line providers of health care and is seeking to decentralise health care services to the primary care level. As a result, many of these situations will occur outside of tertiary and regional hospitals where there may be no doctors.<sup>399</sup> Consider the realities of medical services in rural and traditionally "black" South Africa where patients are lucky if they see the same care professional more than once, let alone the same doctor. Moreover the requirement that the medical practitioner confers with an independent medical practitioner who has knowledge of the illness from which the patient suffers and who has personally checked the medical history and personally examined the patient, is all but impossible to implement in circumstances such as these.<sup>400</sup>
- iv) In conclusion, some might believe that South Africa, with its infamous past of white-on-black racism, should be the last place in the world to legalise assisted suicide or euthanasia. Concern was expressed regarding the influence of racism on this issue.<sup>401</sup> In this developing country with its obvious lack of respect for life

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<sup>397</sup>Victor Southwell.

<sup>398</sup>Victor Southwell.

<sup>399</sup>NPPHCN.

<sup>400</sup>Victor Southwell.

<sup>401</sup>Dr Willem Landman.

in general and our high crime and violence statistics, legal "permission to kill" would surely be abused.<sup>402</sup> South Africa has a history of human rights abuses and even with stringent preconditions, abuse of euthanasia may occur. South Africa has an inhomogeneous population. The Dutch experience indicates that even in a homogenous, well-educated and socioeconomically developed country there is a tendency for the "slippery slope" to occur. This would be much more of a problem in South Africa.<sup>403</sup> South Africa has a violent society in which many preventable deaths are not prevented and abuse of the euthanasia law, which could well become widespread, could worsen the situation.<sup>404</sup>

2. The state of the health care system elicited a fair amount of response of its own:
  - i) Currently the health care system is under tremendous financial strain as demand for health care far outstrips available resources.<sup>405</sup> In specialised fields there are closure of hospitals, overcrowding, numerous resource constraints and the retrenchment and the relocation of health personnel.<sup>406</sup>
  - ii) The Commission was charged with having utilitarian motives behind the camouflage of compassion.<sup>407</sup> That the new euthanasia bill is part of the "solution" to cope with the massive problems confronting our Health Department, especially as it attempts to cope with the AIDS epidemic, and to accommodate abortion on demand within an already overburdened system. Would not the Bill, if passed, greatly assist in rationing the scarce resources of health care? After all, the care of the elderly, the terminally ill and of those in a persistent vegetative state is very costly, and it may be deemed reasonable to expend health care resources on those

<sup>402</sup>Denise van Schalkwyk, Chief Social Worker, Groote Schuur Hospital.

<sup>403</sup>Prof KRL Huddle.

<sup>404</sup>Dr Elizabeth Murray.

<sup>405</sup>NPPHCN; D Moellendorf.

<sup>406</sup>Human Life International SA.

<sup>407</sup>Human Life International; Africa Christian Action.

considered more worthwhile to society. The question was posed whether this was perhaps the rationale behind the proposed Bill: to exonerate those responsible for the care of these patients and avoid any further inconvenience and expense? The only logical argument for euthanasia is the economic one, and at the moment a large majority sees it instantly as immoral. At a time when all the countries in the developed world have to make rationing decisions, the concept of euthanasia on economic grounds should be feared. Surely even those initially most sincere and idealistic in their support for voluntary euthanasia must recognise that. The economic aspect of medical practice is a very real one in this country with an apparently shrinking health budget. There simply are not sufficient resources to give every individual the best treatment. Poor risk patients have to be turned away from treatment programmes when facilities are limited. There are not enough ICU beds for optimum treatment of all. The emphasis should however be on the need for more palliative care, not for killing. We need to deliver the best we can, not throw in the towel.<sup>408</sup>

3. Thirdly it was contended that legalising voluntary euthanasia is likely to lead by logical progression to involuntary euthanasia and even compulsory euthanasia with consequent loss of respect for the value of life.<sup>409</sup> No safeguards would be able to stem the tide. Respondents referred to experience from The Netherlands as set out in the Remmelink Report.<sup>410</sup> According to the Report commissioned by the Dutch Ministry of Justice, there were more than three thousand deaths from euthanasia in the Netherlands in 1990. More than one thousand of these were not voluntary. Other assessments have been far less conservative, and these figures predate February 1994 when euthanasia in that country was effectively legalised. The public conscience is changing quickly to accept the active termination of the lives of severely disabled neonates and comatose patients. The Royal Dutch Medical Association (KNMG) and the Dutch Commission for the Acceptability of Life Terminating Action have recently recommended that active

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<sup>408</sup>Dr T Germond.

<sup>409</sup>Hospice Association of Southern Africa; Africa Christian Action.

<sup>410</sup>Christian Medical Fellowship of SA.

termination of the lives of patients suffering from dementia is morally acceptable under certain conditions.<sup>411</sup> In 1996 a second report, covering the year 1995 was produced. According to its estimates, the cases of euthanasia in the strict sense had increased by one thousand, those of doctors acting with partial or explicit intention to end the lives of patients, by seven thousand, those of omission of treatment with intention of causing death, by nearly seven thousand, an increase of 34 percent. For the year 1995, one thousand four hundred and sixty three reports as required by law were sent in.<sup>412</sup> Respondents felt that the situation in the Netherlands deteriorated very rapidly<sup>413</sup> and that it is not an illustration of autonomy but the worst possible example of paternalism.<sup>414</sup> It could lead to a situation where those "useless" to society (bedridden, paralysed, senile etc.) can also be put to sleep.<sup>415</sup> Comparisons with the pre-war situation in Nazi Germany were also made. Leo Alexander in his famous paper on the Nazi doctors states that in the beginning there was merely a subtle shift in the basic attitude of physicians. It started with the attitude that there is such a thing as "a life not worth living." Is that not the attitude that underlies present day calls for euthanasia? Can South Africa therefore be sure that it will not be embarking on a slippery slope if it legalises euthanasia?

4) Voluntary informed consent is in principle impossible. A sick, frightened patient near the end of life is not in a position to make a well-considered decision.<sup>416</sup> A patient with a terminal illness is vulnerable, he lacks the knowledge and skills to alleviate his own symptoms, and may be suffering from fear about the future and anxiety about the effect his illness is having on others. It is very difficult for him or her to be entirely objective about his own situation. Patients often suffer from depression or a false sense of worthlessness which may affect their judgement. Their decision making may equally be

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<sup>411</sup>British Christian Medical Fellowship; Dr James Paul.

<sup>412</sup>Rev Justin Swanson referring to Van den Wal, G & Van der Maas, PJ **Euthanasie en andere Medische Beslissingen rond het Levenseinde** SDU den Haag, 1996.

<sup>413</sup>Glen Behn; W van der Merwe.

<sup>414</sup>Christian Medical Fellowship of SA.

<sup>415</sup>Dorothy-Anne Howitson, National Council for the Physically Disabled.

<sup>416</sup>Christian Medical Fellowship of SA; SA Council of Churches.

affected by confusion, dementia or troublesome symptoms which could be relieved with appropriate treatment.<sup>417</sup>

5) Legalising this form of euthanasia could result in the coercion of patients to request euthanasia especially with respect to vulnerable groups, minority groups and disempowered groups.<sup>418</sup> A patient may be subjected to direct pressure by relatives or heirs to ask for euthanasia, or indirect pressure to ask for euthanasia rather than continue to burden relatives or those caring for them.<sup>419</sup> The result is that "elderly people begin to consider themselves a burden to the society and feel under an obligation to start conversations on euthanasia, or even request it".

bb) Arguments of commentators in favour of active euthanasia

1. Because of the unique circumstances regarding the diversity of cultures in South Africa specific safeguards will have to be implemented to deal with these situations in order to reduce the potential for personal, professional and institutional abuse. These considerations will necessitate additional procedural safeguards and the ongoing transformation of the healthcare system.<sup>420</sup> The following arguments were stated:

i) (aa) With progressive urbanisation taking place throughout the country, comes increasing replacement of traditional communitarian values and practices with more individualistic ones, and, consequently, an increased need to expand end-of-life options.<sup>421</sup>

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<sup>417</sup>British Christian Medical Fellowship; Christian Medical Fellowship; R Higgens; Prof L Schlebush, Head of Department of Medically Applied Psychology, University of Natal; F Lobinger.

<sup>418</sup>Prof KRL Huddle; Dr Elizabeth Murray; Christian Medical Fellowship of SA.

<sup>419</sup>The Right to Live Campaign, Kwazulu Natal.

<sup>420</sup>Dr Willem Landman.

<sup>421</sup>Dr Willem Landman.

(bb) It was further noted that some forms of euthanasia are not completely unheard of in traditional communities:<sup>422</sup> In certain tribes twins and triplets were regarded as anathema. The Commission was furthermore referred to the tradition where a very old person who was about to die would be laid at the bivouac entrance after a ritual at night, to be trampled to death in the morning when the gates were opened. Although seemingly cruel, it was regarded as a dignified death. In war times weak soldiers of seemingly waning strength would be killed or left to die.<sup>423</sup>

(cc) With eleven official languages, misunderstanding in personal communication is a very real possibility. Patients should therefore be able to communicate and discuss treatment options in their first language, and give informed consent without language being an impediment to their understanding. Where physicians are unable to do this, qualified interpreters should facilitate the process and certify that patients understand all aspects of their decision.<sup>424</sup>

- ii) A general legal prohibition of assisted suicide and euthanasia, however, simply on the ground that traditional people may have difficulties understanding these options and the conditions under which they would operate, would be condescending and unjustifiably paternalistic. Such end-of-life options would be consistent with rights guaranteed by the Constitution and they would be in no way be imposed on anyone.<sup>425</sup> But, clearly, the creation of a legal right to active assistance in dying, in the forms of assisted suicide and euthanasia, would impose new educational responsibilities on society. In the Northern Territory of Australia it was reported that many Aborigines were led to believe by opponents of the legislation that the Rights of the Terminally Ill Act gives doctors the right to kill

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<sup>422</sup>Freddie Mashego.

<sup>423</sup>See also Schapera, I **The Khoisan Peoples of SA** London Routledge and Kegann Paul 1965 266 and De Beer, FC **Groepsgebondenheid in die Familie-, Opvolgings-, en Erfreg van die Noord-Ndebele** DPhil thesis University of Pretoria 1986 on 317.

<sup>424</sup>Mac Farlane, JM "Death and dying in Australia - some medico-legal problems for legislators" **Med Law** 1997, 16 179-186 as referred to by Dr Willem Landman in his submission.

<sup>425</sup>Dr Willem Landman.

you.<sup>426</sup> This carries a lesson in relation to unsophisticated people in South African society and shows the need for a well-conducted public education campaign.

- iii) The question of the scarcity of healthcare resources is an issue of equity that has to be addressed in the transformation process to a national health service. The issues of less affluent communities with regard to the rights of the terminally ill should be identified in order to address them. These issues include:<sup>427</sup>
- \* non-discrimination with regard to access to resources
  - \* access to quality palliative care
  - \* rights and responsibilities of home based carers
  - \* need for extra-legal education with regard to rights
  - \* simplified and widely available living wills
  - \* provision of counselling and informed consent regarding the nature of the illness
  - \* recognition of the rights of 'partners' who may not be recognised as a spouse in terms of a 'civil marriage'
  - \* effective and accessible complaints and enforcement mechanisms
  - \* HIV/AIDS input.<sup>428</sup>
- iv) Concerns about racism in this context, although understandable, are unfounded in view of the countervailing considerations,<sup>429</sup> such as the following: (a) procedural safeguards are directed at eliminating all forms of unjustified assisted suicide and euthanasia; (b) generally speaking, physicians are held in high esteem in South Africa and the complicity of state-employed physicians in the state-sanctioned murder of black activist Steve Biko in 1977 is not the norm; (c) there was a strong anti-apartheid tradition among the medical profession, including academic medicine; (d) the overwhelming majority of the members of the South African

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<sup>426</sup>South Australian Voluntary Euthanasia Society.

<sup>427</sup>Lawyers for Human Rights.

<sup>428</sup>Lawyers for Human Rights.

<sup>429</sup>Dr Willem Landman.

Parliament are black (and they also approved radically progressive abortion legislation); (e) during the 1990s admissions of black students to medical schools have increased significantly and the Government is committed to addressing the remaining imbalances; and (f) there is no evidence of abuse in Intensive Care Units in respect of withholding or withdrawal of life-sustaining treatment.<sup>430</sup>

2. Although there is no proven abuse in South African Intensive Care Units in respect of withholding or withdrawal of life-sustaining treatment, some might nevertheless worry about the risk of abuse should assisted suicide and euthanasia be legalized because healthcare resources are considerably scarcer in South Africa than in industrialised countries. The scarcity of resources would however not necessarily lead to unjustified killing in the name of assisted suicide or euthanasia, provided that the procedural safeguards are in place and honoured. From another angle one could argue that it is preferable for a patient, who meets all the criteria for assisted suicide or euthanasia, to know that there is an escape route when medical insurance cover is exhausted, rather than having to suffer due to a combination of scarce resources and legal prohibition.<sup>431</sup> Although this would appear to compromise the voluntary nature of an assisted suicide or euthanasia request, it is probably no different from other healthcare decisions made in the prevailing circumstances of justice. Since there is the problem of limited resources of the state the question is posed why people should not be allowed to die peacefully if that is what they want.<sup>432</sup> The Commission was asked to consider the less affluent people who do not have the wealth of a Dr Clarke to pay for treatment.<sup>433</sup> Keeping people alive is also a moneymaking project and can harm the lives of the families of terminally ill patients.<sup>434</sup> The financial implications of a long illness cause great concern to the aged. It is a sad fact

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<sup>430</sup>Turner JS, Michell, WL, Morgan CJ et al 1996 "Limitation of life-support: frequency and practice in a London and a Cape Town intensive care unit" **Intensive Care Medicine** 22, 1020-1025.

<sup>431</sup>See the discussion of the Soobramey case above.

<sup>432</sup>Cedric Biggs.

<sup>433</sup>RMS Broadbent, 81 years old.

<sup>434</sup>Peter Hamilton.



that the present Government is unable to fund the aged in old age homes. It is also a fact that the population generally is living longer, and most of them in poverty and that medical costs are becoming prohibitive. Aged people are often living in extreme distress.<sup>435</sup>

3. The slippery-slope argument against legalising assisted suicide and euthanasia in both its logical and empirical versions, is overworked and probably a bogeyman. It does not follow, as a matter of logic, that the reasons justifying euthanasia, namely, mercy and respect for autonomy, would lead to killings that are not justifiable by mercy or respect for autonomy.<sup>436</sup> There is no obvious reason why there would be abuse only in respect of one subset of end-of -life medical decisions, namely assisted suicide and euthanasia, but not in respect of others, namely withholding or withdrawal of life-sustaining treatment. In addition, available empirical evidence does not show that ethically or legally justified assistance in dying leads to unjustified killing. There is no evidence of abuse in respect of existing practices which hasten death, such as withholding or withdrawal of life support when a competent patient requests it, or terminating life-sustaining medical treatment of an incompetent, terminally ill person without an advance directive. Significantly, a comparative study of limitation of life support in intensive care units (ICU's ) in the United Kingdom and South Africa shows no significant differences.<sup>437</sup> The persistent suggestion that widespread "involuntary" euthanasia is practised in the Netherlands derives from a misreading of the Rummelink report. This misreading depends on the word "involuntary" as a catch-all term regardless of the attendant circumstances. Included in it are those many cases in which the central participant was terminally comatose when the decision not to prolong life was taken.<sup>438</sup> Furthermore, a number of factors have contributed to the increase of voluntary euthanasia and medically assisted suicide from 2.1 percent to 2.7 percent of total deaths in the five-year period. Mortality rates increased as a consequence of the aging of the population. The proportion of deaths from cancer increased as a

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<sup>435</sup>Eulalie Stott, Alderman of the City of Cape Town.

<sup>436</sup>Kuhse H 'Euthanasia' in P Singer (ed) **A Companion to Ethics** Basil Blackwell Oxford 294 at 301 as referred to by Dr Willem Landman in his submission.

<sup>437</sup>Dr Willem Landman with reference to Turner et al, 1996.

<sup>438</sup>The Voluntary Euthanasia Society, London.

consequence of a decrease in deaths from heart disease. Life-prolonging techniques became increasingly available and there were possibly generational and cultural changes in patients' attitudes. The slightly fewer cases of ending life without an explicit request may be a result of the increasing openness with which end-of-life decisions are discussed with patients.<sup>439</sup> Reference to Hitler's Germany and Stalin's Russia to allow doctors to engage in euthanasia are obfuscating and irresponsible. It groundlessly equates incomparable actions, bound together only by the same designation, and it cheapens the suffering of the victims of totalitarianism. For the Nazis, the motivation was neither mercy nor respect for autonomy, but achieving the racial purity of the Volk. Significantly research indicates that survivors of the holocaust found no similarity between assisted suicide as contemplated in a purely medical context (which some of them indeed oppose) and the Nazi policy of legalized murder, euphemistically called "euthanasia".<sup>440</sup> Convinced opponents of any shift in the law sometimes employ emotive arguments drawn from this other, aberrant use of the word, but such arguments serve only to confuse issues in what is already a complex debate.<sup>441</sup>

4.198 It was emphasised in all the submissions received by the Commission, whether for or against euthanasia, that potential abuse of statutory law must be prevented or contained as effectively as possible, hence the importance of procedural safeguards that would ensure greater certainty about the voluntariness of the request for assisted suicide or euthanasia. In this regard it was suggested that the procedural safeguards proposed by the Commission in the draft bill need to be tightened.<sup>442</sup> Guidelines should be very comprehensive and strict.<sup>443</sup> Specific proposals in this regard were the following:

- a) Additional specificity in the bill is required. It would be desirable to specify the number of requests for euthanasia or assisted suicide and the interval between them

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<sup>439</sup>South Australian Voluntary Euthanasia Society , SAVES Fact Sheet No 17.

<sup>440</sup>Dr Willem Landman and references made therein.

<sup>441</sup>The Voluntary Euthanasia Society submission to the House of Lords.

<sup>442</sup>Dr Willem Landman.

<sup>443</sup>Southern African Anglican Theological Commission (Cape Town group).

that would be required before compliance with the requests would be permitted.<sup>444</sup> The period between the initial request for assisted suicide and the act should be prolonged to give the patient time to reflect on his decision,<sup>445</sup> but without becoming overbearing. An informed and well-considered decision, made known in the form of an oral request, should be followed by a waiting period of a stipulated number of days (seven, for example), there should then be a written request followed by a second waiting period (of 48 hours for example) and there should be repeated, formalised opportunities to rescind the decision.<sup>446</sup>

- b) Some respondents were in favour of the patient seeing a psychiatrist<sup>447</sup> while others did not consider a psychiatric examination mandatory.<sup>448</sup> It was felt that a hopelessly ill, irremediably suffering patient does not have to show freedom from clinical depression to justify seeking ultimate relief. It should only be necessary where the hopelessly ill criterion is not being met.<sup>449</sup> It was proposed that an assessment of the patient's 'mental competence' should include an assessment of whether the patient is suffering from depression which may impair decision making.<sup>450</sup> Counselling should furthermore be provided to the patient, including counselling on the importance of consulting with family members, partners and relatives.<sup>451</sup>
- c) A certificate of request must be signed by the patient and the medical practitioner.<sup>452</sup> The certificate of request must be signed by another medical

<sup>444</sup>Prof S Benatar et al.

<sup>445</sup>United Christian Action.

<sup>446</sup>ME Chomse; Dr Willem Landman ; M Lavies.

<sup>447</sup>United Christian Action; SA Nursing Council.

<sup>448</sup>Prof Geoffrey Falkson; South Australian Voluntary Euthanasia Society.

<sup>449</sup>South Australian Voluntary Euthanasia Society.

<sup>450</sup>Lawyers for Human Rights.

<sup>451</sup>Lawyers for Human Rights.

<sup>452</sup>SA National Consumer Council; Lawyers for Human Rights.

practitioner in the presence of the first medical practitioner and the patient, after he has discussed the case with the other two and is satisfied that the certificate is in order, the patient is of sound mind, that the patient's decision to end his life has been made freely, voluntarily and after due consideration and all conditions have been met.<sup>453</sup> The request should be documented, attested by an independent witness, and confirmed after a period of re-evaluation.<sup>454</sup>

- d) An interpreter with prescribed professional qualifications must be present at all critical times.<sup>455</sup>
- e) The care of patients experiencing 'difficult deaths' may fall outside of the expertise of many primary care physicians. Where the patient's medical practitioner has no special qualifications in the field of palliative care,<sup>456</sup> the patient should be referred to a hospice programme or a physician experienced in palliative care.<sup>457</sup>
- f) The medical practitioner shall not assist the patient if he believes that palliative care is available to alleviate the patient's pain.<sup>458</sup> Any guidelines regarding assisted death should be structured within the context of comprehensive care of the terminally ill, and thus should be seen as a last resort for those patients who have been provided adequate and quality palliative care and have explored every other option.<sup>459</sup>
- g) The written report of the medical practitioner should be submitted.<sup>460</sup> The legislation grants a wide range of duties and powers to medical practitioners. It

<sup>453</sup>United Christian Action.

<sup>454</sup>Prof Geoffrey Falkson.

<sup>455</sup>United Christian Action.

<sup>456</sup>United Christian Action.

<sup>457</sup>Lawyers for Human Rights.

<sup>458</sup>United Christian Action.

<sup>459</sup>Lawyers for Human Rights.

<sup>460</sup>United Christian Action.

will therefore be necessary to ensure that mechanisms are created to review discretionary powers of medical practitioners in terms of the Act.<sup>461</sup> It was furthermore recommended that the nature, duties and procedures of the South African Interim Medical and Dental Council be reviewed in order to ensure that this body is able to respond to complaints, queries and reviews.<sup>462</sup> A register should be kept (by hospital, province or central health department) to legally document all such cases.<sup>463</sup>

- h) The majority of patients in South Africa live in a complex cultural milieu where members of the extended family often have considerable decision making power. Strategies should be devised to deal with these and also to provide emotional or psychological support and counselling to affected families.<sup>464</sup>
- (i) Concern was expressed in general that no attempt has been made to accommodate the needs of terminally ill and dying persons who are younger than 18 years.<sup>465</sup> Some argue persuasively that minors with, for example, end-stage renal disease or terminal cancer and who have the required cognitive and emotional wherewithal, should have the right to refuse life-sustaining treatment.<sup>466</sup> It follows that some mature older minors might be able to exercise the right to other life-shortening options for themselves, such as assisted suicide and euthanasia.<sup>467</sup> As has been

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<sup>461</sup>See also the submission of the Society of Advocates of Natal in which they argued that consideration should be given to the appointment of curators-ad-litem in cases falling under section 5. The purpose would be to obtain a declaration from the court to the effect that, based on the available evidence and the report of the curator, no circumstances have been revealed which justify the making of an order interdicting the medical practitioner concerned from acceding to the patient's request.

<sup>462</sup>Lawyers for Human Rights.

<sup>463</sup>Prof Geoffrey Falkson.

<sup>464</sup>NPPHCN.

<sup>465</sup>Alfred Allan.

<sup>466</sup>See also discussion on competent minor and cessation of treatment on page 45 para 4.28 above.

<sup>467</sup>Dr Willem Landman.

seen above competent minors may refuse treatment. It has also been indicated that minors are under the decision-making authority of their parents and parents are presumed to do what is in the best interest of their children. Some balance needs to be maintained therefore between the decision-making authority of the parents and the decision-making ability of minors by recognising some joint-decision making process and taking into account the minor's particular vulnerability.<sup>468</sup>

- j) Patients should be protected against the self-interest of third parties as this can easily outweigh what is best for the patient. Relatives may be eager for the patient's early death because it will relieve them of the burden of caring for him. Alternatively they may be attracted by the wealth they may inherit.<sup>469</sup>
  
- k) In discussing the question whether the medical practitioner should be the only person authorised to perform euthanasia two approaches could be ascertained:
  - i) Physicians, who make factual determinations as required by the procedural safeguards, and who are the only ones authorized to prescribe the drugs necessary for terminating life, remain in full control as the only persons legally permitted to assist with suicide and perform euthanasia; or
  - ii) Designated other persons (nurses or other health care practitioners caring for the terminally ill) are also legally empowered to assist in dying in circumscribed ways.

Some respondents felt that the action should take place in a hospital. A medical doctor should be the lead person of the team to offer euthanasia.<sup>470</sup> A social support system should be ensured to assist the family as well as the health care professionals.<sup>471</sup> It is important that other members of the health care team be

<sup>468</sup>Dr Willem Landman.

<sup>469</sup>United Christian Action ; F Lobinger; SK Schonegevel.

<sup>470</sup>This is also the position in the Netherlands.

<sup>471</sup>Department of Health.

included in the decision making process and that all is not left to a medical practitioner. A multi-disciplinary panel is essential. This is especially important when the question of sound decision- making either by the patient or on the behalf of the patient is addressed.<sup>472</sup>

Other views were that the limitation that only a doctor may perform euthanasia is unnecessary and problematic. Presumably it was introduced as a hedge against abuse. However it seems unnecessary given the other procedural safeguards that are, and could be, introduced. Respondents agreed that medical doctors are indispensable in the process leading to the termination of life in the clinical context. Their expertise is required for making diagnoses and prognoses and for outlining clinical options. However some respondents felt that there was no reason why only doctors should be permitted to provide this assistance or relief. Patients may well prefer securing such assistance from spouses, children, parents or friends. Dying is a lonely event and comfort may be drawn from having those close to one involved. To deny people this option seems an unnecessary interference with their liberty, should other safeguards be in place. Allowing people other than medical practitioners to assist in suicide or assisted suicide has an additional advantage. If doctors were the sole practitioners of euthanasia and assisters of suicide there is a danger, many fear, that animosities towards and distrust of the medical profession might increase. However if the act of euthanasia or assisted suicide is not seen as the preserve of doctors alone, the image of the medical profession would not thereby be tainted in the broader society.<sup>473</sup> Anecdotal evidence suggests that this is already happening in countries like the United States. Should such a practice become law in South Africa, additional procedural safeguards need to ensure that assisters of suicide and performers of euthanasia are knowledgeable about methods of assistance in dying. Moreover, physicians would have to be vigilant about possible conflicts of interest between the family members and the patient, as well as disagreements among family members. However, in principle, these kinds of difficulties are no more different from those of a physician

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<sup>472</sup>Prof L.Schlebusch ; Southern African Anglican Theological Commission (Cape Town).

<sup>473</sup>Prof S Benatar et al.

authorising the termination of life-sustaining medical treatment of an incompetent, terminally ill person without an advance directive at the request of the family. Should persons other than physicians be legally empowered to assist in dying, other healthcare workers, such as nurses or aides, who might be intimately involved in care, should also be permitted to assist with suicide or perform euthanasia. Moreover, with the inclusion of traditional healers in health-care delivery, it is conceivable that they may feel entitled to assist in dying. If any person who is not a physician were to be legally empowered to assist, it should be in the form of actual administration (such as handing over pills or giving a lethal injection) and not in making clinical determinations.<sup>474</sup>

**c) Recommendation of the Commission**

**4.199 From the submissions received it is clear that in so far as active euthanasia is concerned society is divided and moral controversy is rife. It places the SA Law Commission in the difficult position of having to clarify the principles on which legal intervention should proceed in the absence of a moral consensus on this issue.**

**4.200 Dworkin<sup>475</sup> maintains that the common thread or moral principle at stake is the principle of the sanctity of life. He says that the crucial jurisprudential question is whether the principle of the sanctity of life should be given effect in law and if so, in what form. He contends that the principle of the sanctity of life should not become a legal principle because the principle admits of different 'quasi-religious' interpretations. If the principle were to be given effect in law, the courts or the legislature would have to take sides in what is essentially religious disputes and adopt an 'official' (state) view of the sanctity of life. This would be contrary to the democratic ideal of freedom of religion. On this basis, Dworkin seeks to show that the appropriate jurisprudential stance over euthanasia is one which**

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<sup>474</sup>Dr Willem Landman.

<sup>475</sup>Dworkin R **Life's dominion: an argument about abortion and euthanasia** London Harper Collins Publishers 1993.



accommodates both the conservative and the liberal positions.<sup>476</sup>

**4.201** In *Sv Makwanyane* <sup>477</sup> Judge Chaskalson stated that "public opinion may have some relevance to the enquiry, but, in itself, it is no substitute for the duty vested in the courts to interpret the Constitution and to uphold its provisions without fear or favour. If public opinion were to be decisive there would be no need for constitutional adjudication.

**4.202** It would therefore seem as though the only way in which an answer will present itself is if the discussion could be conducted with total objectivity in terms of the constitutional principles.<sup>478</sup> The different competing constitutional rights relevant to this matter have already been identified by our commentators. In discussing the content of the right to life principle in sec 11 of the Constitution Joanne Fedler<sup>479</sup> states that in its most basic form s11 provides a guarantee to citizens that they have the right "to be alive". What remains to be answered is whether quality of life will be read into the language of s 11 broadening its ambit. In *S v Makwanyane* it was held that the right to life was subject to s 33 <sup>480</sup> (Interim Constitution) and that a limitation of this right would not amount to its extinction.<sup>481</sup> A law authorising euthanasia may therefore be a reasonable and justifiable limitation on the

<sup>476</sup>Plomer, A " Review: Dworkin R Life's dominion: an argument about abortion and euthanasia" 1996 **The Modern Law Review** 479..

<sup>477</sup>At 431 B-D.

<sup>478</sup>Scott 2.

<sup>479</sup>Fedler J **Life Chapter 15** in Chaskalson M et al (ed) **Constitutional law of South Africa** Kenwyn Juta & Co 1996 at 15-1.

<sup>480</sup>Fedler states on 15-7 that with the exception of only one judicial opinion (Sachs J at para 353) all the **Makwanyane** judgements that dealt with limitation, held that the right to life was subject to s33; See also Nadasen S " 'Suffer the little children..' euthanasia and the best interests of the child" 1997 **THRHR** 124 at 131(hereinafter referred to as "Nadasen").

<sup>481</sup>Sec 33(1)(b) of the Interim Constitution rendered a limitation on a right by a law of general application impermissible where such limitation 'negates the essential content' of the right in question. It has been argued that the essential content of the right to life was being alive and that any act which limited the right extinguishes the nucleus of the right and thus could not be justified under s 33. Sec 36 (1) of the final Constitution does not prohibit limitations which negate the essential context of the right. Thus it is clear that laws which authorises the taking of human life are, at least in principle, capable of justification under the limitations clause.( Fedler on 15-8).

right to life. Fedler concludes<sup>482</sup> that the constitutional survival of the proposed legislation<sup>483</sup> will therefore depend on whether the Court gives 'life' a content value, importing some form of quality of life beyond mere existence;<sup>484</sup> secondly whether it accepts that there are circumstances in which a person's quality of life has degenerated to such an extent that to prolong the dying process runs counter to the right to life guarantee; and thirdly, to what degree the other rights of a terminally ill patient embody values of an open and democratic society which would justify a limitation of the right to life in circumstances where a person is little more than alive.

**4.203** The issues in this paper entail medical, legal and ethical concerns in regard to end of life decisions, reflecting the broader moral and ethical concerns of society.

**4.204** The different positions, conservative as well as liberal, are set out as follows:

**i) Option 1: Confirmation of the current legal position**

4.205 With reference to the respondents who voiced their opposition to active euthanasia<sup>485</sup> it is recommended that there be no change to the current law in South Africa prohibiting active voluntary euthanasia and physician assisted suicide. Since the right to refuse medical treatment is far removed from the right to request euthanasia the Commission strongly endorses the right of the competent patient to refuse consent to medical treatment but holds that a law to permit euthanasia unacceptable. The Commission is of the opinion that the arguments in favour of legalising voluntary euthanasia as set out above are not sufficient reason to weaken society's

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<sup>482</sup>At 15-8.

<sup>483</sup>Referring to the bill enclosed with Working Paper 53, but equally applicable in the current discussion.

<sup>484</sup>See Nadasen on 129-131.

<sup>485</sup>See above for discussion of the rationales on 79 and further.

prohibition of intentional killing as entrenched in sec 11 of the Constitution and which is considered to be the cornerstone of the law and of social relationships. Whilst acknowledging that there may be individual cases in which euthanasia may be seen by some to be appropriate, these cases cannot reasonably establish the foundation of a general pro-euthanasia policy. It would be impossible to establish sufficient safeguards to ensure that euthanasia were truly voluntary and would not inevitably lead to involuntary or compulsory euthanasia. Dying should not be seen as a personal or individual affair, the death of a person affects the lives of others. The issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.

4.206 It has to be acknowledged that the rejection of voluntary euthanasia as an option for an individual entails a compelling social responsibility to care adequately for those who are elderly, dying or disabled. This responsibility exists despite the inevitable constraints on health care resources. High-quality palliative care should be made more widely available and the training of health care professionals should be given greater priority.

## **ii) Option 2: Decision making by medical practitioner**

4.207 This is the option that was set forward in Discussion paper 71. It has been amended to incorporate proposals made in so far as the tightening of safeguards are concerned:

### ***Cessation of life***

5. (1) *Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall give effect to the request if he or she is satisfied that-*

(a) *the patient is suffering from a terminal or intractable and unbearable illness ;*

(b) *the patient is over the age of 18 years and mentally competent;*

- (c) *the patient has been adequately informed in regard to the illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;*
  - (d) *the request of the patient is based on a free and considered decision;*
  - (e) *the request has been repeated without self-contradiction by the patient on two separate occasions at least seven days apart, the last of which is no more than 72 hours before the medical practitioner gives effect to the request;*
  - (f) *the patient, or a person acting on the patient's behalf in accordance with subsection (6), has signed a completed certificate of request asking the medical practitioner to assist the patient to end the patient's life;*
  - (g) *the medical practitioner has witnessed the patient's signature on the certificate of request or that of the person who signed on behalf of the patient;*
  - (h) *an interpreter fluent in the language used by the patient is present in order to facilitate communication when decisions regarding the treatment of the patient are made where the medical practitioner as contemplated in this section does not share or understand the first language of the patient;*
  - (i) *ending the life of the patient or assisting the patient to end his or her life is the only way for the patient to be released from his or her suffering.*
- (2) *No medical practitioner to whom the request to make an end to a patient's suffering is addressed as contemplated in subsection (1), shall give effect to such a request, even though he or she may be convinced of the facts as stated in that subsection, unless he or she has conferred with an independent medical practitioner who is knowledgeable with regard to the terminal illness from which the patient is suffering and who has personally checked the patient's medical history and examined the patient and*

*who has confirmed the facts as contemplated in subsection (1)(a), (b) and (i).*

*(3) A medical practitioner who gives effect to a request as contemplated in subsection (1), shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner with whom he or she has conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).*

*(4) The termination of a patient's life on his or her request in order to release him or her from suffering may not be effected by any person other than a medical practitioner.*

*(5) A medical practitioner who gives effect to a patient's request to be released from suffering as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act provided that all due procedural measures have been complied with.*

*(6) If a patient who has orally requested his or her medical practitioner to assist the patient to end the patient's life is physically unable to sign the certificate of request, any person who has attained the age of 18 years, other than the medical practitioner referred to in subsection (2) above may, at the patient's request and in the presence of the patient and both the medical practitioners, sign the certificate on behalf of the patient.*

*(7)(a) Notwithstanding anything in this Act, a patient may rescind a request for assistance under this Act at any time and in any manner without regard to his or her mental state.*

*(b) Where a patient rescinds a request, the patient's medical practitioner shall, as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record.*

(8) *The following shall be documented and filed in and become part of the medical record of the patient who has been assisted under this Act:*

- (a) *a note of the oral request of the patient for such assistance;*
- (b) *the certificate of request;*
- (c) *a record of the opinion of the patient's medical practitioner that the patient's decision to end his or her life was made freely, voluntarily and after due consideration;*
- (d) *the report of the medical practitioner referred to in subsection (2) above;*
- (e) *a note by the patient's medical practitioner indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the substance prescribed.*

### **iii) Option 3: Decision making by panel or committee**

4.208 The last option to be considered is that legislation should make provision for the institution of panels or ethics committees to consider requests for active euthanasia. It is interesting to note that similar multi-disciplinary committees have now been instituted in the Netherlands. They are however not being approached before the euthanasia is performed as has been proposed in South Africa, but are part of the review process.

4.209 This option has been proposed and discussed by quite a few commentators.<sup>486</sup> They said that each case will be different and should therefore be considered independently. The Committee or panel should be made up out of medical practitioners, a psychiatrist, and a Judge and at least one other member of the multi-disciplinary team who is able to communicate in the patient's

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<sup>486</sup>See eg. the Department of Health which indicated that it agrees in principle with the proposed Clause 5 except that an addition should be made to subsection 6 allowing for the matter to be referred to a competent body, either another physician or an Ethics Committee.

language.<sup>487</sup> The panel may also include relatives. Members could listen, assess and make a ruling. There should be a clause stipulating a time limit of two or three weeks within which the panel must convene to consider any request. This would give time for the patient, or a representative of the patient, to get to the centre where the panel would be sitting and bring all the medical documentation. It may also be necessary for a visit to the patient by a social worker or some other person deployed by the panel to report on the situation, should the panel feel the documentation is not adequate and the patient is not able to attend the hearing. Clearly all panellists chosen must not be anti-euthanasia and must be people of compassion.<sup>488</sup> If a panel is established, patients would not be influenced by doctors or relatives. A stringent set of rules should be drawn up, before application can be made to this panel and each case then judged individually.<sup>489</sup> No health care provider is obliged to participate in the act requested by the patient. However, the patient's right to have his or her request considered must be respected and therefore forwarded to the proposed Ethics Committee. The multi-disciplinary approach should be followed, also including the family in decision making.<sup>490</sup> The belief was expressed that this format will satisfy those who feel that our society is not ready for euthanasia, and that the danger of abuse is too great. For that reason, it should incorporate criteria which will make permission to obtain physician assisted suicide or voluntary euthanasia difficult, but not impossible. With good palliative care, there will be far less need or requests for this, but there are situations of such unbearable suffering, that not to allow requests for an end to the suffering will be denying these patients the opportunity of a peaceful end rather than have them attempt to commit suicide, often in awful ways, also often not successfully.<sup>491</sup> Given the complexity of selective non-treatment (and other end of life) decisions, any individual decision maker needs advice from an informed group representing different professional fields.<sup>492</sup>

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<sup>487</sup>National Office: Cancer Association of SA.

<sup>488</sup>Dr Selma Browde.

<sup>489</sup>Final Exit Zimbabwe.

<sup>490</sup>Joane Deare, Natal Region, CANSA.

<sup>491</sup>Dr Selma Browde.

<sup>492</sup>Moor, S "Euthanasia in relation to new-born babies - a comparative study of the legal and ethical issues" Part I 1996 **Med Law** 295 and Part II 1996 **Med Law** 537 (hereinafter referred to as "Moor")at 308.

4.210 In order to make provision for a panel as discussed above the following legislation would be necessary:

***Cessation of life***

5. (1) *Euthanasia may be performed by a medical practitioner only, and then only where the request for the euthanasia of the patient has been approved by an ethics committee constituted for that purpose and consisting of five persons as follows:*

- a) *two medical practitioners other than the practitioner attending to the patient;*
- b) *one lawyer;*
- c) *one member sharing the home language of the patient;*
- d) *one member from the multi-disciplinary team; and*
- e) *one family member.*

(2) *In considering and in order to approve a request as contemplated in subsection (1) the Committee has to certify in writing that:*

- a) *in its opinion the request for euthanasia by the patient is a free, considered and sustained request;*
- b) *the patient is suffering from a terminal or intractable and unbearable illness;*
- c) *euthanasia is the only way for the patient to be released from his or her suffering.*

(3) *A request for euthanasia must be heard within three weeks of it being received by the Committee.*

(4) (a) *The Committee which, under subsection (2), grants authority for euthanasia must, in the prescribed manner and within the prescribed period after*



*euthanasia has been performed, report confidentially to the Director-General of Health, by registered post, the granting of such authority and set forth -*

- (i) the personal particulars of the patient concerned;*
- (ii) the place and date where the euthanasia was performed and the reasons therefore;*
- (iii) the names and qualifications of the members of the committee who issued the certificates in terms of the above sections; and*
- (iv) the name of the medical practitioner who performed the euthanasia.*

*(b) The Director-General may call upon the members of the Committee required to make a report in terms of subsection (4) or a medical practitioner referred to in subsection (1) to furnish such additional information as he may require.*

*(5) The following shall be documented and filed and become part of the medical record of the patient who has been assisted under this Act:*

- (a) full particulars regarding the request made by the patient;*
- (b) a copy of the certificate issued in terms of subsection (2);*
- (c) a copy of the report made in terms of subsection (4).*

*\*Offences and penalties to make provision for punishment of prohibited behaviour.*

4.211 Some respondents suggested that the Commission should follow the Dutch law<sup>493</sup> concerning euthanasia since it is liberal, gives clear guidelines for medical doctors and preserves

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<sup>493</sup>For a full discussion of the Dutch position see para 4.86 on 69 above.

the patient's rights at the same time.<sup>494</sup> Prof Labuschagne<sup>495</sup> inter alia discussed the question whether the defence of necessity would be available to a defendant in a euthanasia case in a court in South Africa.<sup>496</sup> He comes to the conclusion that from a legal point of view nothing precludes the courts from following the same route as their counterparts in the Netherlands.

4.212 He refers to a case in the Netherlands in 1995<sup>497</sup> where the requirements were set out as follows:

"Bij de beoordeling van het beroep op noodtoestand dient onderzocht te worden of de arts, in het bijzonder volgens wetenschappelijk verantwoord medisch inzicht en overeenkomstig in de medische ethiek geldende normen, uit onderling strijdige plichten een keuze heeft gedaan die, objectief bescouwd en tegen de achtergrond van de bijzondere

omstandigheden van het onderhavige geval, gerechtvaardigd is te achten".

4.213 The question may therefore be asked whether South Africa should not follow the same legislative path as well. Chesterton contends that the failure to provide legislative guidance

<sup>494</sup>Dr Niek Heering.

<sup>495</sup>Labuschagne 1995 *SALJ* 227 at 229.

<sup>496</sup>The defence of necessity in our law has the same source and elasticity as that of the Dutch law. In his well-known work *De Jure Belli ac Pacis* (1625) 2.2.6.2 Hugo de Groot states as follows: '**in omnibus legibus humanis....summa illa necessitas videtur excepta**'. A German jurist of equal stature, Benedictus Carpsovius, states in the same vein: '**necessitas legem non habet**' (*Responsa Iuris Electoralis* (1642) 6.9.94.1) Other common law authority for a wide interpretation has been identified on previous occasions (JMT Labuschagne "Noodtoestand" 1974 *Acta Juridica* 73 op 74 -5. See further Van der Westhuizen **Noodtoestand as regverdighingsgrond in die Strafreë** unpublished LLD thesis University of Pretoria 197 498-511. A clear basis for the broadening of the impact of necessity as a criminal defence by our courts can be found in the common law. Our courts have in fact made use of it. (**Ex parte die Minister van Justisie: In re S v Van Wyk** 1967 (1) SA 488 (A); **S v Goliath** 1972 (3) SA 1 (A). See furthermore in this regard in 1974 *Acta Juridica* 97-98 with the criticism CH Heyns **A Jurisprudential Analysis of Civil Disobedience in South Africa** (unpublished PhD thesis, Witwatersrand University 1991 692-693). Our courts may therefore follow the same route as that of the courts in the Netherlands.

<sup>497</sup>5 December 1995 Hoge Raad (NJ 1996,322).

beyond procedural measures should be seen as a combination of the Dutch Parliament's failure to agree on a controversial issue and the relative trust and respect felt for the Dutch medical profession.<sup>498</sup> Cica identified the following attitudes as explaining the Dutch approach to euthanasia: a willingness to discuss difficult moral issues openly; the increased secularisation of Dutch society since the sixties; a Calvinist sense of individual responsibility combined with respect for the autonomy of others; the Royal Dutch Medical Association's approval of doctors participating in voluntary euthanasia; great trust in, and respect for, the medical profession; and universal and comprehensive medical coverage.<sup>499</sup>

4.214 Keown on the other hand criticises the position in the Netherlands where he says it is not even possible precisely to identify the legal criteria, let alone define them. He says that the Supreme Court has omitted to lay down a precise list of criteria and lower courts have issued sets of criteria which are far from congruent. The guidelines are vague and entrust decision-making to the individual practitioner only.<sup>500</sup>

4.215 Following the Dutch example in South Africa would entail that active euthanasia remains a criminal offence in terms of the common law. Each instance of euthanasia is reported to the Attorney General who decides on a case-by-case basis whether a doctor should be prosecuted. The decision of the Attorney General will be made in accordance with principles set out in a set of regulations, drawn up by the Attorney General's office in consultation with the medical profession, which states the requirements that a medical practitioner has to fulfill in order to be sure that he will not be prosecuted. The underlying legal basis for the decision of the Attorney General would be the defence of necessity.<sup>501</sup>

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<sup>498</sup>Chesterton 383.

<sup>499</sup>Cica 4 Introduction.

<sup>500</sup>Reference in Chesterton at 377.

<sup>501</sup>In practical terms it would entail amendments to the **Births and Deaths Registration Act 51** of 1992 which regulates the registration of births and deaths; and provides for matters connected therewith; and the **Inquests Act 58** of 1959 which provides for the holding of inquests in cases of deaths or alleged deaths apparently occurring from other than natural causes and for matters incidental thereto.

**4.216 The Commission however decided not to follow the Dutch position in this regard as this option does not present a conclusive answer as to whether active euthanasia is lawful or not. Since the position regarding active euthanasia in South Africa has not been clarified by the courts to the extent that this has been done in the Netherlands, the Commission regards a principled decision in this regard as imperative. The constitutionality of the legislation may also be challenged.**

4.217 It should be noted that the Commission received quite a few proposals to separate active euthanasia from the rest of the report and also to have two separate bills. The following comments were made:

- \* MASA "fears that inclusion of these controversial issues in the Bill will elicit such opposition that there would be a real risk that the entire Bill could be rejected, including those clauses of which enactment is of vital importance to the medical profession and patients. The Association would, therefore support the view that these clauses be dealt with separately from the other clauses."
- \* SAVES stressed the fact that they feel strongly that the section concerning living wills(advanced directives) should be kept entirely separate from that dealing with active euthanasia and doctor-assistance in dying. They recommend that two separate Bills be drafted in order to speed up the legislation of living wills(advanced directives). They further recommend very strongly and urgently that the section dealing with active euthanasia be deleted in its entirety from the Bill since its inclusion in the Bill may endanger, or needlessly delay the passage and implementation of the vitally important provisions of the Bill, which relate to good palliative care. The provisions should rather form the basis of a completely separate Draft Bill. The conceptual, moral and ethical chasm that separates good palliative care from active euthanasia (of any sort) is so wide that it is completely inappropriate to include the two concepts in the same legislation.
- \* Lawyers for Human Rights: Aids and Human Rights Programme would like to

submit that the issues of both assisted suicide and voluntary euthanasia for the terminally ill patients are issues of such complexity that a national summit on such issues is necessary.

- \* Dr Selma Browde said that the only controversial clause in the Bill is the one relating to active voluntary euthanasia, and physician assisted suicide (Clause 5, Cessation of life). In view of this she would like to suggest that two Bills be presented to Parliament simultaneously, one on the Rights of the Terminally Ill or End of Life Decisions, which will contain all the other clauses and the other containing Clause 5 only (with far more stringent checks and balances) and which will be known as the Euthanasia Bill. The advantages are the following:

- \* It will help resolve the confusion between palliative care and euthanasia which is essential if we are to have meaningful discussions on the subject. At present this draft bill and discussion paper is being generally referred to as "The Euthanasia Bill" which is counterproductive to the aim of informing doctors and patients alike that relieving suffering is a necessary and permissible function of the medical profession.

- \* The debate on euthanasia will then be separated from the debate on the other aspects so that it will prevent possible delay in the passing of the Bill relating to rights of the terminally ill, which should be considered as a matter of urgency.

## **E. Involuntary active euthanasia**

- a) Position as set out in Discussion Paper 71

4.218 For the sake of completeness the case of involuntary euthanasia was also discussed in

Discussion paper 71. Involuntary euthanasia involves those cases where a person, acting in sympathy and compassion for a legally competent person, performs euthanasia either by an omission or by a positive act. In these instances there is no request for euthanasia by the patient.

4.219 The Commission's opinion was that no legal system would tolerate this kind of conduct, especially because of the possible abuse which may occur if it were to be accepted.

b) Discussion of submissions received

4.220 Commentators unanimously agreed with the views of the Commission.<sup>502</sup>

c) **Recommendation of the Commission**

**4.221 The Law Commission does not recommend any legal reform in this area.**

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<sup>502</sup>See eg. SA National Consumer Union; Living Will Society; Lawyers for Human Rights; Society of Neurosurgeons of SA.

## CHAPTER 5

### THE INCOMPETENT PATIENT WHO HAS NO PROSPECT OF RECOVERY OR IMPROVEMENT

5.1 This Chapter deals with the situation of mentally incompetent or permanently comatose persons **for whom no hope of recovery or improvement exists** who cannot take their own decisions and cannot therefore request cessation of treatment, assistance with suicide or active voluntary euthanasia. Some of these patients can be referred to as being in a permanently vegetative state. They are not brain dead, but they are in an irreversible, unconscious state. To keep the patient alive, he or she has to be fed artificially, and ventilated, if necessary. Some of the life functions have to be aided.

5.2 The factors that cause this condition are numerous: quite often it is the result of brain injury or asphyxiation as a result of which the blood supply and therefore also the supply of oxygen to the brain is shut off for such a long period that it results in irreversible brain damage. The condition is often the result of a serious stroke, but it can also be the result of brain damage during the birth process, with the result that the child born is in an unconscious, irreversibly vegetative condition for the rest of his or her life.

5.3 In discussing cessation of life-sustaining medical treatment two situations need to be considered separately. The one is where the patient concerned has indicated, before becoming incompetent, in a written and signed document, called a "living will" or "advance directive"<sup>503</sup> or in a power of attorney, his or her wishes regarding life-sustaining treatment. The other situation

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<sup>503</sup>This is the preferred term. The term "living will" can create the impression that one is dealing with a valid will, which is not the case.

is where the patient has not indicated his or her wishes before becoming incompetent.

**(A) Cessation of life-sustaining medical treatment: there is an advance directive (living will) or power of attorney**

**a) Position as set out in Discussion Paper 71**

**i) Introduction**

5.4 A so-called advance directive (living will) is drafted by a competent person who foresees the possibility that he or she may at some future date, as a result of physical or mental inability, be unable to make rational decisions as to his or her medical treatment and care. In this document the drafter therefore endeavours to make certain requests or issue directives to the people who would be responsible for his or her medical treatment. The underlying principle is that a patient has the right to refuse specific treatment, even life-sustaining treatment, and that medical staff are obliged to honour the wishes of a mentally competent patient. When a patient is no longer able to make decisions regarding his or her treatment and care, doctors are dependent on prior consent, directives by an agent or their own judgment, with due observance of the ethical code that binds them. The object of the advance directive (living will) is therefore to give guidelines to medical practitioners as to their conduct in circumstances where the patient is unable to do so himself or herself. It is a particular object of this document to absolve medical practitioners from liability should the treatment or the withholding of such treatment hasten the death of the patient.

5.5 The validity of the consent given and the directions set out in the document is, however, not without its problems. We must therefore determine whether the validity of advance directives (living wills) should be recognised by statute and, if so, what precautionary measures should be taken, if any.

5.6 The main clause of the English version of the Living Will, as made available by the South African Living Will Society to its members for signing, reads as follows:



If the time comes when I can no longer take part in decisions for my own future let this declaration stand as the testament to my wishes. If there is no reasonable prospect of my recovery from physical illness or impairment expected to cause me severe distress or to render me incapable of rational existence, I request that I be allowed to die and not be kept alive by artificial means and that I receive whatever quantity of drugs may be required to keep me free from pain or distress even if the moment of death is hastened.

5.7 As Professor Strauss<sup>504</sup> rightly observes, the advance directive (living will) is not a will in the technical, testamentary sense of the word. It is merely a standing request to medical staff to act in a specific manner in specific circumstances. Professor Strauss is of the opinion that, as far as the request not to be kept alive by artificial means is concerned, it constitutes a legitimate refusal of consent to treatment and that medical practitioners are accordingly obliged to comply with it. In respect of a clause in an advance directive (living will) that authorises the administering of drugs, even if its secondary effect is to hasten death, Professor Strauss<sup>505</sup> feels that complying with such a request would be lawful if the doctor acted in good faith and used the normal drugs in reasonable quantities with the object of relieving pain and not of causing death.<sup>506</sup>

5.8 Various legal systems also use a power of attorney to enable a principal to entrust an agent with the decision-making power regarding the principal's medical treatment and care. The agent is usually a family member or confidant of the principal. The circumstances in which the proxy will come into force are set out in the power of attorney. This happens should the principal no longer be able to make decisions or give instructions to medical practitioners as a result of an illness. Such a power of attorney may also embody the wishes of the principal not to be kept alive artificially in specific circumstances. A power of attorney may therefore often include a so-called "advance directive" or a "health care directive", which corresponds with the usual terms found in an advance directive (living will).

5.9 In our law a power of attorney lapses when the principal becomes mentally incompetent. An agent would therefore not be able to make decisions as to, for example, the performance of

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<sup>504</sup>Strauss **Doctor, patient and the law** 344.

<sup>505</sup>Strauss **Doctor, patient and the law** 345.

<sup>506</sup>See Ch 4, par 4.34 and further for a discussion of the so-called "double effect".

an operation or the discontinuation of artificial respiration or feeding on behalf of a person who is permanently unconscious. Legislation would be necessary to permit this.

5.10 During 1988 the Commission investigated the desirability of making provision for an enduring power of attorney in certain circumstances.<sup>507</sup> The investigation was concerned with decision-making in respect of a mentally incompetent person's property and not his or her person. The Commission proposed two Bills - one to make provision for enduring powers of attorney under certain circumstances and the other to make provision for a simpler, less expensive way of appointing a curator in respect of the property of a mentally incompetent person. Only the latter recommendation was accepted. This led to the **Mentally Ill Person's Legal Interests Amendment Act, 1990**.<sup>508</sup> It was said that the reason why the first-mentioned Bill was not promoted was because its application would have been very limited and that the legislature does not cater for exceptions.

## ii) Comparative Law

5.11 We shall now briefly discuss the main developments regarding advance directives (living wills) in comparative perspective.

### \* The United States of America

5.12 California was the first state to accept legislation with regard to the advance directive (living will) by enacting the **Natural Death Act, 1976**.<sup>509</sup> Subsequently all states have adopted legislation pertaining to advance directives for health care including living wills, health care

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<sup>507</sup>South African Law Commission Report **Enduring powers of attorney and the appointment of curators to mentally incapacitated persons** October 1988.

<sup>508</sup>Act 108 of 1990.

<sup>509</sup>Pozgar, G D **Legal aspects of health care administration** 4th ed Maryland Aspen Publishers 1990 195 (hereinafter referred to as "Pozgar **Health care administration**").

surrogate designations and durable powers of attorney.<sup>510</sup>

5.13 It has been found that the requirements and application of living will and health care agent statutes vary significantly from one state to another. In general all the states provide for a written document signed by the drafter or by someone on his or her behalf, as well as at least two witnesses. In some states people with an interest in the case are excluded as competent witnesses and a few other states provide for the document to be drafted by an attorney. In California an advance directive (living will) lapses automatically after five years.

5.14 Although health care agent statutes in 49 states permit an agent to make decisions when a patient is permanently unconscious, living will statutes in only 38 states include permanent unconsciousness as a qualifying condition. Similarly, only about two-thirds of the states have statutory language permitting living wills or health care agents to withhold or withdraw artificial nutrition and hydration. Also 34 states have living will statutes that explicitly forbid the withholding or withdrawal of life support from pregnant patients and 14 states forbid health care agents from making such a decision.<sup>511</sup>

5.15 In the case **John F Kennedy Memorial Hospital Inc v Bludworth**<sup>512</sup> the Supreme Court of Florida had to decide the following legal question:

In the case of a comatose and terminally ill individual who has executed a so-called "Living" or "mercy" will, is it necessary that a court appointed guardian of his person obtain the approval of a court of competent jurisdiction before terminating extraordinary life support systems in order for consenting family members, the attending physicians, and the hospital and its administrators to be relieved of civil and criminal liability?

5.16 The court held that such approval is not necessary. The court investigated the right of

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<sup>510</sup>As of March 1995, 46 states had laws providing for both living wills and appointments of health care agents. Of the remaining five states, two have laws providing only for living wills and three only for appointments of health care agents.

<sup>511</sup>GAO Report of 9/01/95.

<sup>512</sup>452 So 2d 921 (Fla 1984) at 922.

terminally ill patients to refuse to be kept alive artificially and found, on the basis of quoted authority, that such a right was not only recognised in the state of Florida, but also in other states of the USA. The court subsequently considered the question of who may exercise the right when a person is unable to do it himself or herself as a result of his or her comatose state. In this regard the majority of the court held as follows:<sup>513</sup>

We hold that the right of a patient, who is in an irreversible comatose and essentially vegetative state, to refuse extraordinary life-sustaining measures, may be exercised either by his or her close family members or by a guardian of the person of the patient appointed by the court. If there are close family members such as the patient's spouse, adult children, or parents, who are willing to exercise this right on behalf of the patient, there is no requirement that a guardian be judicially appointed. However, before either a close family member or legal guardian may exercise the patient's right, the primary treating physician must certify that the patient is in a permanent vegetative state and that there is no reasonable prospect that the patient will regain cognitive brain function and that his existence is being sustained only through the use of extraordinary life-sustaining measures. This certification should be concurred in by at least two other physicians with specialities relevant to the patient's condition.

5.17 Regarding the way in which a family member exercises the right on behalf of the patient, the court was of the opinion that conduct is based on the doctrine of "substituted judgment". In this respect the court observed as follows:<sup>514</sup>

Under this doctrine close family members or legal guardians substitute their judgment for what they believe the terminally ill incompetent persons, if competent, would have done under these circumstances. If such a person, while competent, had executed a so-called "living" or "mercy" will, that will would be persuasive evidence of that incompetent person's intention and it should be given great weight by the person or persons who substitute their judgment on behalf of the terminally ill incompetent.

5.18 It is worth noting that in this case the advance directive (living will) was only regarded as persuasive evidence of the wishes of the person concerned and would carry considerable weight with the decision-maker. However, it appears that the advance directive (living will) in itself could

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<sup>513</sup> **John F Kennedy Memorial Hospital Inc v Bludworth** supra at 926.

<sup>514</sup>Op cit 926.

not authorise the discontinuance of artificial life-support systems even when the point had been reached where no recovery was possible. Consent was still required either from the family, the curator or the court.

5.19 Since State legislatures have enacted legislation that gives legal effect to appropriately expressed anticipatory expressed refusals of medical treatment by competent adults, in specified circumstances, US cases exploring the law relating to anticipatory refusals therefore have mainly arisen in States where there is (or was) no such legislation.<sup>515</sup>

5.20 The **Patient Self-Determination Act, 1990**<sup>516</sup> came into force on 1 December 1991. It provides that in all health care institutions receiving federal funding, the hospital staff must, on admission, specifically enquire from patients whether they wish to fill in a form stipulating which treatment they prefer or refuse and whether they wish to appoint a family member or friend to make decisions on their behalf if circumstances may arise in which they are unable to communicate their wishes themselves. The form is completed voluntarily and is regarded as valid and binding. This Act is a federal Act and is accordingly applicable to all the states in America.

5.21 In addition to advance directive (living will) legislation, some states have also made statutory provision for the appointment of agents by way of enduring powers of attorney, in terms of which decisions can be made on behalf of incompetent patients in respect of their medical treatment.

5.22 The first legislation establishing a mechanism for appointing an agent to make health care decisions under an enduring power of attorney was also enacted in California, in 1983.<sup>517</sup> Again many other states enacted similar statutes. Currently more than 30 states have this kind of

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<sup>515</sup>Cica N **Euthanasia - the Australian law in an international context** Part I: Passive voluntary euthanasia Research Paper 3 Department of the Parliamentary Library, Australia 1996-97 (hereinafter referred to as Cica 3) at 6.

<sup>516</sup>This Act was enacted as sections 4206 and 4751 of the **Omnibus Budget Reconciliation Act** of 1990.

<sup>517</sup>**The Durable Power of Attorney Health Care Act** 1983 (California); currently **California Civil Code**, sections 2430-2445.

enduring power of attorney legislation. Many states have legislation combining living will provisions and enduring power of attorney provisions. In addition, 20 states have legislation giving a patient's family members power to make decisions about the life-sustaining medical treatment of a patient when the patient becomes incompetent and has not made an advance directive.<sup>518</sup>

5.23 The advance directive (living will) legislation has been criticised. The writer George D Pozgar holds the following opinion:<sup>519</sup>

Although many interest groups hailed the enactments of natural death or living will acts as providing the solution to the difficult problems inherent in euthanasia situations, the statutes present inadequacies that must be addressed. A person drafting a living will when healthy and mentally competent cannot predict how he or she will feel at the time of a terminal illness. Moreover, unless the document is updated regularly, how can it be ascertained that the document actually reflects what the patient wishes? If a proxy is used and that proxy is a close family member, there could be danger of a conflict of interest, emotionally or legally. Guidelines must be unified and tightened in order to offer better guidance to physicians and courts.

5.24 Recognising the benefits of more uniformity among state advance directive laws, the National Conference on Commissioners on Uniform State Laws<sup>520</sup> approved the model Uniform Health Care Decisions Act in 1993.<sup>521</sup> Although UHCDA has been adopted in only one state, New Mexico, many states have enacted laws containing substantially similar provisions.

\* **Australia**

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<sup>518</sup>Cica 3 on 19 and the references made therein.

<sup>519</sup>Pozgar **Health care administration** 196.

<sup>520</sup>Established in 1892, the Conference has a dual identity as an organisation closely affiliated with the American Bar Association, representing the legal profession, and the original state government association predating the National Governors Association. The purpose of the Conference is to provide uniform model laws for the states to enact; each state is represented by an average of six commissioners, typically appointed by the governor.

<sup>521</sup>UHCDA supercedes earlier, less comprehensive model acts related to advance directives.

5.25 The question regarding the refusal in advance of consent to medical treatment and the artificial support of life is dealt with differently in the different states of Australia.<sup>522</sup> Mainly two approaches are adopted by the different states. Firstly, some states<sup>523</sup> give effect to the advance directive (living will) by way of legislation. Secondly, other states<sup>524</sup> make use of substituted decision-making by an agent appointed according to an enduring power of attorney or a curator appointed by the court.

5.26 South Australia was the first Australian jurisdiction to enact advance directive legislation with the **Natural Death Act, 1983**.<sup>525</sup> The Natural Death Act 1983 was recently repealed and replaced by the **Consent to Medical Treatment and Palliative Care Act 1995 (SA)** which came into effect on 30 November 1995. The new legislation makes provision in sec 7(1) for a person who has attained the age of 18 years and who is of sound mind to make a direction about the medical treatment that the person wants or does not want should he or she in future be in the terminal phase of a terminal illness, or in a persistent vegetative state, and should he or she be incapable of making decisions about medical treatment when the question of administering of treatment arises.

5.27 The Act also introduces a new regime for appointing agents to make health care decisions under enduring powers of attorney. This replaces the old regime established under the **Guardianship and Administration Act 1993 (SA)**. The new legislation provides in sec 8 that a person who has attained the age of 18 years and is of sound mind can execute a 'medical power of attorney', appointing an agent with power to make decisions on his or her behalf about medical treatment. The agent must be over 18 years of age; be someone who has no interest under the principal's will or in the estate of the principal; and cannot be a person who, in a professional or administrative capacity, is involved in the medical treatment of the principal. More than one agent may be appointed, but the medical power of attorney must indicate the order of appointment and

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<sup>522</sup>**Western Australia Report 7-8.**

<sup>523</sup>South Australia, Victoria, The Northern Territory and the Australian Capitol Territory.

<sup>524</sup>South Australia, Victoria and Australian Capitol Territory, New South Wales.

<sup>525</sup>**Western Australia Report 8.**

must not provide for joint exercise of decision-making power by the agents. If the principal has also made an anticipatory direction (under the living will provisions of the legislation), the agent must make decisions consistent with that direction. In sec 13 the Act also clarifies the circumstances under which medical practitioners must respect the anticipatory refusal of emergency treatment - defined as treatment that is necessary to meet the imminent risk to health by a patient who is now incapable of consenting to the treatment.<sup>526</sup>

5.28 In the Northern Territory the **Natural Death Act, 1988** is modelled broadly on the now repealed **Natural Death Act 1983**. Under this Act a person of sound mind above the age of 18 years who desires not to be subjected to life-prolonging treatment in the event of a terminal illness, may make a directive to that effect in the prescribed form. The directive must be witnessed by two persons. A doctor responsible for the patient's treatment is obliged to act in accordance with the directive unless he or she has reason to believe that the patient has revoked it or was not, at the time of giving the directive, capable of understanding its nature and consequences.

5.29 The advance directive provisions in the state of Victoria are contained in the **Medical Treatment Act, 1988**.<sup>527</sup> This Act is premised on the basis that a patient's wishes with regard to the refusal of medical treatment should be complied with in terms of a refusal of treatment certificate. If a patient is unable to make a decision an authorised agent or appointed curator should be able to make the decision on the patient's behalf.

5.30 A person may also appoint an agent by way of an enduring power of attorney to make decisions on his or her behalf as to his or her medical treatment if that person is no longer able to do so. An agent thus appointed or duly appointed guardian of the patient may refuse consent to medical treatment on behalf of the patient if the medical treatment would cause unreasonable distress to the patient or if there are reasonable grounds for believing that the patient, if competent, would have considered the treatment unwarranted.<sup>528</sup> As in the case where the decision is made

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<sup>526</sup>Position as set out in Cica 3 on 10-12.

<sup>527</sup>**Western Australia Report 21.**

<sup>528</sup>Sections 5B(1) and (2).



by the patient himself or herself, a medical practitioner and another person must jointly sign a certificate of refusal of treatment in respect of the refusal by the agent or guardian, if they are satisfied that the agent or guardian has been informed of the nature of the patient's current condition and that they understand the implications of such refusal. A refusal of treatment certificate in the prescribed form must be completed by the medical practitioner, the other person and the agent or guardian.

5.31 An enduring power of attorney is not revoked by the subsequent incapacity of the principal but can be revoked by the principal himself or herself. The Guardianship and Administration Board may suspend or revoke an enduring power of attorney in specific circumstances.<sup>529</sup> One of these circumstances would be if the Board was satisfied that refusal of medical treatment was not in the best interests of the patient.<sup>530</sup>

5.32 The presentation of the refusal of treatment certificate serves as evidence of the patient's refusal of treatment and a medical practitioner who acts in good faith and who refuses to administer or continue medical treatment in reliance on such certificate is not guilty of misconduct or liable in any criminal or civil proceedings.<sup>531</sup>

5.33 Western Australia does not have legislation recognising "advance directives" or "enduring powers of attorney" empowering an agent to make health care decisions.<sup>532</sup>

5.34 In 1991 the Western Australian Law Reform Commission recommended the introduction of legislation broadly modelled on the **Medical Treatment Act 1988(Vic)**.<sup>533</sup>

5.35 The Law Reform Commission's report was submitted in February 1991. Its point of

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<sup>529</sup>Section 5C.

<sup>530</sup>Section 5C(3).

<sup>531</sup>Section 9.

<sup>532</sup>Cica 3 on 18.

<sup>533</sup>Cica 3 on 18.

departure was:<sup>534</sup>

.... that persons have a right to self determination. This includes the right to choose whether or not to be treated, or to continue to be treated, and the right to determine the course of future treatment if their mental or physical condition makes them unable to exercise their right of choice at the time.

5.36 The Law Reform Commission was not in favour of a person stipulating his or her wishes in respect of future medical treatment by way of an advance directive (living will). It preferred an enduring power of attorney whereby an agent could be appointed to make decisions on behalf of the principal regarding his or her treatment according to the requirements that exist at that time.

5.37 The Law Reform Commission advanced the following reasons why it found the advance directive (living will) to be unacceptable:<sup>535</sup>

- \* The drafter of the document issues directives as to his or her medical treatment without knowing the precise circumstances that will exist when the will is required to be activated.
- \* It normally cannot be expected that a person who is healthy when he makes a decision as to the withholding of life-sustaining treatment will take into account all the factors that would have influenced his or her decision if it was made at a time of actual illness or injury.
- \* In most cases the advance directive (living will) is either too specific, thereby failing to cover all circumstances, or too general, thereby causing problems of interpretation, or too discretionary, thereby differing little from a power of attorney.
- \* There are furthermore problems regarding the question of when the advance directive (living will) should come into force. What should be the criteria and who will decide

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<sup>534</sup>**Western Australia Report 9.**

<sup>535</sup>**Western Australia Report 12 - 13.**

whether the criteria have been met?

- \* There are also problems concerning the communication of the information to the attending doctor. Should he or she accept the authenticity of the document at face value? How would he or she be able to ascertain whether the document had been revoked in the mean time?

5.38 The Law Reform Commission favours a system similar to the one entrenched by legislation in the state of Victoria. This entails the competence to appoint an agent, by way of an enduring power of attorney, to make decisions regarding the medical treatment of the principal. The power of attorney takes effect only if the principal becomes incompetent. In cases where no agent has been appointed or where the appointed agent may be unwilling or unable to act, a guardian must be appointed for the incompetent person.<sup>536</sup>

5.39 The decision by the agent or guardian should be based on the decision that the patient would probably have taken in the circumstances, had he or she been able to do so. Where such substituted judgment is inappropriate, the decision should be based on what a reasonable person would probably conceive to be in the best interests of the patient, considering the circumstances. The decision made by an agent or guardian on behalf of the incompetent person should be subject to review at the insistence of any interested party.<sup>537</sup> If an agent or guardian makes a decision in good faith, he or she should not be civilly or criminally liable for that decision. Certain formalities are prescribed to ensure the legality of an enduring power of attorney.

5.40 In order to facilitate proof of refusal of medical treatment, the Law Reform Commission suggests that use should also be made of the refusal of treatment certificate, as is the case in Victoria. Unlike Victoria, it is suggested that such refusal should also apply to palliative care,<sup>538</sup> which is defined as:<sup>539</sup>

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<sup>536</sup>**Western Australia Report 15.**

<sup>537</sup>**Western Australia Report 20.**

<sup>538</sup>**Western Australia Report 23.**

<sup>539</sup>Section 3 of the (Victoria) **Medical Treatment Act, 1988.**

the provision of reasonable medical procedures for relief of pain, suffering and discomfort; or the reasonable provision of food and water.

5.41 Finally, it is recommended that a doctor should escape liability if, in reliance on a refusal of treatment certificate, he or she refuses to perform medical treatment. No liability should furthermore result where a medical practitioner administers drugs for the purpose of controlling or eliminating pain and suffering even if the treatment shortens the patient's life, provided that the doctor acted with the consent of the patient, his or her agent or guardian or that the treatment was reasonable in the circumstances of the case.

5.42 In May 1995 the Hon Ian Taylor MP introduced the **Medical Care of the Dying Bill 1995 (WA)** into Parliament. The long title of this Private Member's Bill is 'An Act to affirm and protect the rights of terminally ill persons to refuse unwanted medical treatment, to protect medical practitioners and other health professionals and for related purposes'. At the end of 1996 the Bill entered the Committee stage and has not been finalised yet.<sup>540</sup>

5.43 In the Australian Capital Territory **The Medical Treatment Act 1994 (ACT)** was passed in 1994. It was initially part of a Private Member's Bill the **Voluntary and Natural Death Bill 1993** introduced into the ACT Legislative Assembly in 1993 which aimed to make active euthanasia lawful in specified circumstances. The Bill also contained provisions enabling a competent adult to make advance directives and medical powers of attorney provisions. The Select Committee however decided that it was 'politically inopportune' to proceed with the Bill in that form, resulting in the current act being passed. The Medical Treatment Act 1994 is broadly modelled on the Medical Treatment Act 1988 (Vic). It makes provision for both the advance directive and the enduring power of attorney.

5.44 On 2 February 1998 a new law entitled **The Guardianship Amendment Act 1997** was proclaimed in New South Wales by which a person may appoint an "enduring guardian" who will have legal authority to refuse unwanted medical treatment on the person's behalf. Medical

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<sup>540</sup>Cica 3 on 18.

practitioners who override an enduring guardian's refusal to medical treatment will be committing an offence.

5.45 Tasmania and Queensland do not have legislation recognising "advance directives" or "enduring powers of attorney" empowering an agent to make health care decisions.<sup>541</sup>

\* **Canada**

5.46 In 1992 the Canadian Province of Ontario<sup>542</sup> enacted legislation giving legal effect to living wills and enabling the appointment of an agent under an enduring power of attorney to make health care decisions. Enduring power of attorney legislation in Nova Scotia and Quebec allows an agent to make health care decisions on behalf of the incompetent principal.<sup>543</sup>

5.47 In 1993 the province of British Columbia enacted the **Representation Agreement Act 1993** to enable adults to arrange in advance how and by whom decisions about their health care, personal care or financial affairs will be made should they become incapable of making decisions independently. One key objective is to create a new legal document called a representation agreement in which the adult may name as his representative another adult, a Public trustee, and for specific purposes a credit union or trust company. The representation agreement will avoid the costly process of applying to court for the appointment of a person to make decisions for an adult who is unable to make decisions independently. A novel approach is to provide an adult who grants decision making authority to another person with protection should the other person misuse this authority. This is done by naming as monitor another adult who must make sure that the representative complies with his or her duties.<sup>544</sup>

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<sup>541</sup>Cica 3 on 18-19.

<sup>542</sup>**Consent to Treatment Act 1992 (Ontario); Substitute Decisions Act 1992 (Ontario).**

<sup>543</sup>**Medical Consent Act 1989 (Nova Scotia); Civil Code of Quebec, Arts 1701.1 and 1731.1 -1731.11.**

<sup>544</sup>**Commonwealth Law Bulletin, July 1994.**

5.48 In Alberta the Alberta Law Reform Institute initially<sup>545</sup> recommended that the advance directive (living will) should not be used exclusively. In the report the problems that were foreseen with this document were stated as follows:<sup>546</sup>

The living will concept has a number of inherent problems, the most significant of which is that it involves the individual having to anticipate what medical condition he or she may be faced with in the future, and what treatment options may be available at that time. This inevitably leads to difficulties of interpretation. ... Most standardized or prescribed forms of living will attempt to overcome the problem of anticipation by resorting to generalized and imprecise language, employing such terms as "heroic measures" and "extraordinary treatment". However, this merely exacerbates the problem, because these terms are capable of a wide range of interpretations. In the end, the attending physician may find that the living will is simply too vague and ambiguous to provide any useful guidance as to the patient's wishes.

5.49 The principal recommendation in the Alberta Report and the Joint Report was that legislation be introduced to give legal effect to health care directives. The Alberta Law Reform Institute and the Health Law Institute argued that a health care directive would enable individuals to exercise control over future health care decisions in a number of ways.<sup>547</sup> Firstly, it could be used to appoint someone as a health care agent, who would have legal authority to make health care decisions on behalf of the individual in the event of his or her becoming incapable of making these decisions personally. Secondly, the health care directive could identify anyone whom the individual does not wish to act as his or her health care proxy. Thirdly, it could be used to provide instructions and information concerning future health care decisions, for example, instructions as to what types of medical treatment the individual would not want in certain circumstances. If these advance instructions were unambiguous and relevant to the health care decision being considered, they would be legally binding and would have to be followed.<sup>548</sup>

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<sup>545</sup> Alberta Law Reform Institute **Advance Directives and substitute decision-making in personal healthcare** Report for discussion No 11 November 1991 (hereinafter referred to as "Alberta Report").

<sup>546</sup> **Alberta Report** 30.

<sup>547</sup> Alberta Law Reform Institute and The Health Law Institute **Advance directives and substitute decision making in personal health care** Joint Report No 64 March 1993 (hereinafter referred to as Joint Report).

<sup>548</sup> **Joint Report** 7 - 8.

5.50 The Alberta Law Reform Institute identified a need to create a system of substitute decision-making for those patients who have no guardian and who have not appointed a health care agent.<sup>549</sup> It recommended that this be done by way of a statutory list of proxy decision-makers. In the event of a patient being mentally incapable of making a health care decision, the first available person on the statutory list would have the legal authority to make the decision on the patient's behalf. It was recommended that the statutory list be as follows:<sup>550</sup>

- (a) A guardian appointed under the Dependent Adults Act (or the equivalent legislation) with authority to make health care decisions on behalf of the patient;
- (b) a health care agent appointed by the patient pursuant to a health care directive;
- (c) the patient's spouse or partner;
- (d) the patient's children;
- (e) the patient's parents;
- (f) the patient's siblings;
- (g) the patient's grandchildren;
- (h) the patient's grandparents;
- (i) the patient's uncle and aunt;
- (j) the patient's nephew and niece;
- (k) any other relative of the patient;
- (l) the patient's healthcare practitioner.

5.51 Another key recommendation of the Alberta Law Reform Institute concerned the criteria for substitute decision-making.<sup>551</sup> As we have seen,<sup>552</sup> the view was taken that if the patient's health care directive contains instructions which are unambiguous and relevant, these should be legally binding. What happens if there are no such instructions? In the Alberta Report it was proposed that, where possible, proxies should apply a substituted judgment test - that is, they should decide according to what they believe the patient would have decided if competent, rather than according

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<sup>549</sup>**Alberta Report** 58 - 65.

<sup>550</sup>**Joint Report** 9.

<sup>551</sup>**Alberta Report** 65 - 70.

<sup>552</sup>See para 5.49 above.

to what they consider to be in the patient's best interests. This view was affirmed in the Joint Report.<sup>553</sup>

5.52 In December 1991 the Law Reform Commission of Saskatchewan published a report recommending the enactment of legislation giving legal effect to advance health care directives.<sup>554</sup> However, the Saskatchewan recommendations are much narrower in scope than those of other Canadian provincial law reform agencies. In particular, the Saskatchewan Commission took the position that advance directives (living wills) should be limited to cases of "last illness". Thus, the Commission recommended that an advance directive (living will) should be given recognition "if it is intended to take effect when the maker is suffering from a condition that is terminal, or will result in a significant diminished quality of life."<sup>555</sup>

5.53 It is further important to take note of the following conclusion of the Saskatchewan Commission:<sup>556</sup>

But whether the Living Will is drafted in broad or narrow terms, in detail or in generalities, it can take effect in Canada only as a manifestation of a refusal to consent to medical treatment ... At present, most physicians are more apt to regard a living will as a "guide or a framework for patient management" than as a legally binding document. Under current practice in Saskatchewan hospitals, when an advance directive is known to attending physicians, a psychological assessment of the patient and involvement of family members is often given equal weight with the patient's expressed wishes in determining a course of action.

5.54 In January 1992 the Newfoundland Law Reform Commission published a discussion paper on advance directives and attorneys for health care.<sup>557</sup> Its recommendations on health care

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<sup>553</sup>Op cit 10.

<sup>554</sup>Law Reform Commission of Saskatchewan **Proposals for an advance health care directives act** December 1991 at 16 (hereinafter referred to as "**Saskatchewan Report**").

<sup>555</sup>**Saskatchewan Report** 29.

<sup>556</sup>**Saskatchewan Report** 20.

<sup>557</sup>Newfoundland Law Reform Commission **Advance health care directives and attorneys for health care** Discussion Paper No 6 1992 (hereinafter referred to as "**Newfoundland Discussion Paper**").



directives are very similar to that of the Alberta Law Reform Institute and the Health Law Institute<sup>558</sup> and to those of the Manitoba Law Reform Commission.<sup>559</sup> The basic position adopted by the Newfoundland Discussion Paper is that individuals should be able to use a health care directive to appoint a health care proxy, and also to provide information and instructions which would be binding on the proxy. As with the Manitoba Report, the focus of the Newfoundland Discussion Paper is limited to health care directives. It does not consider the additional issue of whether there should be a statutory list of proxy decision-makers, so as to deal with the situation where the patient has not appointed a health care agent.

5.55 Against this background, we take a detailed look at some of the recommendations made in the Newfoundland Discussion Paper. Firstly, the Newfoundland Law Reform Commission submitted that the Canadian Criminal Code should be amended to make it clear that criminal law imposes no duty on a medical practitioner to initiate or maintain medical treatment contrary to the instructions of the patient.<sup>560</sup> Legislation should furthermore be enacted to recognise the patient's common law right to refuse medical treatment by granting a competent individual the opportunity to give advance instructions regarding his or her medical treatment and/or to delegate decision-making powers to his or her nominated agent.

5.56 It is further recommended that it should be possible for an individual to use a health care directive or to authorise an attorney to make health care decisions on that person's behalf. A health care decision should include the giving, refusal or withdrawing of consent to any and all types of medical care, treatment, diagnostic procedures, palliative care, medication as well as non-medical matters which are necessarily incidental to medical care. This should include life-prolonging treatment, psychiatric treatment, the administration of nutrition and hydration and admission to medical or psychiatric treatment facilities or removal from such institutions.<sup>561</sup>

5.57 The Newfoundland Law Reform Commission further recommends that a health care

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<sup>558</sup>**Joint Report 12.**

<sup>559</sup>See paragraph 5.67 *et seq* below.

<sup>560</sup>**Newfoundland Discussion Paper 101.**

<sup>561</sup>**Newfoundland Discussion Paper 101.**

directive should be in writing and signed by the person making it.<sup>562</sup> Neither the agent appointed in that health care directive nor the spouse of that agent should be qualified to witness the execution of the directive. A signed, handwritten health care directive of the maker should be valid without any necessity of witnessing, but where the maker signs it with a mark other than his or her signature the execution should be attested by two witnesses.<sup>563</sup>

5.58 It is also recommended that health care facilities (such as hospitals) should be required to enquire, upon admission, whether the patient has made or revoked a directive and to request a copy of the directive, if any.<sup>564</sup>

5.59 The Newfoundland Law Reform Commission believes, however, that the responsibility for communicating the contents of a health care directive should remain with the maker.<sup>565</sup> Where the patient is incapable (unconscious) the medical practitioner should be required to ensure whether such a directive exists or whether an authorised agent has been appointed to attend to the patient's interests. These requirements should also be applicable in emergency situations.

5.60 It is recommended that a health care provider who has been furnished with a copy of a directive should be required to include it in the patient's medical record in such a way that it is brought to the attention of other members of the medical staff.<sup>566</sup>

5.61 Such a directive should only become effective upon a determination that the maker is not mentally capable of making or communicating with respect to medical treatment.<sup>567</sup>

5.62 The legislation should specify that a person who is mentally capable of taking a decision with respect to treatment is also able to understand the information that is relevant to the decision

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<sup>562</sup>Op cit 102.

<sup>563</sup>Op cit 101.

<sup>564</sup>Op cit 103.

<sup>565</sup>Ibid.

<sup>566</sup>Ibid.

<sup>567</sup>**Newfoundland Discussion Paper 103.**

and is able to appreciate the reasonable foreseeable consequences of such a decision. The legislation should specify that a principal who has drawn up a valid health care directive is presumed to be capable of doing so unless the contrary is proved.<sup>568</sup>

5.63 The Newfoundland Law Reform Commission feels it should be possible to revoke a health care directive by -

- (i) a subsequent validly executed healthcare directive;
- (ii) a declaration in writing that revokes the directive and that is executed in the same manner as a directive;
- (iii) the burning, tearing up or other destruction of the directive by the principal (or by some person in his or her presence and by his or her direction) with the intention of revoking the directive.<sup>569</sup>

5.64 It is recommended that a medical practitioner who fails to comply with the valid instructions of a health care agent should be subject to the charges of battery and negligence and to administering treatment without the patient's consent.<sup>570</sup>

5.65 Any person who, without the principal's consent, wilfully conceals, cancels, alters, falsifies or forges a health care directive or any amendment or revocation of such directive or who wilfully withholds any personal knowledge thereof, should be guilty of an offence and liable for damages in a civil action.<sup>571</sup>

5.66 Lastly, the Newfoundland Law Reform Commission recommends that the statutory provisions concerning such directives should be accompanied by an educational campaign to ensure that the general public is aware of the availability of the mechanisms. Health care facilities and professional medical associations should also be encouraged to provide educational support to their

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<sup>568</sup>Ibid.

<sup>569</sup>Op cit 104 - 105.

<sup>570</sup>Op cit 106.

<sup>571</sup>**Newfoundland Discussion Paper 107.**

members and staff regarding health care directives.<sup>572</sup>

5.67 After due research the Manitoba Law Reform Commission brought out a report in June 1991 entitled **Self-determination in health care (living wills and health care proxies)**. Extensive legislation was suggested in the report in order to make provision for health care directives. Again the point of departure was that individuals should have a free choice in making provision for:<sup>573</sup>

... health care directives in which they can set out their wishes respecting future health care and can appoint health care proxies to make future decisions on their behalf. The decision contained in health care directives or made by health care proxies should be legally binding; the failure to respect them should have the same consequences as the failure to respect a direction concerning current medical treatment. No one should incur liability simply because they honestly gave or followed such a decision. Finally, the making of health care directives should entail only as much formality as is manifestly necessary to protect the maker from fraud and undue influence.

5.68 In the report the following warning was however issued regarding the use of health care directives:<sup>574</sup>

Persons considering the use of a health care directive should not, of course, overlook its possible drawbacks. Personal circumstances and medical technology change and a direction given today may not reflect a maker's wishes ten or twenty years later; a maker who fails to review and update a health care directive may face very serious and unwanted consequences indeed. A vague or imprecise health care directive may also pose problems: the making of a health care directive that refuses "heroic treatment" may give psychological comfort to a maker, yet prove meaningless to physicians. Makers must be made aware that they should avoid ambiguous language in their health care directives and that the assistance of a physician in making one may be helpful; where precision is not possible, the appointment of a health care proxy should be seriously considered.

5.69 The recommendations of the Manitoba Law Reform Commission have now been embodied

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<sup>572</sup>Ibid.

<sup>573</sup>Manitoba Law Reform Commission **Report on self-determination in health care (living wills and health care proxies)** Report No 74 1991 at 40 (hereinafter referred to as "Manitoba Report").

<sup>574</sup>**Manitoba Report** 40.

in the **Health Care Directives Act**.<sup>575</sup> The Act received Royal Assent in June 1992.<sup>576</sup>

5.70 Following the 1993 decision of the Supreme Court of Canada in the **Rodriguez case**,<sup>577</sup> in February 1994, a Special Committee of the Senate of Canada was set up to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide. The report of this committee - entitled **Of life and death**<sup>578</sup> - was tabled on 6 June 1995. The report's recommendations include inter alia the following:

- \* That those provinces and territories that do not have advance directive legislation adopt such legislation.
- \* That the provinces and territories establish a protocol to recognise advance directives executed in other provinces and territories.
- \* That the federal Ministry of Health, in cooperation with the provinces and territories, sponsor a national campaign designated to inform the public as to their rights with respect to the refusal of life-sustaining treatment.

\* **United Kingdom**

5.71 In the United Kingdom there is at present little doubt as to the legal right of a patient of sound mind to refuse medical treatment.<sup>579</sup>

5.72 The effect of advance directives (living wills) or the appointment of an agent has, however, not been expressly tested by the English courts and no legislation in this regard has yet been

<sup>575</sup>S. M. 1992, c 33 as quoted in the **Alberta Report** 11.

<sup>576</sup>**Alberta Joint Report** 11.

<sup>577</sup>**Rodriguez v British Columbia (Attorney General)** (1993) 107 DLR (4th) 342.

<sup>578</sup>Canadian Special Senate Committee on Euthanasia and Assisted Suicide **Of life and death** June 1995.

<sup>579</sup>**Airedale NHS Trust v Bland** supra; Dyer, C (ed) **Doctors, patients and the law** Oxford Blackwell 1992 (hereinafter referred to as "Dyer") on 115.

proposed.

5.73 The English **Enduring Powers of Attorney Act, 1985**, does not provide for medical control of an incompetent patient (unlike recent similar legislation in the USA and Australia). Neither does the Scottish legislation on this point, the **Law Reform (Miscellaneous Provisions) Scotland) Act, 1990**, bring any relief.

5.74 As far as the English courts are concerned, attention can be drawn to the recent **Airedale NHS Trust v Bland**-case<sup>580</sup> in which the court on several occasions<sup>581</sup> referred approvingly to the usefulness of such an advance directive (living will). This was done despite the fact that consent as such was not raised. Lord Goff,<sup>582</sup> for instance, held that a patient's right to refuse medical treatment could be extended to incompetent patients in cases where they had expressed their wishes at an earlier date. He warned, however, that special care should be taken to ensure that such consent is still applicable at the time when the medical decision has to be taken.

5.75 In 1993 after the House of Lords handed down its decision in the **Bland-case** a Select Committee was established to investigate the legal, ethical and social issues surrounding medical treatment decisions at the end of life. In the **Report of the Select Committee**<sup>583</sup> the following recommendations are made with regard to advance directives (living wills) and powers of attorney:

- 296. We recommend the development of advance directives, but conclude that legislation for advance directives generally is unnecessary.
- 297. We recommend that a code of practice on advanced directives should be developed.
- 298. We do not favour the more widespread development of a system of proxy decision-making.

5.76 The British Government issued a document responding to the recommendations of the

<sup>580</sup>**Airedale NHS Trust v Bland** supra.

<sup>581</sup>Op cit 843 a-b, 852 j, 866 e-f.

<sup>582</sup>Op cit 866 e-f.

<sup>583</sup>Op cit 58.

House of Lords Select Committee on Medical Ethics in May 1994.<sup>584</sup> The Government agreed with the Select Committee's support for the right of a competent patient to refuse to consent to any medical treatment. The Government also stated that it agrees generally with the Select Committee's conclusions about the value of advance directives. It agreed that the development of a professional code on advance directives would be valuable. It noted however that the Law Commissions of England/Wales and Scotland were considering the issue of advance directives and that any professional code would need to take into account any decisions made by the Government in response to the Law Commissions' recommendations.

5.77 Although the usefulness of advance directives (living wills) is acknowledged by writers,<sup>585</sup> the validity of a directive will eventually depend on the extent to which the courts are prepared to recognise the previously expressed wishes of the patient as indicative of his or her intention at the time when the medical decision has to be made. Until the validity of advance declarations is settled in English law by court decision or statute, doctors are advised by legal scholars to treat such declarations with caution.<sup>586</sup> This is not to say that advance declarations should not be taken into account in determining treatment, but the overriding consideration must be what is in the best interest of the patient.<sup>587</sup>

5.78 Certain writers argue that certainty as to the legal position will only be attained through legislation. In this regard it is recommended that the advance directive (living will) should be a combination of the written instructions regarding medical treatment and the appointment of an agent.<sup>588</sup>

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<sup>584</sup>Government Response to the Report of the Select Committee on Medical Ethics Cm 2552 London HMSO May 1994.

<sup>585</sup>Mason, J K and McCall Smith, R A **Law and medical ethics** 3 rd ed London Butterworths 1991 at 339 (hereinafter "Mason and McCall Smith").

<sup>586</sup>Dyer at 116.

<sup>587</sup>Mason and McCall Smith 340.

<sup>588</sup>Kennedy, I & Grubb, **A Medical law: text and materials** London Butterworths 1989 at 1154.

5.79 The Law Commission of England and Wales <sup>589</sup> published a discussion paper in 1991 providing an overview of the entire field of mentally incapacitated adults, but without making specific recommendations, with the object of providing a basis for discussion and possible legislation. In February 1995 it issued its report on the law relating to the way decisions may be made on behalf of mentally incapacitated adults. In this report, the Law Commission recommended that legislation be introduced to-

- \* recognise a particular kind of advance directive (described as an 'advance refusal of treatment' ); and
- \* enable the appointment of an agent under an enduring power of attorney (described as a 'continuing power of attorney') to make healthcare decisions in the event of the principal losing capacity to make those decisions.

The Law Commission included draft legislation, the **Mental Incapacity Bill**, as an appendix to this report to give effect to its recommendations.<sup>590</sup>

5.80 In January 1996 the Parliamentary Secretary of the Lord Chancellor's Department made the following statement in Parliament:

The Government have considered the Law Commission report on mental incapacity very carefully and are grateful on this subject. The Government appreciate that this is an important and sensitive subject raising moral and ethical issues on which many people will have strong views.

The Government have decided not to legislate on the basis of the Law Commission's proposals in their current form and have also concluded that it would be inappropriate to make any proposals to Parliament in the absence of full public consultation. The Government propose to issue a consultation paper on mental incapacity in due course.<sup>591</sup>

5.81 On December 10, 1997 the Lord Chancellor released on behalf of the Government a Green

<sup>589</sup>Law Commission **Mentally incapacitated adults and decision-making: an overview** Consultation Paper No. 119 London HMSO 1991.

<sup>590</sup>See also Law Commission **Mentally incapacitated adults and decision-making: a new jurisdiction** Consultation Paper No. 128 London HMSO 1993.

<sup>591</sup>Cica 3 on 21-22.



paper (Consultation Paper) **Who decides?**. It was based on the Law Commission study, lasting five years, into all aspects of running the affairs of mentally incapacitated adults. The Government's Green paper asked for views on these proposals. A decision is expected later this year.<sup>592</sup>

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<sup>592</sup>Voluntary Euthanasia Society, England.

(iii) **The legal position in South Africa**

5.82 Professor Strauss<sup>593</sup> defines a "Living Will" as follows:

Legally it is a declaration in which a person **in anticipando** by way of an advance directive refuses medical attention in the form of being kept alive by artificial means.

5.83 In principle every person of sound mind is legally entitled to refuse medical treatment. In this sense it can be said that the individual has a right to die. The refusal of treatment should however be clearly stated. Professor Strauss argues that if a person in a specific situation is entitled to refuse specific medical treatment at that moment, there is no reason why he would not be entitled at an earlier stage to express a standing refusal of specific treatment. This argument would of course also apply to refusal of any treatment at all. Professor Strauss is of the opinion that medical practitioners would be obliged to give effect to such explicit statements and that they could even expose themselves to liability should they disregard the patient's wishes.

5.84 On the other hand, Mr Dörfling<sup>594</sup> is of the opinion that there should be a weighing up of the right of members of the community to refuse treatment, or the so-called right to die, and the medical practitioner's moral duty to treat.

5.85 The idea of the living will has been criticised for linguistic and medical vagueness, potential legal unenforceability and lack of attention to patients' underlying values and beliefs. The reliance of patients on their physicians to comply with the preferences stated in these documents may be misplaced due to physicians' lack of knowledge about the documents' legal reliability and physician anxiety relating to potential civil and criminal liability. Several writers have questioned the assumption inherent in advance directives that individuals, while competent, can determine what their values and preferences will be once their abilities and capacities have diminished. Mr Dörfling foresees the following problems regarding the use of the advance directive (living will) if it is not regulated by statute:

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<sup>593</sup>Strauss **Doctor, patient and the law** 344.

<sup>594</sup>Dörfling 195.

- (a) It is doubtful whether it could be expected of medical staff to comply with the living will - their moral and ethical codes could compel them to act.
- (b) It is not certain whether a medical practitioner who complies with the living will could be subject to criminal or even civil prosecution.
- (c) There is no criminal sanction for the abuse of such a living will through destruction, concealment or fraud, for instance.
- (d) The question remains as to whether the cessation of life-supporting treatment is punishable.

5.86 Mr Dörfling mentions that the legal persuasions of the community as well as medical and ethical standards change continually and that the law would therefore have to adapt continually. He also foresees problems concerning the possible revocation of the document at a later stage.

5.87 There is at present no judgment on record in which the matter of the advance directive(living will) has specifically been discussed. It was however stated in **Clarke v Hurst NO**<sup>595</sup> that effect should be given to a patient's wishes as expressed when he was in good health. In this case the court decided the question of whether the patient's artificial feeding should be discontinued with reference to the convictions of the community as interpreted by the court. The patient's wishes as set out in his "Living Will" were not used as the only criterion. Nevertheless the court remarked as follows:<sup>596</sup>

It is indeed difficult to appreciate a situation, save where the patient is suffering unbearable pain or is in a vegetative state, where it would be in his best interests not to exist at all. The patient in the present case has, however, passed beyond the point where he could be said to have an interest in the matter. But just as a living person has an interest in the disposal of his body, so **I think the patient's wishes as expressed when he was in good health should be given effect.** (Our emphasis)

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<sup>595</sup>1992 4 SA 630 (D) at 660.

<sup>596</sup>Op cit 660 E - F.

**(iv) Conclusion**

5.88 When a purpose-made document (an advance directive (living will) or power of attorney) contains requests or instructions to medical practitioners, staff or other persons as to which treatment the drafter consents to or which he or she refuses, such requests or refusals are just as legally valid as they would have been had the person given them orally, provided of course that the person was competent to make such requests or issue such instructions. Certain questions, however, may arise for the person who has to act on this request or instruction. Firstly, the validity of the document may be questioned. Furthermore, the possibility may always exist that the document may have been revoked. There may also be a dispute as to the interpretation of the contents of the document. Finally, medical staff could face difficult choices should the family of the patient issue different instructions to those contained in the document. It should also be remembered that an instruction given in a written document will not be legally valid if it would not have been legally valid had it been given orally. As the law stands at the moment, a deliberate act that causes the death of a patient would still be unlawful, except in exceptional circumstances, notwithstanding the authorisation contained in the document. Doctors are not jurists and they would therefore not always be able to judge out of hand whether requests and instructions contained in an advance directive (living will) are legally valid.

5.89 As can be seen from the comparative legal study above, some jurisdictions rely on enduring powers of attorney, sometimes combined with an advance directive (living will), whereby decisions as to the application, refusal or cessation of treatment are left to an agent who is usually a family member or confidant. Even if enduring powers of attorney were to acquire validity, there would still be other problems to consider. The central question is still whether the death of the patient can be brought about legally. By implementing the enduring power of attorney the decision-making is simply shifted from the doctor to the agent. The agent would still not be able to consent legally to action or treatment causing death if the patient would not have been legally able to do the same if he or she had been in a position to do so. The problem is aggravated where the death of the patient may be of pecuniary interest to the agent. Inevitably, a principal will not readily entrust decisions concerning his or her life or death to a total stranger.

5.90 It would appear that the ordinary case regarding consent to medical treatment, without the possibility of the termination of life, does not really cause problems. It is seldom, if ever, necessary to appoint a curator in order to get authorisation for an operation or other medical treatment.

**b) Discussion of submissions received**

5.91 There was a minority view to the effect that the Living Will should not become legally binding. It was felt that the terms of the advance directive as laid out in the proposed legislation are too vague and open to abuse.<sup>597</sup> Patients may be unable to make decisions due to the fact that they may be affected by medication, overwhelmed or depressed by problems, suffering from various degrees of senility, temporarily unconscious or comatose, or suffering from Alzheimers.<sup>598</sup> The question should then be asked when the directive comes into operation. Should it be at the onset of incompetence or at a later date; who should make the decision. The directive may furthermore be drawn up while the person is well (and possibly young) and when his or her outlook may be different to what it might be when he or she is faced with the actual situation. Where communication with a patient is difficult, doctors may be tempted to rely on the directive rather than make the effort to communicate with the patient. Advance directives indicate a lack of trust in the doctor and this "vote of no confidence" does not encourage either party in the doctor-patient relationship to communicate. The advance directive should not be totally binding on the physician but should be given serious consideration.<sup>599</sup>

5.92 The majority of respondents however felt that the validity of the Living Will or the

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<sup>597</sup>See eg. Africa Christian Action.

<sup>598</sup>Rev Justin Swanson.

<sup>599</sup>Prof RKL Huddle.

Enduring Power of Attorney, or both, must be recognised by statute<sup>600</sup> and should be accorded the same value and be as legally binding as the expressed will of a competent patient.<sup>601</sup> It will prevent a third party from imposing his or her will on that of the patient.<sup>602</sup> The five-year National AIDS Plan for South Africa, which was drawn up by the National AIDS Convention of SA (NACOSA) and accepted by Cabinet in mid 1995 highlights as a priority the necessity to secure the legal status of the living will and to establish inclusive guidelines around physician assisted suicide.<sup>603</sup> Respondents were of the opinion that the Living Will could safeguard medical practitioners provided that such advance directives are free from ambiguity or their intention is interpreted by a proxy duly appointed by the patient.<sup>604</sup> An advance directive merely serves as an instrument which expresses the patient's exercise of his or her right to die as a logical extension of his or her right to refuse treatment.<sup>605</sup>

5.93 There were a few specific recommendations:

1. A medical practitioner should consult with any partner of the terminally ill person, and not only relatives, before giving effect to the document. Consultation with the terminally ill person's legal practitioner may safeguard the medical practitioner against any possibility of effecting an advanced directive which has already been revoked.<sup>606</sup> In addition to informing the interested relatives and family members of the patient, the medical practitioner should be required to obtain their

<sup>600</sup>See eg. SAVES The Living Will Society; Joane Deare, Natal Region, CANSA; National Office: Cancer Association of SA; SA National Consumer Union; Southern African Anglican Theological Commission (Cape Town); RMS Broadbent; M Lavies; SK Schonegevel; EMD Pope; Prof RKL Huddle; Dr HJC du Plessis; Craig Brady; Alfred Allan; Department of Health; TA Mc Bean; Theresa Hannan; Rev Justin Swanson; HJ Barker; Society of Neurosurgeons of SA.

<sup>601</sup>Southern African Anglican Theological Commission (Cape Town); Society of Advocates of Natal.

<sup>602</sup> Department of Health.

<sup>603</sup>NAPWA.

<sup>604</sup>Southern African Anglican Theological Commission (Cape Town).

<sup>605</sup>Van Oosten Status Report 1025-6.

<sup>606</sup>Lawyers for Human Rights.

consent(sec7(3)).<sup>607</sup>

2. Include "or should not be instituted" before "should be discontinued" in sec 6(1).<sup>608</sup>
3. The advance directive should enable a terminally ill patient to state his or her wishes and not only to provide for the withdrawal of treatment, therefore making provision for a wish to continue treatment, where available.<sup>609</sup>
4. The condition of the patient should be confirmed by two medical practitioners<sup>610</sup> and a member of the multi-disciplinary team.<sup>611</sup> On the other hand it was stated that the possibility of having access to a "second opinion" by another competent medical practitioner is problematic since such competency might not always be readily available in the given circumstances of time and place.<sup>612</sup>
5. To prevent health care providers from **interpreting** what the patient might have meant in his or her Living Will, it is recommended that certain minimal requirements be spelled out in a specific document, allowing for additional specifications to be added.<sup>613</sup> With regards to format, it should be flexible in the interests of promoting the validity of such documents. Since clear and unambiguous statements are a necessity for ensuring validity of the documents, legislation should make provision for the development of draft documents as a matter of urgency.<sup>614</sup>
6. A Treatment Refusal Form should be developed for inclusion in the medical records of the patient when he or she is admitted to hospital. It should also be established at that point if the patient has a Living Will. This will give certainty to

<sup>607</sup>United Christian Action; Africa Christian Action; This suggestion is opposed by the The Living Will Society since it would mean that the patient's will may be overridden by the family's wishes.

<sup>608</sup>SA Nursing Council.

<sup>609</sup>Lawyers for Human Rights.

<sup>610</sup>SA Nursing Council.

<sup>611</sup>National Office: Cancer Association of SA.

<sup>612</sup>(Fr) Hyacinth Ennis.

<sup>613</sup>Department of Health.

<sup>614</sup>Lawyers for Human Rights.

the health care personnel.<sup>615</sup> This idea was supported strongly<sup>616</sup> and it was recommended that the American "Self-Determination Act of 1990" be studied in order that similar regulations pertaining to the "Admittance or consent to treatment" forms used by hospitals and all health care institutions be incorporated within the draft bill. It was felt that it is of the utmost importance that all hospitals, nursing homes, hospices, frail care centres and other health care institutions should make provision on each specific admittance form for the question: "Have you signed a Living Will or advance directive?" and if the answer is in the affirmative, regulations should instruct that the Living Will is kept in the patient's "In-patient" File for the duration of his or her stay in the given health care institution. Members of the Living Will Society are advised that when signing the hospital consent form, the words....'subject to the directions as stated in my Living Will' should be written immediately before their signature.

7. There should be a conscientious clause for doctors who do not see their way open to consider such requests. Practitioners should be obliged to refer such patients to another practitioner.<sup>617</sup>
8. Wide scale paralegal training on such documents should take place in order to increase access to advance directives and power of attorneys in the country.<sup>618</sup>
9. Witnesses should not be named in the directive, not be related to the patient and not be the patient's health care providers.<sup>619</sup>
10. Consideration to be given to the issue of verbal 'advance directives' and whether there may be certain circumstances under which such directives could be recognised as an indication of the wishes of the terminally ill person.<sup>620</sup>
  - i) It was noted that should assisted suicide and euthanasia be legalised, it may be

<sup>615</sup>Department of Health.

<sup>616</sup>The Living Will Society.

<sup>617</sup>Alfred Allan; Southern African Anglican Theological Commission (Cape Town); SA National Consumer Union.

<sup>618</sup>Lawyers for Human Rights.

<sup>619</sup>Lawyers for Human Rights.

<sup>620</sup>Lawyers for Human Rights.



argued that the logical conclusion would be that advance directives should, on grounds of consistency, make provision for a lethal injection in cases of, for example, a patient in a permanent vegetative state.<sup>621</sup>

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<sup>621</sup>Dr Willem Landman.

(c) **Recommendation of the Commission**

**5.94** As stated in Discussion Paper 71 and supported in the majority of submissions it seems desirable to gain statutory recognition for advance directives and enduring powers of attorney, provided that compliance with the wishes set out in the document would not be unlawful. It is, however, questionable whether it is necessary to prescribe rigid requirements in this regard, such as the use of a specific form of document or a refusal of treatment certificate as is prescribed in some other jurisdictions. It would also be necessary to afford medical practitioners and persons acting under the direction of the medical practitioners, legal protection against any civil or criminal liability if life-sustaining treatment is suspended. It is equally important to offer these medical practitioners and their assistants an escape mechanism to refuse to do anything in terms of this Act if this would be in conflict with their moral or ethical codes.

**5.95** Although the point was discussed, it should be noted that not one commentator requested that the Living Will should be able to legalise active euthanasia. Furthermore, the possibility of abuse of such a provision in a Living Will is an important factor mitigating against legalising such a provision. The Commission is therefore of the view that a Living Will should only be recognised as valid and legally enforceable in so far as it requests a passive form of cessation of life.

**5.96** After due consideration of the proposals and recommendations put forward in the submissions the Commission proposes the following clauses:

*Directives as to the treatment of a terminally ill person*

6. (1) *Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive declaring that if he or she should ever suffer from a terminal illness and would as a result be unable to make or communicate decisions concerning his or her medical treatment or its cessation, medical treatment should not be instituted or any medical treatment which he or she may receive should be discontinued and that only*

*palliative care should be administered.*

(2) *A person as contemplated in subsection (1) shall be competent to entrust any decision-making regarding the treatment as contemplated in that subsection or the cessation of such treatment to a competent agent by way of a written power of attorney, and such power of attorney shall take effect and remain in force if the principal becomes terminally ill and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof.*

(3) *A directive contemplated in subsection (1) and a power of attorney contemplated in subsection (2) and any amendment thereof, shall be signed by the person giving the directive or power of attorney in the presence of two competent witnesses who shall sign the document in the presence of the said person and in each other's presence.*

(4) *When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) or (2) regarding his medical treatment or the cessation thereof have been issued, the decision-making regarding such treatment or the cessation thereof shall, in the absence of any court order or the provisions of any other Act, vest in such guardian or curator.*

***Conduct in compliance with directives by or on behalf of terminally ill persons***

7. (1) *No medical practitioner shall give effect to a directive regarding the refusal or cessation of medical treatment or the administering of palliative care which may contribute to the hastening of a patient's death, unless-*

(a) *the medical practitioner is satisfied that the patient concerned is suffering*

*from a terminal illness and is therefore unable to make or communicate considered decisions concerning his or her medical treatment or the cessation thereof; and*

*(b) the condition of the patient concerned, as contemplated in paragraph (a), has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition because of his expert knowledge of the patient's illness and his or her examination of the patient concerned.*

*(2) Before a medical practitioner gives effect to a directive as contemplated in subsection (1) he shall satisfy himself, in so far as this is reasonably possible, of the authenticity of the directive and of the competency of the person issuing the directive.*

*(3) Before giving effect to a directive as contemplated in subsection (1), a medical practitioner shall inform the interested family members of the patient of his or her findings, that of the other medical practitioner contemplated in paragraph (b) of subsection (1), and of the existence and content of the directive of the patient concerned.*

*(4) If a medical practitioner is uncertain as to the authenticity as regard to the directive or its legality, he shall treat the patient concerned in accordance with the provisions set out in section 8 below.*

*(5) (a) A medical practitioner who gives effect to a directive as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and the manner in which he implemented the directive.*

*(b) A medical practitioner as contemplated in paragraph (b) of subsection (1) shall record in writing his findings regarding the condition of the patient concerned.*

(6) *A directive concerning the refusal or cessation of medical treatment as contemplated in subsection (1) and (2) shall not be invalid and the withholding or cessation of medical treatment in accordance with such a directive, shall, in so far as it is performed in accordance with this Act, not be unlawful even though performance of the directive might hasten the moment of death of the patient concerned.*

**B. Cessation of life-sustaining medical treatment: there is no advance directive (living will) or power of attorney**

**a) Position as set out in Discussion Paper 71**

**i) Introduction**

5.97 In this case the question - whether the patient should be kept alive indefinitely by artificial means - has to be answered with reference to objective, legislative or judge-made rules.

5.98 The traditional view of our courts with regard to euthanasia in respect of an incompetent person is perhaps best reflected in the judgment of De Wet J P in **S v De Bellocq**.<sup>622</sup> In this case the mother, who had some medical knowledge, killed her child who had suffered brain damage at birth and who would have been an imbecile for the rest of his life. De Wet J P states as follows:<sup>623</sup>

The law does not allow any person to be killed whether that person is an imbecile or very ill. The killing of such a person is an unlawful act and it amounts to murder in law.

The Court did however describe the case as very tragic and handed down a sentence which can effectively be regarded as a dismissal.

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<sup>622</sup>1975 3 SA 538 (T). For a discussion of this case see Strauss, S A "Onvrywillige genadedood: 'n belangrike Transvaalse beslissing" 1969 **THRHR** 385.

<sup>623</sup>Op cit 539 C - D.

5.99 In the last few decades a turnabout has been observed in the traditional view of the law in these areas and in several countries judgments can now be found indicating that although euthanasia is not allowed, cessation of treatment may be permissible under specific circumstances and subject to certain conditions.

5.100 This means that the patient cannot be actively killed (as was the case in **S v De Bellocq**).<sup>624</sup> The life-sustaining mechanisms may however be withdrawn from the patient. The patient then dies of natural causes, for example cessation of one or other of his life-functions, infections that are not treated or, eventually, from thirst or hunger.

(ii) **Comparative law**

5.101 We will now briefly discuss the main features of the development in comparable legal systems:

\* **The United States of America**

5.102 The first and best-known judgment in this respect is the case of **Karen Quinlan**<sup>625</sup> that was decided in 1976 in the state of New Jersey. Karen Quinlan was in a persistent vegetative state and there was no hope of her recovering. Her father sought to be appointed as her guardian. He also applied for the power to authorise the cessation of all further extraordinary medical treatment that would prolong her life functions in an artificial manner. The Supreme Court of New Jersey granted the application and furthermore stated that should her father authorise the cessation of artificial preservation of life functions and Karen should die as a result, he would not be criminally liable for her death.

5.103 The judgment of the court was based on her constitutional rights to privacy and self-

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<sup>624</sup>Supra.

<sup>625</sup>**In re Quinlan** 81 NJ 10; 355 A 2d 647 (NJ 1976).

determination. The reasoning of the court appears from the judgment of Hughes C J:

Having concluded that there is a right of privacy that might permit termination of treatment in the circumstances of this case, we turn to consider the relationship of the exercise of that right to criminal law. We are aware that such termination of treatment would accelerate Karen's death. The County Prosecutor and the Attorney-General maintain there would be criminal liability for acceleration. Under the statutes of the State, the unlawful killing of another human being is criminal homicide. NJS 2A: 113 - 1, 2, 5. We conclude that there would be no criminal homicide in the circumstances of this case. We believe, firstly, that the ensuing death would not be homicide but rather expiration from existing natural causes. Secondly, even if it were to be regarded as homicide, it would not be unlawful.

These conclusions rest upon definitional and constitutional bases. The termination of treatment pursuant to the right of privacy is, within the limitations of this case **ipso facto** lawful. Thus, a death resulting from such an act would not come within the scope of the homicide statutes proscribing only the unlawful killing of another. There is a real and, in this case, determinative distinction between the unlawful taking of the life of another and the ending of artificial life-support systems as a matter of self-determination.

Furthermore, the exercise of a constitutional right such as we have here found is protected from criminal prosecution. See **Stanley v Georgia** (supra, 394 US at 559; 89 S Ct at 1245; 22 L Ed 2d at 546). We do not question the State's undoubted power to punish the taking of human life, but that power does not encompass individuals terminating medical treatment pursuant to their right of privacy. See **id** at 568; 89 S Ct at 1250; 22 L Ed 2d at 551. The constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime. **Eisenstadt v Baird** (supra, 405 US at 445-6; 92 S Ct at 1034-5; 31 L Ed 2d at 357-8). **Griswold v Connecticut** (supra, 381 US at 481; 85 S Ct at 1679-80; 14 L Ed 2d at 512-13). And, under the circumstances of this case, these same principles would apply to and negate a valid prosecution for attempted suicide were there still such a crime in this State.

5.104 This matter was taken further in three more decisions of the Supreme Court of New Jersey. In the case of **In re Claire Conroy**<sup>626</sup> the court furthermore explained why a person should be allowed to take a decision on behalf of an unconscious patient in the said circumstances:

.... on balance the right to self-determination ordinarily outweighs any countervailing State interests (in preservation of the individual's life) and competent persons generally are permitted to refuse medical treatment even at the risk of death. ... In view of the case law,

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<sup>626</sup>98 NJ 321; 486 A 2d 1209 (NJ 1985).

we have no doubt that Ms Conroy, if competent to make the decision and if resolute in her determination, could have chosen to have her naso-gastric tube withdrawn. Her interest in freedom from non-consensual invasion of her bodily integrity would outweigh any State interest in preserving life or in safeguarding the integrity of the medical profession. In addition, rejecting her artificial means of feeding would not constitute attempted suicide, as the decision would probably be based on a wish to be free of medical intervention rather than a specific intent to die, and her death would result, if at all, from her underlying medical condition, which included her inability to swallow.

5.105 In the case of **In re Nancy Ellen Jobes**<sup>627</sup> it is further explained why a person should be allowed to take the said decision on behalf of an unconscious patient:

We state again that the fateful decision to withdraw life-supporting treatment is extremely personal. Accordingly, a competent patient's right to make that decision generally will outweigh any countervailing State interests. See **Farrell** (supra, 108 NJ at 354; 529 A 2d at 414). An incompetent patient does not lose his or her right to refuse life-sustaining treatment. Where such a patient has clearly expressed her intentions about medical treatment, they will be respected. See **Peter** (supra, 108 NJ at 378; 529 A 2d at 425).

Where an irreversibly vegetative patient like Mrs Jobes has not clearly expressed her intentions with respect to medical treatment, the **Quinlan** 'substituted judgment' approach best accomplishes the goal of having the patient make her own decision. In most cases in which the 'substituted judgment' doctrine is applied, the surrogate decision-maker will be a family member or close friend of the patient. Generally it is the patient's family or other loved ones who support and care for the patient, and who best understand the patient's personal values and beliefs. Hence, they will be best able to make a substituted medical judgment for the patient.

This approach was confirmed in **In re Hilda M Peter**.<sup>628</sup>

5.106 In the **Jobes** case<sup>629</sup> the court said that there was a precognition for the execution of the decision by the surrogate-guardian. The guardian had to obtain statements by at least two medical practitioners who were qualified neurologists, in which they declared that the patient was in a persistent vegetative state and that there was no possibility that the patient would ever recover to a state of intellectual consciousness.

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<sup>627</sup>108 NJ 394; 529 A 2d 434 (NJ 1987).

<sup>628</sup>108 NJ 365; 529 A 2d 419 (NJ 1987).

<sup>629</sup>Supra.



5.107 In 1990 the case of **Nancy Cruzan** was heard before the Supreme Court of America.<sup>630</sup> Nancy was involved in a car accident as a result of which she was in a persistent vegetative state for six years.<sup>631</sup> Her parents sought a court order authorising the removal of her gastrostomy feeding tube, but this was refused. On appeal to the Supreme Court the decision was affirmed as it was found that the court **a quo** was constitutionally justified in requiring that a patient's wishes be proved by clear and convincing evidence. The reason for this is that the state has an unqualified interest in the preservation of human life and that it has a duty further to guard against potential abuse in such situations. An erroneous decision could furthermore not be rectified. The court **a quo** was therefore entitled to make a finding on the facts that clear and convincing evidence of the patient's wishes did not exist. (Before the accident Nancy had merely indicated to friends in an informal manner that she would not wish to live in such a state.)

5.108 Although the US Supreme Court therefore acknowledged the patient's constitutional right to refuse treatment, it was not required to accept the substituted judgment of family members in the absence of evidence that the wishes of the family and those of the patient corresponded. A court of lower jurisdiction did, however, subsequently consent to the removal of the gastrostomy feeding tube on the basis of new evidence.

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<sup>630</sup>**Cruzan v Director Missouri Department of Health** supra at 2841. See also Dworkin at 237.

<sup>631</sup> In his submission Rev Justin Swanson criticised the outcome of this case saying that Nancy Cruzan died 12 days after artificial feeding was discontinued.

\* **The United Kingdom**

5.109 The position concerning cessation of life-sustaining treatment (or selective non-treatment as it is known in England) was to a large extent resolved when this question was addressed by the House of Lords in February 1993 in the case of **Airedale NHS Trust v Bland**.<sup>632</sup> In this case the applicant health authority sought a declaratory order to the effect that, despite the inability of the patient to give consent, his life-sustaining treatment should be discontinued and that no further medical treatment should be furnished except for the purpose of enabling him to die peacefully with dignity and the minimum of pain, and that if death should occur then the cause of death should be attributed to the original cause of his condition and not to the cessation of medical treatment. The termination of medical treatment should therefore not give rise to any civil or criminal liability on the part of any person. The application was supported by the family of the patient.

5.110 The respondent, the 21-year-old Anthony Bland, had been in a persistent vegetative state for 3½ years after suffering a severely crushed chest injury which caused catastrophic and irreversible brain damage. Although not brain dead, he had to use a nasogastric tube, catheter and enemas for normal bodily functions and he had no cognitive function. The unanimous opinion of all the doctors who examined him was that there was no hope of recovery or improvement.

5.111 In these circumstances it was thought appropriate to cease further treatment (artificial feeding and furnishing of antibiotic treatment). It was conceded that this would probably result in the patient's death from starvation within one to two weeks. At no stage did Bland give his consent in this regard.

5.112 The application was opposed by the Official Solicitor (acting as guardian **ad litem**), who claimed that the proposed action would amount to murder.

5.113 The judge granted the order as requested, whereupon the Official Solicitor appealed to the

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<sup>632</sup>[1993] 1 All ER 821 (CA). For a discussion of this case, see Finnis, J M "**Bland: Crossing the Rubicon?**" 1993 **The Law Quarterly Review** 329.

Court of Appeals and thereafter to the House of Lords. In both these instances the original order was affirmed.

5.114 The House of Lords held that a doctor, who has in his or her care a patient who is incapable of consenting to treatment, is under no absolute obligation to prolong the patient's life regardless of the quality thereof. The court referred with approval to the 'best interest' condition as set out in **F v West Berkshire Health Authority**<sup>633</sup> and held that medical treatment (which includes artificial feeding) may be withheld if it is in the patient's best interest not to be treated any further (since such treatment is futile and do not confer any benefit on the patient).<sup>634</sup>

5.115 To determine what course of action would further the best interests of the patient, the court used the test laid down in **Bolam v Friern Hospital Management Committee**,<sup>635</sup> namely whether the proposed conduct would be in accordance with the opinion of a large informed and responsible group of medical practitioners.

5.116 As the cessation of life-supporting treatment in this case was in accordance with the criteria set out in a discussion paper by the British Medical Association,<sup>636</sup> the court found that the **Bolam** requirement had been complied with.

5.117 The court stated, however, that similar cases should be referred to the court on an *ad hoc* basis and furthermore that the issue should be referred to Parliament for consideration of possible

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<sup>633</sup>[1989] 2 All ER 545; [1990] 2 AC 1.

<sup>634</sup>See also **Frenchay Healthcare NHS Trust v S** [1994] 2 All ER 403 and the discussion by Labuschagne, J M T "**Frenchay Healthcare NHS Trust v S** [1994] 2 All ER 403 (CA): Eutanatiewe beëindiging van mediese behandeling" 1996 **SACJ** 80.

<sup>635</sup>[1957] 2 All ER 118; [1957] 1 WLR 582.

<sup>636</sup>British Medical Association **Treatment of patients in persistent vegetative state**, in which the following criteria were set out:

- (a) Rehabilitative efforts for at least 6 months after the injury;
- (b) the diagnosis of irreversible PVS should only be considered confirmed after 12 months;
- (c) the diagnosis should be confirmed by two other independent doctors;
- (d) the wishes of the family should be respected.

legislation in this regard.

5.118 It is generally accepted that a patient's stated will should be respected.<sup>637</sup> In **Airedale NHS Trust v Bland**<sup>638</sup> Lord Goff of Chieveley stated:

[I]t has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued ... the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it.

5.119 The next question which was also argued in the British courts was whether cessation of treatment should also be allowed in cases where persons are not in a vegetative state, but have no normal brain function, and where this condition is irreversible. One thinks here of the child who is born as an imbecile as a result of a serious brain defect.

5.120 In the case of **Re J (a minor)**<sup>639</sup> J, an infant, had suffered serious brain damage at birth. Large areas of his brain where there should have been brain tissue had become fluid-filled. He often suffered convulsions and there were episodes during which he stopped breathing. He was twice linked to a ventilator for fairly long periods. Chances were good that he would develop spastic quadriplegia. It was debatable whether he would ever be able to sit up or hold his head upright. He was unlikely ever to be able to speak. He would, however, be able to feel pain to the same extent as a normal baby and it was possible that he would achieve the ability to smile or to cry. His life-expectancy was limited. The question arose whether J should again be ventilated in the event of his again stopping to breathe. Two medical practitioners submitted a report which indicated that it would not be in J's interest to be ventilated again. The court issued an order in accordance with the experts' report. The argument raised against the issuing of the order was that the court was not in a position to evaluate the consequences of death and that respect for the sanctity of human life and the requirements of public policy precluded attempts by the court to

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<sup>637</sup>See **Re T (adult: refusal of medical treatment)** *supra*; **Airedale NHS Trust v Bland** *supra*.

<sup>638</sup>*Supra* at 866 d - e.

<sup>639</sup>[1990] 3 All ER 930.

evaluate the quality of life of a disabled person. This submission was rejected by the Court of Appeal.

5.121 The Court of Appeal based its decision on the best interests of the child. Balcombe L J stated:<sup>640</sup>

I have already cited the passage from the speech of Lord Hailsham LC in **Re B (a minor) (wardship: sterilisation)** [1987] 2 All ER 206 at 212; [1988] AC 199 at 202 which established that issues of public policy, as such, cannot prevail over the interests of the ward. In my judgment there is no warrant, either on principle or authority, for the absolute submission. There is only the one test: that the interests of the ward are paramount. Of course the Court will approach those interests with a strong predilection in favour of the preservation of life, because of the sanctity of human life. But there neither is, nor should there be any absolute rule that, save where the ward is already terminally ill, i e dying, neither the Court nor any responsible parent can approve the withholding of life-saving treatment on the basis of the quality of the ward's life. (For my part I would not accept that the so-called "cabbage" cases could be treated as an exception to this suggested rule, since in deciding that a child whose faculties have been destroyed is a "cabbage" of itself involves making a judgment about the quality of that child's life.) I say that there is no such rule because there is no authority to that effect: indeed the judgments in **Re B (a minor) (wardship: medical treatment, 1981)** [1990] 3 All ER 927; [1981] 1 WLR 1421 are consistent only with there being no "absolute" rule. I say that there should be no such rule because it could in certain circumstances be inimical to the interests of the ward that there should be such a requirement: to preserve life at all costs, whatever the quality of the life to be preserved, and however distressing to the ward may be the nature of the treatment necessary to preserve life, may not be in the interests of the ward.

5.122 It was also submitted that the court could not issue a life-ending order unless it was absolutely certain that the quality of the child's subsequent life would be intolerable to the child and demonstrably so awful that in effect the child must be condemned to die. Balcombe L J expressed his rejection of this argument as follows:<sup>641</sup>

Here again I cannot accept the submission in the terms in which it was framed, which treats the language used by Templeman and Dunn L J J in **Re B (a minor) (wardship: medical treatment)** [1990] 3 All ER 927 at 929 - 30; [1981] 1 WLR 1421 at 1424 as if they had

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<sup>640</sup>Op cit 942.

<sup>641</sup>Ibid.

intended to lay down a test applicable to all circumstances, which clearly they did not. Further, I would deprecate any attempt by this Court to lay down such an all-embracing test since the circumstances of these tragic cases are so infinitely various. I do not know of any demand by the Judges who have to deal with these cases at first instance for this Court to assist them by laying down any test beyond that which is already the law: that the interests of the ward are the first and paramount consideration, subject to the gloss on that test which I suggest, that in determining where those interests lie the Court adopts the standpoint of the reasonable and responsible parent who has his or her child's best interests at heart.

5.123 It was clear that the court was prepared to evaluate the quality of life of the patient and that considerations of public policy would not get in the way of such an evaluation.

5.124 In **Clarke v Hurst NO**<sup>642</sup> no criticism was raised against **Re J (a minor)**.<sup>643</sup> As a matter of fact the court based its decision on the principles stated.

### (iii) The legal position in South Africa

5.125 The question whether a court may order the cessation of life-sustaining mechanisms with regard to a patient in a permanent vegetative state on the application brought by an interested person was first discussed in **Clarke v Hurst NO**.<sup>644</sup>

5.126 The patient had had a heart attack during 1988 as a result of which his heartbeat and breathing ceased. Resuscitative measures restored his heartbeat, but only after he had suffered serious brain damage. He became deeply comatose and never regained consciousness. His

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<sup>642</sup>Supra.

<sup>643</sup>Supra.

<sup>644</sup>1992 4 SA 630 (D). For a discussion of this important case, see Lupton, M L "**Clarke v Hurst NO, Brain NO & Attorney-General, Natal**" 1992 **SACJ** 342; Dörfling, DF "Eutanasie: die reg van die **curator personae** om verdere behandeling van 'n pasient te verbied - 'n nuwe regverdigingsgrond in die Suid-Afrikaanse reg" 1993 **TSAR** 345; Boister, N "Causation at the death?" 1993 **THRHR** 516.

swallowing mechanism was not functioning and he had to be fed by means of a nasogastric tube. He was in what is commonly known as a persistent vegetative condition. He had been in this condition for about four years without any sign of improvement.

5.127 He was a member of SAVES The Living Will Society. He had signed a so-called "Living Will", the essential clause of which reads as follows:<sup>645</sup>

If there is no reasonable expectation of my recovery from extreme physical or mental disability ... I direct that I be allowed to die and not be kept alive by artificial means and heroic measures. I ask that medication be mercifully administered to me for terminal suffering even though this may shorten my remaining life ...

The court's order was, however, not founded on Dr Clarke's directive as expressed in the Living Will.

5.128 As the Living Will did not have accepted legal status, his wife applied to the court for a declaratory order whereby she would be appointed **curatrix personae** to her husband's person with powers in that capacity to authorise the discontinuance of any further medical treatment or feeding to her husband. This in fact amounted to an application for a declaratory order to the effect that the discontinuance of her husband's artificial feeding regime, which would inevitably lead to his death, would not be unlawful - a case therefore of cessation of treatment. The Attorney-General of Natal, who was cited as respondent, opposed the application on the grounds that the proposed action would be **prima facie** unlawful and that the court did not have the authority to tie his (the Attorney-General's) hands with an order as proposed as to the question of whether prosecution should be instituted.

5.129 The court found that in determining legal liability for terminating a patient's life, there was no justification for drawing a distinction between the omission to institute life-sustaining treatment and the discontinuation thereof. Just as in the case of an omission to institute life-sustaining procedures, legal liability would depend on whether there was a duty to institute such procedures,

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<sup>645</sup>Clarke v Hurst NO supra at 633 G-H.

so in the case of the discontinuance of such procedures liability depends on whether there is a duty to continue such procedures. A duty not to discontinue life-sustaining procedures could not arise if the procedures instituted have proved to be unsuccessful. The mere maintenance of certain biological functions such as heartbeat, respiration, digestion and blood circulation, without the functioning of the brain, cannot be equated with life. It would therefore not be unlawful to discontinue the artificial maintenance of that level of life.

5.130 The court further held that it would not be contrary to public policy if a court would in cases of this nature make an evaluation of the quality of life in order to determine whether life-sustaining measures should be discontinued.

5.131 The court held that the decision as to whether the discontinuance of artificial feeding of the patient and his resultant death would be wrongful depended on whether, judged according to the **boni mores** of the community, it would be reasonable to discontinue such feeding. The **boni mores** in turn depended on the quality of life that remained to the patient - in other words, the facts of the particular case.

5.132 In the present case, after extensive medical evidence was placed before the court, it was decided that the applicant would not act unlawfully by authorising the cessation of the artificial feeding of the patient, even though this would hasten the patient's death.

#### (iv) Conclusion

5.133 In our opinion there is a clearly distinguishable trend in Western legal systems, as confirmed in the judgments of the courts, that in suitable cases and subject to suitable precautions, the life of a patient who is in an irreversible vegetative state, may be ended by cessation of life sustenance mechanisms and means.

5.134 In light of the judgment in **Clarke v Hurst NO**<sup>646</sup> the confirmation of the said principle in legislation will not be a revolutionary step. Legislation can, however, establish specific guidelines

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<sup>646</sup>Supra.



and set the conditions for such a step to be allowed. If legislation is deemed necessary or advisable to end the use of life-sustaining mechanisms where a patient is kept alive by artificial means, guidelines could be laid down.

**b) Discussion of submissions received**

5.135 Although the majority of respondents agreed with the procedure set out in sec 8 of the Bill, dealing with the conduct of the doctor in the absence of a directive where the patient is incompetent, there were respondents who did not agree. The main problem identified was the inclusion of the words "maintenance of artificial feeding" in the definition of "life-sustaining medical treatment".<sup>647</sup> They asked for a greater recognition of the ethical distinction between ordinary and extraordinary means of sustaining human life.<sup>648</sup> The respondents held that a patient should always receive nutrition and hydration since that constitutes ordinary care.<sup>649</sup> Removal of extraordinary means is permissible. This would for instance apply to a patient who would need to be in the ICU indefinitely. Removal of ordinary means is not permissible, unless that applies to means that are death-delaying rather than life-supporting.<sup>650</sup> It cannot be said that a person who dies of hunger or thirst in a hospital or similar institution has died a natural death.<sup>651</sup> In the absence of a directive the medical practitioner should be guided by the Court's opinion.<sup>652</sup>

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<sup>647</sup>United Christian Action; Human Life International SA; Africa Christian Action.

<sup>648</sup>SACBC.

<sup>649</sup>United Christian Action; Pro-Life; Office of the Chief Rabbi; Islamic Medical Association.

<sup>650</sup>Rev Justin Swanson; United Christian Action; Doctors for Life; (Fr) Joseph Murphy; (Fr) Hyacinth Ennis.

<sup>651</sup>United Christian Action; A Rogers.

<sup>652</sup>Cora Klopper: Southern Transvaal Region, CANSA.

5.136 The greater majority of commentators agreed in principle<sup>653</sup> that nutrition and hydration should form part of medical treatment<sup>654</sup> but had recommendations on points of detail. The following comments were made:

1. In so far as the confirmation of the condition of the patient is concerned it was held that it is essential that the second medical practitioner be from a totally separate institution.<sup>655</sup> If the second medical practitioner mentioned in sec 8(1) is linked to the same hospital, clinic or similar institution as the chief medical practitioner, he may have a vested economic interest which could influence his views. Some respondents furthermore wanted two medical practitioners to confirm the opinion not one<sup>656</sup> whereas others felt that confirmation of the condition of the patient should only be provided where reasonably possible.<sup>657</sup>
2. Secondly it was contended that it should be a medical practitioner and not the chief medical officer of the hospital who gives the authorisation for cessation of treatment.<sup>658</sup> The withdrawal of treatment may be desirable in respect of patients outside institutions where there is no 'chief medical practitioner' and a medical

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<sup>653</sup>Joane Deare, Natal Region, CANSA; SA National Consumer Union; Anglican Church; Dr HJC du Plesis; Prof KRL Huddle; Methodist Church ; NPPHCN; M Lavies ; F Lobinger; Logan Naidoo; Natal Law Society; Society of Neurosurgeons of SA; Lawyers for Human Rights supported this section due to the fact that HIV and AIDS impacts most severely upon those in the lower socio-economic classes many of these patients will not have enacted a living will or durable power of attorney. Furthermore, should an interested party wish to request the withdrawal of life-sustaining treatment, an application to court would be time-consuming and costly.

<sup>654</sup> See Dr Willem Landman who said the term "medical treatment or artificial nutrition and hydration" should be used in all the relevant sections for the sake of completeness and clarity; Rev Harris, Methodist Church said it may seem callous to withdraw nutrition and hydration, with the result that the patient starves to death or dies of thirst, but the presumption is that such a patient is incapable of feeling.

<sup>655</sup>United Christian Action.

<sup>656</sup>SA Nursing Council.

<sup>657</sup>Living Will Society.

<sup>658</sup>Critical Care Association of South Africa.

superintendent is furthermore in general not concerned with the clinical management of the patient and should not be given any authority in making or implementing this sort of clinical decision.<sup>659</sup>

3. The Chief Medical Officer should consult with a Hospital Ethics Committee if it exists.<sup>660</sup> A member of the multi-disciplinary team should be involved in the decision making process.<sup>661</sup>
4. Under no circumstances should the court be empowered to override the wishes of the interested family members or close family of the patient especially if family members hold strong religious or moral views opposing the cessation of life-sustaining medical treatment.<sup>662</sup> It was also recommended that any legislation which confers rights and decision-making powers on the families of terminally ill people should include the rights of other committed partners. This would include the partners of homosexuals who may be dying of a terminal illness as well as those cohabiting with the patient in a situation which is not legally recognised as a marriage. These people may in fact be in the best position to give evidence regarding the wishes of the terminally ill person.<sup>663</sup> There was agreement that such decisions should be made in consultation with the patient's partner, family members and relatives.<sup>664</sup>
5. The legislation grants a wide range of duties and powers to medical practitioners. It will therefore be necessary to ensure that mechanisms are created to review

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<sup>659</sup>Living Will Society.

<sup>660</sup>Department of Health.

<sup>661</sup>National Office: Cancer Association of SA.

<sup>662</sup>United Christian Action; S Loyd.

<sup>663</sup>Lawyers for Human Rights.

<sup>664</sup>Lawyers for Human Rights; S Loyd; See however the Critical Care Society of SA who felt that the family should not be forced to take responsibility for the decision since this may be an unnecessarily emotionally traumatic thing for them to do.

discretionary powers of medical practitioners in terms of the Act. It was therefore recommended that the nature, duties and procedures of the SA Interim Medical and Dental Council be reviewed in order to ensure that this body is able to respond to complaints, queries and reviews. The present capacity of this body to do so is inadequate. Alternatively other more speedy and accessible means of review should be enacted in terms of the legislation, or by means of regulations in terms of the legislation. Extra-legal education is imperative to inform both medical practitioners and communities of their rights and obligations in this respect.<sup>665</sup>

6. The importance of enacting safeguards to ensure that decisions regarding the withdrawal of life-sustaining treatment, which are made on the basis of resource constraints, are made in a manner which is just and fair and non-discriminatory was emphasised.<sup>666</sup>
7. Where there is no advance directive and the wishes of the patient have to be determined from surrounding circumstances, factors that may be taken into account are the following: previous declarations, religious affinity, personal views on life, life-expectancy, and the amount of pain the patient has suffered.<sup>667</sup>

c) **Recommendation of the Commission**

**5.137 There are always cases in which the person concerned has neither drafted a document nor authorised any person to make decisions on his or her behalf. The same questions concerning the termination of life will however be raised in these cases. Where the patient is terminally ill as defined in this legislation and furthermore unable to make or communicate decisions concerning his or her medical treatment, it would appear desirable**

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<sup>665</sup>Lawyers for Human Rights.

<sup>666</sup>Lawyers for Human Rights; Theresa Hannan.

<sup>667</sup>Labuschagne 1995 **Obiter** at 175 for a discussion of Duitse Bundesgerichtshof, Urt 13/9/1994, NstZ 1995, 80 in which factors to be taken into account were set out.

to empower the medical practitioner treating the patient to authorise the cessation of treatment, subject to the provision that the interested family members agree with the decision. In such cases it would appear unnecessary to burden those involved with the costs that would be incurred in a court application. Any interested party is of course free to approach the court in this regard if this is deemed necessary.

**5.138** These principles will also be applicable in the treatment of severely disabled babies<sup>668</sup> who are terminally ill.<sup>669</sup> Where a hopeless prognosis is clear and cannot be improved with treatment, there is neither a moral nor a legal obligation to impose (or continue) treatment of the baby.<sup>670</sup>

**5.139** In our opinion there is a need to ensure legal certainty as regards the problems now under discussion. Legislative confirmation and clarification of the position where there is no advance directive (living will) or power of attorney (i.e. to confirm and clarify *Clarke v Hurst NO*)<sup>671</sup> are necessary. Taking into consideration all the proposals and recommendations made the Commission proposes the following clause:

*Conduct of a medical practitioner in the absence of a directive*

8. (1) *If a medical practitioner responsible for the treatment of a patient in a hospital, clinic or similar institution where a patient is being cared for, is of the opinion that the patient is in a state of terminal illness as contemplated in this Act and unable to make or*

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<sup>668</sup>Neonatal intensive care includes resuscitation, mechanical ventilation, artificial tube feeding and other technologically sophisticated means of maintaining seriously handicapped and seriously ill or low-birth weight neonates.

<sup>669</sup>Moor at 295; Snyder RD "End of life decisions at the beginning of life" 1996 **Med Law** 283; Nel, JP "Regsvrae rondom die geneeskundige behandeling van ernstig gestremde pasgeborenes" 1998 **THRHR** 73 & 1998 **THRHR** 252.

<sup>670</sup>Moor at 297.

<sup>671</sup>Supra.

*communicate decisions concerning his or her medical treatment or its cessation, and his or her opinion is confirmed in writing by at least one other medical practitioner who has not treated the person concerned as a patient, but who has examined him and who is competent to submit a professional opinion regarding the patient's condition on account of his expertise regarding the illness of the patient concerned, the first-mentioned medical practitioner may, in the absence of any directive as contemplated in section 6(1) and (2) or a court order as contemplated in section 9, grant written authorisation for the cessation of all further life-sustaining medical treatment and the administering of palliative care only.*

*(2) A medical practitioner as contemplated in subsection (1) shall not act as contemplated in subsection (1) if such conduct would be contrary to the wishes of the interested family members of the patient, unless authorised thereto by a court order.*

*(3) A medical practitioner as contemplated in subsection (1) shall record in writing his findings regarding the patient's condition and any steps taken by him in respect thereof.*

*(4) The cessation of medical treatment as contemplated in subsection (1) shall not be unlawful merely because it contributes to causing the patient's death.*

### ***Powers of the court***

**9.** *(1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may, if satisfied that a patient is in a state of terminal illness and unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, order the cessation of medical treatment.*

*(2) A court shall not make an order as contemplated in subsection (1) without the*

*interested family members having been given the opportunity to be heard by the court.*

*(3) A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who have expert knowledge of the patient's condition and who have treated the patient personally or have informed themselves of the patient's medical history and have personally examined the patient.*

*(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not thereby incur any civil, criminal or other liability whatsoever.*

**C. Non-voluntary active euthanasia<sup>672</sup>**

**a) The position as set out in Discussion Paper 71**

5.140 In conclusion the question should also be discussed with regard to the nature of the life-ending behaviour. In all the decisions discussed above, it is the consent to cessation of life-sustaining mechanisms and measures that is at issue. In the end the patient dies a natural death, either from an illness like pneumonia left untreated, or as a result of hunger or thirst.

5.141 The following question is frequently posed in the euthanasia debate: why can't a person's life be ended actively in such circumstances by administering a lethal substance?. Why should the patient have to keep suffering until he or she eventually dies of hunger or thirst?

5.142 This question was also stated and discussed in **Clarke v Hurst NO.**<sup>673</sup> For the sake of completeness the question and answer suggested by Thirion J is quoted in full:<sup>674</sup>

But now, if it would be reasonable for the applicant in the present case to discontinue the artificial nutritioning of the patient knowing that such a step would result in the death of the patient, why would it not be reasonable for someone to simply suffocate the patient to death? The deprivation of food would as assuredly kill the patient as the deprivation of oxygen. I think the distinction is to be found in society's sense of propriety - its belief that things should happen according to their natural disposition or order. The person who pre-emptes the function of the executioner and kills the condemned man while he is taking the last few steps to the gallows, acts wrongfully irrespective of his motive for killing the condemned man. He acts wrongfully because he has no right to meddle in the matter.

In my view the distinction between the act of the doctor who, while following the precepts and ethics of his profession, prescribes a drug in a quantity merely sufficient to relieve, and with the object of relieving, the pain of his patient, well knowing that it may also shorten

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<sup>672</sup>Non-voluntary euthanasia should be distinguished from involuntary euthanasia. Involuntary euthanasia is commonly used to refer to life termination against a person's will as distinct from non-voluntary euthanasia carried out in the assumed interest of the patient whose consent cannot be obtained.

<sup>673</sup>Supra.

<sup>674</sup>Op cit 657 B-H.



the patient's life, and the act of the doctor who prescribes an overdose of the drug with the object of killing his patient, is that the former acts within the legitimate context and sphere of his professional relationship with his patient while the latter does not act in that context. Consequently, society adjudges the former's conduct justified in accordance with its criterion of reasonableness and therefore not wrongful, while it condemns the conduct of the latter as wrongful.

The distinction between what is wrong and what is right cannot always be drawn according to logic. Logic does not dictate the formation of society's legal or moral convictions.

The distinction can also be justified on rational grounds. The doctor who brings about the death of his patient by prescribing an overdose of the drug with the object of killing the patient, causes the death of the patient in a manner which is unrelated to his legitimate function as a doctor. He changes not only the course but also the cause of his patient's death. To allow conduct of this nature would open the door to abuse and subject people to the vagaries of unauthorised and autocratic decision-making.

5.143 For many there may be persuasive force in the arguments quoted above. But for others to allow the removal of the life-sustaining apparatus, but not to allow active euthanasia does not seem to be logical. The opinion as set out in **Clarke v Hurst NO**<sup>675</sup> may, so it is argued, also result in serious suffering. One is inclined to take the patient in a persistent vegetative state, who cannot really express pain and suffering, as the point of reference and example. However, the argument is that one should take the example of a person bitten by a dog with rabies, who is in the final stages of an irreversible and unbearable state of pain and suffering. Such a patient is apparently legally and mentally totally incompetent; according to all medical knowledge it is an irreversible state; but what is more, the patient may be experiencing unbearable pain and suffering and if he could have talked, it would only have been to beg for the hastening of his death. Should the line be drawn right through?<sup>676</sup>

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<sup>675</sup>Supra.

<sup>676</sup>Two cases (Prins and Kadijk) in the Netherlands should be noted, in which doctors ended the lives of severely disabled infants by active euthanasia. They were in severe pain and were expected to die within months. See in this regard Labuschagne, JMT "Aktiewe eutanasie van n swaar gestremde baba: n Nederlandse hof herstel die **ius vitae necisque** in n medemenslike gewaad" 1996 SALJ 216; Nadasen, at 124.

**b) Submissions received**

5.144 In so far as the court's powers are concerned it was clear from submissions dealing with this question that Option 1 (sec 9) dealing with cessation of treatment was mostly supported and preferred to option 2 (sec 10) dealing with active euthanasia.<sup>677</sup> One view was that no court should be allowed to order the performance of any medical procedure which would have the effect of terminating a patient's life.<sup>678</sup> The court should furthermore not be empowered to make an order which is in conflict with the wishes and convictions of the close family. There were however respondents who indicated that they were divided within their organisations in their preference for Option 1 or 2. They said that they would however prefer that all forms of treatment should be withdrawn rather than that active steps be taken to hasten death.<sup>679</sup>

**c) Recommendation of the Commission**

**5.145 The Commission does not recommend any legislation in this regard.**

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<sup>677</sup>SACBC Parliamentary Liaison Office ; DG, Dept of Health ; SA Nursing Council ; National Office: Cancer Association of SA ; SA Consumer Council ; Prof RKL Huddle; Society of Advocates of Natal; MASA.

<sup>678</sup>SACBC Parliamentary Liaison Office

<sup>679</sup>South African Anglican Theological Commission (Cape Town); Hospital Association of SA.



## CHAPTER 6

### A DRAFT BILL ON END OF LIFE DECISIONS

6.1 In the preceding chapters, we have endeavoured to set out the various problem areas. As discussed in Chapter 1<sup>680</sup> above the SA Law Commission is of the opinion that the position in regard to all of these problem areas should be formalised in a bill. The Commission has taken into account all the proposals and comments received. The Bill contained in Discussion paper 71<sup>681</sup> has been amended accordingly where necessary.

6.2 The draft bill in Annexure C to this report reflects the Commission's provisional positions.

6.3 In so far as the name of the Bill is concerned respondents were divided equally in their choice between the two options proposed.<sup>682</sup> The Commission has decided to use the second option namely "**End of Life Decisions Act 1998**".

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<sup>680</sup>See above Para 1.30.

<sup>681</sup> See above para 1.16.

<sup>682</sup>"Rights of the Terminally Ill Act" was preferred by inter alia SA Nursing Council, Department of Health, Southern Transvaal Region: CANSA; National Office: Cancer Association; Judge President, Northern Cape Division; "End of Life Decisions Act" was inter alia preferred by Mandisa Sonqishe, Cancer Association, (Fr) Hyacinth Ennis; Prof S Benatar et al. ; SA Council of Churches.

**ANNEXURE A****LIST OF RESPONDENTS TO WORKING PAPER 53****COMMENTS RECEIVED FROM INDIVIDUALS**

1. Ambrogi, D
2. Benatar, S R(Prof)
3. Bremer, PM (Dr)
4. Brien, MAE (Dr)
5. Bruce Brand, AA
6. Cairney, R
7. Calitz, EM
8. Cameron, DA (Dr)
9. Datlen, B
10. De Andrade, L
11. Devine, OO
12. Domisse, J (Prof)
13. Du Plessis, CF (Attorney General, Northern Cape)
14. Ennis, H (Fr)
15. Fanner, M
16. Fourie, E
17. Geddes, C (Dr)
18. Glazewski, J
19. Grout, TG (Dr)
20. Harris, GW (Dr)
21. James, MFM (Prof)
22. Kalk, WJ (Prof)
23. Katz, M (Prof)
24. Leslie, E (Fr)
25. Leveson, O
26. Lobinger, F (Bishop)
27. McKenzie, B (Dr)
28. McLean, G R (Dr)
29. Mobeng, J
30. Munnik, GGA (Judge)

31. Phillips, J
32. Pilz, C
33. Rabinowitz, R (Dr)
34. Roberts, LJ (Attorney General, Eastern Cape)
35. Robinson, LW
36. Rowland, MP (Bishop)
37. Schwarer, AH (Adv)
38. Spencer, D (Dr)
39. Stephens, BS
40. Swanton, J (Fr)
- ii Van den Heever, P
- ii Van Heerden, B
- ii Von Lieres und Wilkau, KPCO (Attorney General, Witwatersrand Local Division)
- ii Walters, ID (Dr)
- ii Yonge, AC
- ii Yonge, NCW

#### **COMMENTS RECEIVED FROM ORGANISATIONS**

47. Baptist Union Christian Citizen Committee
48. Cape Bar Council
49. Die Vereniging van Prokureursordes van die RSA
50. Department of National Health and Population Development (two submissions)
51. Die Gereformeerde Kerk Waterkloofrand
52. Doctors who Respect Human Life
53. Johannesburg Bar Council
54. Medical Association of South Africa
55. Natal Law Society (two submissions)
56. Oranjemed
57. Pretoria Sungardens Hospice
58. SAVES The Living Will Society
59. South African Medical and Dental Council
60. World Federation of Doctors Who Respect Human Life

**LIST OF RESPONDENTS TO DISCUSSION PAPER 71****A. COMMENTS RECEIVED FROM INDIVIDUALS**

1. Abratt, R
2. Allan, A
3. Baker, J
4. Barker, HJ(Attorney)
5. Behn, G
6. Benatar, D
7. Benatar, S (Prof)
8. Biggs, C
9. Boehm, M
10. Booyesen, JL
11. Brady, C
12. Broadbent, RMS
13. Browde, S (Dr)
14. Catton, DG (Dr)
15. Chapman, J
16. Chomse, ME
17. Cica, N
18. Claassen, AC
19. Crossland, K
20. Crossland, T
21. Dangantye, J
22. De Necker, J
23. De Villiers, JM
24. De Vries, PC
25. Driessen, J
26. Du Plessis, HJC (Dr)
27. Du Plooy, CW
28. Du Toit, SJG
29. Egan, N
30. Ennis, H (Fr)
31. Falkson, G (Prof)
32. Firth, S
33. Fowler, H
34. Foyn, R
35. Frauenstein, MEE
36. Froman, D (Dr)
37. Gattonby, ID
38. Germond, T (Dr)et al

39. Goodall, J (Dr)
40. Goosen, B
41. Gosher, M
42. Hagg, N
43. Hamilton, P
44. Hanan, T
45. Harmon, T
46. Harris, V (Rev)
47. Harrison, P
48. Heering, N (Dr)
49. Henley, L
50. Hicks, G(Dr)
51. Higgens, R
52. Huddle, KRL (Prof)
53. Janse van Rensburg, HM
54. Joubert, D
55. Kali, B
56. Kenna, S
57. Keown, J
58. Knight, V
59. Kriek, JJ (Judge)
60. Krugel, SJ
61. Kushke, H (Dr)
62. Labuschagne, JMT (Prof)
63. Larson, JV (Dr)
64. Lavies, M
65. Lawson, MJ
66. Ledesman, I
67. Le Roux, AMB
68. Lloyd, S
69. Lobinger, F (Bishop)
70. Lyle, UM
71. Mahlangu, J
72. Makhiwiting, W
73. Malulyck, E
74. Mashego, F
75. Mason, H
76. Mason, M
77. McBean, TA
78. Meyer, LL
79. Michell, L
80. Miesner, K
81. Moelendorf, D
82. Moloto, S
83. Murphy, J (Fr)
84. Murray, E (Dr)
85. Murray, J



86. Murray, JV (Dr)
87. Myburgh, S
88. Naidoo, L (Att)
89. Nash, E
90. Nhlabathu, SP
91. O'Leary, A
92. Olivier, J
93. Olivier, S
94. Pather, T
95. Paul, J (Dr)
96. Pretorius, C
97. Pretorius, P
98. Pope, EMP
99. Potgieter, Y
100. Robbins, G
101. Rogers, A
103. Schlebusch, L (Prof)
104. Schmid, R
105. Schonegevel, SK
106. Selolo, H
107. Schutte, A
108. Simpson, D
109. Simpson, J
110. Simpson, G
111. Simpson, G
112. Smit, JHN
113. Southwell, V
114. Sowter, F
115. Stockwell, HJ
116. Stott, E
117. Strydom, DP
118. Swanton, J (Fr)
119. Swart, JG (Prof)
120. Taylor, C
121. Thompson, I (Fr)
122. Van der Merwe, W
123. Van Niekerk, JP de V
124. Van Oosten, FFW (Prof)
125. Van Schalkwyk, D
126. Viera, MC
127. Von Reiche, FVA (Magistr)
128. Vos, H
129. Wright, A (Dr)

**B) COMMENTS RECEIVED FROM ORGANISATIONS**

130. African Christian Action
131. African Christian Democratic Party (ACDP)
132. Cancer Association
133. Christian Coalition
134. Christian Doctors in South Africa
135. Christian Lawyers Association
136. Christian Medical Fellowship, London
137. Christian Medical Fellowship, South Africa
138. Council for the Aged
139. Covenant Life Church
140. Critical Care Society
141. Department of Justice: Ulundi
142. Department of Health
143. Doctors for Life
144. Ethics Committee, Medical School, University of the Witwatersrand
145. Final Exit, Zimbabwe
146. Free Church
147. Gereformeerde Kerk in Suid-Afrika
148. Hospice Association of South Africa
149. Hospital Association
150. Howick and District Council for the Care of the Aged (HADCA)
151. Human Life International
152. Internal Fellowship of Christian Churches
153. Islamic Medical Association of South Africa
154. Lawyers for Human Rights
155. MASA
156. Methodist Church
157. Mothwa Haven
158. Mpumalanga Provincial Government
159. Muslim Lawyers Association
160. National Association for People with Aids (NAPWA)
161. National Council for People with Disabilities, Johannesburg
162. National Council for People with Physical Disabilities, Eastern-Cape
163. National Council of Women in South Africa
164. Nederduits-Gereformeerde Kerk (two submissions)
165. National Primary Health Care Network (NPPHCN)
166. Office of the Chief Rabbi
167. Pro Life
168. Right to Life Campaign
169. SAVES Living Will Society
170. Society of Advocates of Natal
171. Society of Neurosurgeons of South Africa
172. Soroptimist International of the Highveld
173. South African Anglican Theological Commission (Cape Town)
174. South African Catholic Bishops Conference Parliamentary Liaison Office

## (SACBC)

175. South African Consumer Union
176. South African Council of Churches
177. South African Medical and Dental Council
178. South African Nursing Council
179. South Australian Voluntary Euthanasia Society
180. United Christian Action
181. Victims of Choice
182. Voluntary Euthanasia Society, Canada
183. Voluntary Euthanasia Society, London
184. World Federation of Doctors who respect Human Life

**ANNEXURE C**

**BILL**

**To regulate end of life decisions and to provide for matters incidental thereto.**

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**To be introduced by the Minister of Justice**

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BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:

**Definitions**

**1. (1)** In this Act, unless the context otherwise indicates-

'competent witness' means a person of the age of 18 years or over who at the time he witnesses the directive or power of attorney is not incompetent to give evidence in a court of law and for whom the death of the maker of the directive or power of attorney holds no benefit;

'court' means a provincial or local division of the High Court of South Africa within whose jurisdiction the matter falls;

'family member' in relation to any person, means that person's spouse, parent, child, brother or sister;

'intractable and unbearable illness' means an illness, injury or other physical or mental condition, but excluding a terminal illness, that-

- (a) offers no reasonable prospect of being cured; and
- (b) causes severe physical or mental suffering of a nature and degree not reasonable to be endured.

'lawyer' means an attorney as defined in section 1 of the Attorney's Act, 1979 (Act 53 of 1979) and an advocate as defined in section 1 of the Admission of Advocates Act, 1964 (Act 74 of 1964);

'life-sustaining medical treatment' includes the maintenance of artificial feeding;

'medical practitioner' means a medical practitioner registered as such in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);

'nurse' means a nurse registered as such in terms of the Nursing Act 50 of 1978 and authorised as a prescriber in terms of section 31(14)(b) of the proposed [South African Medicines and Medical Devices Regulatory Authority Bill]<sup>683</sup>;

'palliative care' means treatment and care of a terminally ill patient with the object of relieving physical, emotional and psycho-social suffering and of maintaining personal

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<sup>683</sup>Editorial note: Now Act 132 of 1998 assented to 11 December 1998, date of commencement to be proclaimed.

hygiene;

'spouse' includes a person with whom one lives as if they were married or with whom one habitually cohabits;

'terminal illness' means an illness, injury or other physical or mental condition that-

- (a) in reasonable medical judgement, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering; or
- (b) causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.

### **Conduct of a medical practitioner in the event of clinical death**

2.(1) For the purposes of this Act, a person is considered to be dead when two medical practitioners agree and confirm in writing that a person is clinically dead according to the following criteria for determining death, namely -

- (a) the irreversible absence of spontaneous respiratory and circulatory functions; or
- (b) the persistent clinical absence of brain-stem function.

(2) Should a person be considered to be dead according to the provisions of sub-section (1), the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of treatment.

### **Mentally competent person may refuse treatment**

3.(1) Every person -

- (a) above the age of 18 years and of sound mind, or
- (b) above the age of 14 years, of sound mind and assisted by his or her parents or guardian,

is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.

(2) Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in subsection (1) is, that such a person's refusal is based on the free and considered exercise of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.

(3) Care should be taken when taking a decision as to the competency of a person, that an individual who is not able to express him or herself verbally or adequately, should not be classified as incompetent unless expert attempts have been made to communicate with that person whose responses may be by means other than verbal.

(4) Where a medical practitioner as contemplated in subsection (2) does not share or understand the first language of the patient, an interpreter fluent in the language used by the patient must be present in order to facilitate discussion when decisions regarding the treatment of the patient are made.

#### **Conduct of medical practitioner in relieving distress**

4.(1) Should it be clear to a medical practitioner or a nurse responsible for the treatment of a patient who has been diagnosed by a medical practitioner as suffering from a terminal illness that the dosage of medication that the patient is currently receiving is not adequately alleviating the patient's pain or distress, he or she shall -

- (a) with the object to provide relief of severe pain or distress; and
- (b) with no intention to kill

increase the dosage of medication (whether analgesics or sedatives) to be given to the patient until relief is obtained, even if the secondary effect of this action may be to shorten the life of the patient.

(2) A medical practitioner or nurse who treats a patient as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and his or her conduct in treating the patient, which record will be documented and filed in and become part of the medical record of the patient concerned.

### **Active voluntary euthanasia**

#### **Option 1:**

No legislative enactment

#### **Option 2:**

#### **Cessation of life**

5.(1) Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall give effect to the request if he or she is satisfied that-

- (a) the patient is suffering from a terminal or intractable and unbearable illness ;
- (b) the patient is over the age of 18 years and mentally competent;



- (c) the patient has been adequately informed in regard to the illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;
  - (d) the request of the patient is based on a free and considered decision;
  - (e) the request has been repeated without self-contradiction by the patient on two separate occasions at least seven days apart, the last of which is no more than 72 hours before the medical practitioner gives effect to the request;
  - (f) the patient, or a person acting on the patient's behalf in accordance with subsection (6), has signed a completed certificate of request asking the medical practitioner to assist the patient to end the patient's life;
  - (g) the medical practitioner has witnessed the patient's signature on the certificate of request or that of the person who signed on behalf of the patient;
  - (h) an interpreter fluent in the language used by the patient is present in order to facilitate communication when decisions regarding the treatment of the patient are made where the medical practitioner as contemplated in this section does not share or understand the first language of the patient;
  - (i) ending the life of the patient or assisting the patient to end his or her life is the only way for the patient to be released from his or her suffering.
- (2) No medical practitioner to whom the request to make an end to a patient's suffering is addressed as contemplated in subsection (1), shall give effect to such a request, even though he or she may be convinced of the facts as stated in that subsection, unless he or she has conferred with an independent medical practitioner who is knowledgeable with regard to the terminal illness from which the patient is suffering and who has personally checked the patient's medical history

and examined the patient and who has confirmed the facts as contemplated in subsection (1)(a), (b) and (i).

(3) A medical practitioner who gives effect to a request as contemplated in sub-section (1), shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner with whom he or she has conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).

(4) The termination of a patient's life on his or her request in order to release him or her from suffering may not be effected by any person other than a medical practitioner.

(5) A medical practitioner who gives effect to a patient's request to be released from suffering as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act provided that all due procedural measures have been complied with.

(6) If a patient who has orally requested his or her medical practitioner to assist the patient to end the patient's life is physically unable to sign the certificate of request, any person who has attained the age of 18 years, other than the medical practitioner referred to in subsection (2) above may, at the patient's request and in the presence of the patient and both the medical practitioners, sign the certificate on behalf of the patient.

(7) (a) Notwithstanding anything in this Act, a patient may rescind a request for assistance under this Act at any time and in any manner without regard to his or her mental state.

(b) Where a patient rescinds a request, the patient's medical practitioner shall, as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record.

(8) The following shall be documented and filed in and become part of the medical record of the patient who has been assisted under this Act:

- (a) a note of the oral request of the patient for such assistance;
- (b) the certificate of request;
- (c) a record of the opinion of the patient's medical practitioner that the patient's decision to end his or her life was made freely, voluntarily and after due consideration;
- (d) the report of the medical practitioner referred to in subsection (2) above;
- (e) a note by the patient's medical practitioner indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the substance prescribed.

### **Option 3: Decision by panel or committee**

#### **Cessation of life**

**5.(1)** Euthanasia may be performed by a medical practitioner only, and then only where the request for the euthanasia of the patient has been approved by an ethics committee constituted for that purpose and consisting of five persons as follows:

- a) two medical practitioners other than the practitioner attending to the patient;
- b) one lawyer;
- c) one member sharing the home language of the patient;
- d) one member from the multi-disciplinary team; and
- e) one family member.

(2) In considering and in order to approve a request as contemplated in subsection (1) the Committee has to certify in writing that:

- a) in its opinion the request for euthanasia by the patient is a free, considered and sustained request;
  - b) the patient is suffering from a terminal or intractable and unbearable illness;
  - c) euthanasia is the only way for the patient to be released from his or her suffering.
- (3) A request for euthanasia must be heard within three weeks of it being received by the Committee.
- (4) (a) The Committee which, under subsection (2), grants authority for euthanasia must, in the prescribed manner and within the prescribed period after euthanasia has been performed, report confidentially to the Director-General of Health, by registered post, the granting of such authority and set forth -
- (i) the personal particulars of the patient concerned;
  - (ii) the place and date where the euthanasia was performed and the reasons therefore;
  - (iii) the names and qualifications of the members of the committee who issued the certificates in terms of the above sections; and
  - (iv) the name of the medical practitioner who performed the euthanasia.
- (b) The Director-General may call upon the members of the Committee required to make a report in terms of subsection (4) or a medical practitioner referred to in subsection (1) to furnish such additional information as he may require.
- (5) The following shall be documented and filed and become part of the medical record of the patient who has been assisted under this Act:
- (a) full particulars regarding the request made by the patient;
  - (b) a copy of the certificate issued in terms of subsection (2);
  - (c) a copy of the report made in terms of subsection (4).

**Directives as to the treatment of a terminally ill person**

6.(1) Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive declaring that if he or she should ever suffer from a terminal illness and would as a result be unable to make or communicate decisions concerning his or her medical treatment or its cessation, medical treatment should not be instituted or any medical treatment which he or she may receive should be discontinued and that only palliative care should be administered.

(2) A person as contemplated in subsection (1) shall be competent to entrust any decision-making regarding the treatment as contemplated in that subsection or the cessation of such treatment to a competent agent by way of a written power of attorney, and such power of attorney shall take effect and remain in force if the principal becomes terminally ill and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof.

(3) A directive contemplated in subsection (1) and a power of attorney contemplated in subsection (2) and any amendment thereof, shall be signed by the person giving the directive or power of attorney in the presence of two competent witnesses who shall sign the document in the presence of the said person and in each other's presence.

(4) When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) or (2) regarding his medical treatment or the cessation thereof have been issued, the decision-making regarding such treatment or the cessation thereof shall, in the absence of any court order or the provisions of any other Act, vest in such guardian or curator.

**Conduct in compliance with directives by or on behalf of terminally ill persons**

7.(1) No medical practitioner shall give effect to a directive regarding the refusal or cessation of medical treatment or the administering of palliative care which may contribute to the hastening of a patient's death, unless-

(a) the medical practitioner is satisfied that the patient concerned is suffering from a terminal illness and is therefore unable to make or communicate considered decisions concerning his or her medical treatment or the cessation thereof; and

(b) the condition of the patient concerned, as contemplated in paragraph (a), has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition because of his expert knowledge of the patient's illness and his or her examination of the patient concerned.

(2) Before a medical practitioner gives effect to a directive as contemplated in subsection (1) he shall satisfy himself, in so far as this is reasonably possible, of the authenticity of the directive and of the competency of the person issuing the directive.

(3) Before giving effect to a directive as contemplated in subsection (1), a medical practitioner shall inform the interested family members of the patient of his or her findings, that of the other medical practitioner contemplated in paragraph (b) of subsection (1), and of the existence and content of the directive of the patient concerned.

(4) If a medical practitioner is uncertain as to the authenticity as regard to the directive or its legality, he shall treat the patient concerned in accordance with the provisions set out in section 8 below.

(5) (a) A medical practitioner who gives effect to a directive as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and the manner in which he or she implemented the directive.

(b) A medical practitioner as contemplated in paragraph (b) of subsection (1) shall record in writing his or her findings regarding the condition of the patient concerned.

(6) A directive concerning the refusal or cessation of medical treatment as contemplated in sub-section (1) and (2) shall not be invalid and the withholding or cessation of medical treatment in accordance with such a directive, shall, in so far as it is performed in accordance with this Act, not be unlawful even though performance of the directive might hasten the moment of death of the patient concerned.

### **Conduct of a medical practitioner in the absence of a directive**

8.(1) If a medical practitioner responsible for the treatment of a patient in a hospital, clinic or similar institution where a patient is being cared for, is of the opinion that the patient is in a state of terminal illness as contemplated in this Act and unable to make or communicate decisions concerning his or her medical treatment or its cessation, and his or her opinion is confirmed in writing by at least one other medical practitioner who has not treated the person concerned as a patient, but who has examined him or her and who is competent to submit a professional opinion regarding the patient's condition on account of his or her expertise regarding the illness of the patient concerned, the first-mentioned medical practitioner may, in the absence of any directive as contemplated in section 6(1) and (2) or a court order as contemplated in section 9, grant written authorisation for the cessation of all further life-sustaining medical treatment and the administering of palliative care only.

(2) A medical practitioner as contemplated in subsection (1) shall not act as contemplated in subsection (1) if such conduct would be contrary to the wishes of the interested family members of the patient, unless authorised thereto by a court order.

(3) A medical practitioner as contemplated in subsection (1) shall record in writing his or her findings regarding the patient's condition and any steps taken by him or her in respect thereof.

(4) The cessation of medical treatment as contemplated in subsection (1) shall not be unlawful merely because it contributes to causing the patient's death.

### **Powers of the court**

9.(1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may, if satisfied that a patient is in a state of terminal illness and unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, order the cessation of medical treatment.

(2) A court shall not make an order as contemplated in subsection (1) without the interested family members having been given the opportunity to be heard by the court.

(3) A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who have expert knowledge of the patient's condition and who have treated the patient personally or have informed themselves of the patient's medical history and have personally examined the patient.

(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not thereby incur any civil, criminal or other liability whatsoever.

### **Interpretation**

10. The provisions of this Act shall not be interpreted so as to oblige a medical practitioner to do anything that would be in conflict with his or her conscience or any ethical code to which he or she feels himself or herself bound.



**Short title**

- 11.** This Act shall be called the End of Life Decisions Act 1999.