

AN ANALYSIS OF ASSISTED DYING AND THE PRACTICAL IMPLEMENTATION THEREOF IN SOUTH AFRICAN CRIMINAL LAW

By

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“Why can’t we treat death with a certain amount of humanity and dignity, and decency and God forbid, maybe even humour? Death is not the enemy, gentlemen. If we’re going to fight a disease, let’s fight one of the most terrible diseases of all: indifference... A doctor’s mission should not just be to prevent death, but also to improve the quality of life. That’s why you treat a disease, you win, you lose. You treat a person, I guarantee you, you’ll win, no matter what the outcome.”

– Robin Williams, (1998) *Patch Adams*.

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SUMMARY

This dissertation will examine the legality of assisted dying procedures performed in the Republic of South Africa. This is due to the rising awareness about terminal patients' dignity and autonomy at the end of their life. The physician's liability, who assists such a patient to end their life, will be examined and whether there is any legal recourse available will be explored. Comparisons will also be made between other legal systems, including Canada, the Netherlands, Oregon of the United States of America and England and Wales. These jurisdictions have been chosen to provide a wide variety of perspectives and possible alternatives that South Africa should take into consideration should parliament or the courts decide to argue the matter. Other sources are also considered, such as the influence of the history and development of the common law crime of murder, as well as the role the Health Professions Council of South Africa will play. Possibly most importantly, the material criminal law of South Africa is thoroughly studied with all forms of assisted dying in mind. This is to establish what kind of liability, criminal or otherwise, a physician might incur should they decide to assist a patient in these circumstances. Lastly, recommendations are made based on the research done throughout this dissertation, which would ideally assist in any future arguments made on the topic.

KEY WORDS AND PHRASES

| | | | |
|--------------------|----------------------------|-----------------|------------------|
| Euthanasia | Physician-Assisted Suicide | Murder | Assisted Dying |
| Criminal Liability | Medical Malpractice | Palliative Care | Canada Bill C-14 |
| Slippery Slope | Dignified Death | Necessity | Terminal Illness |

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*“O me! O life! of the questions of these recurring; of the endless trains of the faithless... of cities filled with the foolish; what good amid these, O me, O life?” Answer. That you are here - that life exists, and identity; that the powerful play goes on and you may contribute a verse. That the powerful play *goes on* and you may contribute a verse. What will your verse be?” – Robin Williams (1989) Dead Poet’s Society*

I would like to express my heartfelt gratitude to some of the people without whom this dissertation would never have seen a printer:

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And now without further ado...

A

AN ANALYSIS OF ASSISTED DYING AND THE PRACTICAL IMPLEMENTATION THEREOF IN SOUTH AFRICAN CRIMINAL LAW

A van der Merwe

2017

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Glossary

Advance directive

It can be one of two things: Living wills and lasting power of attorney. *“Living wills (also referred to as instructional advance directives) are written documents designed to allow people to express their preferences regarding the withholding of specified treatments if at any time in the future they are no longer able to take such decisions. The lasting power of attorney (also referred to as a “proxy directive”) allows an individual to appoint someone else as a health care proxy (for example, a trusted friend or relative) to make health care decisions on his or her behalf.”*¹

Assisted dying

For purposes of this dissertation this phrase will be used as an umbrella term, which includes voluntary active or passive euthanasia and physician-assisted suicide.

Assisted suicide

Conducts wherein one aids another person to kill themselves. This applies to anyone who is not a registered medical practitioner and who does not employ medical procedures with which to hasten or cause the death.

¹ Jordaan L (2011) “The Legal Validity of an Advance Refusal of Medical Treatment in South African Law (Part 1)” *De Jure* Volume (1): 34.

Euthanasia

“The intentional termination of the life with a noble motive by another at the explicit request of a terminally ill person who dies.”²

Euthanasia, active

“This involves unlawfully and intentionally causing the death of a person through a direct action, in response to a request from the person.”³

Euthanasia, involuntary

“This term is used to describe the causing of the death of a patient in opposition to their wishes and is regarded as murder.”⁴

Euthanasia, passive

“This ... involves the hastening of the death of a person by withdrawing some form of life-sustaining support and letting nature take its course. Eg: a) removing the life support equipment; b) stopping of medical procedures, medication; c) stopping food and water allowing the person to dehydrate or starve to death; d) not delivering CPR (cardio-pulmonary resuscitation) and allowing a person whose heart has stopped, to die.”⁵

² Carstens P & Pearmain D (2007) *Foundational Principles of South African Medical Law*: 200, fn 409.

³ Carstens, *supra*: 203, fn 425.

⁴ Carstens, *supra*: 204, fn 429.

⁵ Carstens, *supra*: 203, fn 426.

Euthanasia, voluntary

“This is used to describe the causing of the death of a patient with their consent or some form of advanced directive such as a living will.”⁶

Homicide

It has been noted that some jurisdictions refer to “homicide” instead of “murder”, however there might be little or no difference. Therefore, the author will use the colloquial term from those jurisdictions.

Murder

The unlawful and intentional killing of another live human being.

Palliative care / End-of-life care

“Treatment designed to relieve symptoms of disease rather than to cure it.”⁷

Patient

Someone who is ill and seeks a physician’s help. For purposes of this dissertation the patient will be referred to as a woman, unless case law is being discussed in which the patient was a man.

⁶ Carstens, *supra*: 204, fn 428.

⁷ Venes, D (2017) *Taber’s Cyclopedic Medical Dictionary* (23): 1740.

Physician-assisted dying/suicide

“[A] physician supplies information and / or the means of committing suicide (eg a prescription for a lethal dose of sleeping pills, or a supply of carbon monoxide gas) to a person, in order for him / her to terminate his / her life.”⁸

Physician

Someone registered as a medical practitioner in the relevant jurisdiction in terms of the relevant legislation. For purposes of this dissertation the physician will be referred to as a man, unless case law is being discussed in which the physician was a woman.

Self-administer

The patient’s ability to ingest or inject a medical substance provided by the physician in order to cause her own death.

⁸ Carstens, *supra*: 204, fn 427.

CHAPTER 1

INTRODUCTION

1 INTRODUCTION

Nothing in this world is certain, except for death and taxes. These truths have not changed, but the consistent advancement in the fields of medical and health sciences have given humans the ability to postpone death, even if just for short while in certain circumstances. Unfortunately the symptoms that precede death in cases of terminal illness cannot always be relieved satisfactorily. Which leads to death - sometimes providing something medical intervention cannot: a release from pain and suffering.

The topic of death has been debated since people have been capable of thought and how people approach that stage of their life will be the main topic of discussion in this dissertation. The debate surrounding assisted dying has gained some new momentum in South Africa and foreign countries, with countries allowing the practice and others who are steadfast in their disallowance thereof.

Assisted dying and all its various forms will be discussed with the ultimate goal of providing an answer to whether it should be a crime in South Africa. This of course means that the dissertation will be written from a criminal law perspective and the material criminal law, along with possible defences, will be explored.

2 HYPOTHESIS AND PURPOSE OF THE DISSERTATION

The author hypothesizes that it is legally justifiable for assisted dying to occur in South Africa without the physician incurring any liability, criminal or otherwise, provided he acts within the confines of certain parameters. This, however, does not mean that it would necessarily be practical, given the many resources that would have to be employed in order to avoid any abuse and safeguard the integrity of the medical profession.

The other purpose of this dissertation is to provide a new outlook on the debate, taking into account all the latest arguments, court cases and research. This will ideally allow people to broaden their minds and create new arguments from various perspectives. If appropriate the author will also make recommendations based on the research whether assisted dying is legally feasible or not in South Africa.

3 MOTIVATION AND VALUE OF CONTRIBUTION

As stated earlier, humans have always been fascinated with death and there are many cultures in the world who considered the way in which someone died to be just as important as how they lived. This can be illustrated through the Japanese practice of *seppuku*¹ or the Viking belief that the afterlife in Valhalla² was reserved for warriors who died in battle.³ In modern times people are less concerned with the honour of such a death, but focus more on the dignity, or lack thereof, that accompanies the period

¹ Ancient Origins (2016) "The Honorable Death: Samurai and Suicide in Feudal Japan" *Ancient Origins: Reconstructing the Story of Humanity's Past* available online at www.ancient-origins.net/history-ancient-traditions/honorable-death-samurai-and-suicide-feudal-japan-005822. Accessed 2017/10/24. A ritual which allowed a Japanese person, usually a samurai, to commit honourable suicide whereby they disembowelled themselves, after which his second would decapitate him. It is understandably no longer practiced.

² Norse Mythology "Valhalla and Folkvangr" *Norse Mythology* available online at norse-mythology.net/valhalla-in-norse-mythology. Accessed 2017/10/24. According to the mythology fallen warriors would be taken to the halls of Valhalla, where they would drink at night and fight during the day. This would continue until Odin called upon them to battle in *Ragnarök*, the end of the world.

³ Historian on the Warpath (2011) "Spartan Burial Practices and Honoring Fallen Soldiers" *Historian on the Warpath* available online at www.scottmanning.com/content/spartan-burial-practices. Accessed 2017/10/24. Even in ancient Sparta only warriors who died in battle or women who died during childbirth was allowed a headstone.

leading up to the final moment. This attitude might change over time, but currently there are inconsistencies with what people want and what is allowed by law.

The main contribution by this dissertation will be that it contains the most recent research and analysis of assisted dying done on master's level. It is also the most complete in terms of its analysis of assisted dying within the context of South African criminal law. Ultimately this will shed light on answering whether assisted dying in some circumstances is a crime and if any defence exists which could change this.

4 RESEARCH METHODOLOGY AND STRUCTURE OF DISSERTATION

To achieve the main objective and contribute to the law, the author will initiate the analysis by researching the common law crime of murder and focusing on the development of the crime. This is to create a foundation from which the ensuing chapters will start. Thereafter, the applicable South African legal principles will be discussed, such as the relevant Constitutional principles, the basic elemental requirements of a crime and all applicable case law, the most recent of which is the *Estate Stransham-Ford*⁴ case. All of this will of course be done with assisted dying in mind and where necessary, the specific forms will be identified and examined.

This analysis of South Africa will be followed by a comparative study between the legal systems of Canada, the Netherlands, the state of Oregon in the United States of America and England and Wales. Each part will conclude with recommendations for South Africa and whether something similar should be done or avoided. The relevant and applicable legislation, case law, legal principles and secondary sources from each legal system will be studied.

⁴ *Minister of Justice and Correctional Services v Estate Stransham-Ford* (531/2015) 2016 ZASCA 197 (6 December 2016).

Lastly, the Health Professions Council of South Africa will be examined and their powers and responsibilities should any changes occur within the law. The dissertation will then conclude by making recommendations for South Africa based upon all the above mentioned chapters.

4.1 CHOICE OF LEGAL SYSTEMS

The jurisdictions chosen for this dissertation are, as mentioned above, South Africa, Canada, the Netherlands, the United States of America's state of Oregon and England and Wales. These jurisdictions have been specifically chosen for their unique and varying positions regarding the topic of assisted dying, as well as their relevance to South Africa.

4.1.1 SOUTH AFRICA

The main objective of the dissertation is to analyse the applicability of assisted dying in South Africa. There have also been recent developments within our courts, with a new application being lodged at the time of the writing of this dissertation.⁵

4.1.2 CANADA

Canada has recently adopted a bill decriminalizing the practice of assisted dying in certain prescribed circumstances. Not only do the Canadians now have the youngest Bill to do this, their Charter of Rights and Freedoms makes their Constitution similar to ours in South Africa.⁶

⁵ A combined application has been lodged in the Johannesburg High Court by Dr. Suzanne Walter and Dieter Harck.

⁶ The South African Bill of Rights was largely influenced by the Canadian Charter.

4.1.3 THE NETHERLANDS

Arguably, the Dutch have the oldest legislation on the matter, which makes them suited for observing the long term effects of decriminalizing assisted dying and if possible, how to avoid the less desirable ones.

4.1.4 THE UNITED STATES OF AMERICA – OREGON

The state of Oregon has the oldest legislation on the topic in the United States of America (USA) and every subsequent state that has followed a similar path has based theirs upon Oregon's. What makes their legislation applicable to this research is the limited scope thereof and the various studies done regarding the matter.

4.1.5 ENGLAND AND WALES

England has refused to allow any form of assisted dying, apart from allowing people to travel to Switzerland to do so. But it is exactly for this reason that they are also included in this dissertation; to provide a counterweight the above legal systems' arguments which do allow assisted dying.

5 DELENIATIONS AND LIMITATIONS

The dissertation will only include research done on the legal systems mentioned above. Furthermore, the main focus will be on the criminal law and its relevant aspects to the discussion. Where appropriate mention may be made to other aspects of law, such as civil law.

It must also be stated from the onset that the author will refer to "assisted dying" throughout the dissertation for the sake of simplicity. This phrase, however, only includes the parameters of assisted dying which could conceivably be lawful, such as voluntariness and decision making capacity from the patient, passive and active

euthanasia and physician-assisted suicide. Unless specifically stated otherwise, the phrase will mean conduct which falls within those parameters.

6 CONCLUSION

In order to understand this debate and why people are so passionate about it, a complete study has to be done – working within the limitations mentioned above – including as many legal systems and sources as possible. In order to do this the above mentioned sources will be examined and the possible applications thereof in South African criminal law will be commented on.

However, in order to create a proper foundation for the discussion, the history and development of the crime of murder must first be studied.

CHAPTER 2

THE HISTORY AND DEVELOPMENT OF MURDER IN SOUTH AFRICAN CRIMINAL LAW

1 INTRODUCTION

The purpose of this chapter is to create a foundation for the discussion of assisted dying, which is to follow in subsequent chapters. The practice of assisted dying has been interpreted to fall within the ambit of the definition of murder, thus this crime's development and interpretation must be analysed.

Murder is considered to be one of, if not *the*, most serious crime a person can commit. This is most likely due to the fact that, without life, no other pleasures or rights can be enjoyed. Every major religion has some form of prohibition against killing, the most famous in Western culture being the Judeo-Christian maxim "*thou shalt not kill*". This concept that *killing*, in itself, is reprehensible has become so entrenched in human society, that even merciful killing is hard to justify, legally and morally. The development of murder from "*thou shalt not kill*" to "*the unlawful and intentional causing of death of another [living] human being*"¹ will be discussed in this chapter, as well as how this relates to assisted dying.

People who seek euthanasia or assistance with suicide, usually due to some form of suffering, are treated kindly and receive sympathy for their plight – although sometimes that is all they receive. But people who offer to help them end their life receive scorn and are branded "murderer". This is the reason the development of *murder* is important

¹ Snyman CR (2014) *Criminal Law* (6): 437.

to take into account. *Murder* and all forms of assisted dying have their own specific definitions and requirements, but they are all treated more or less the same in terms of conviction.² The entrenched right to life in the Constitution with its simplistic and wide protection does not help to simplify matters of distinction.³

A historical discussion will follow, its purpose being to analyse the origin of the common law crime of murder through Roman law, Roman-Dutch law and English law.⁴ Afterwards there will be a discussion on how this evolved into its modern South African version, followed by comments on the wording of the definition and how assisted dying fits within its parameters.

2 ROMAN LAW

Roman law is based on the premise that the killing of a person is only punishable if it is intentional.⁵ This gave rise to the distinction between *dolus* and *culpa*,⁶ which of course led to the difference between murder and culpable homicide;⁷ two distinct crimes and not varying forms of one crime.

Roman law also did not consider all forms of intentional killing as *ipso facto* unlawful and, therefore, punishable.⁸ They recognized that some forms of killing could negate the unlawfulness of the act, such as self-defence. It is possible to say that both Roman

² With the exception of voluntary passive euthanasia. See Chapter 3: The Criminality of Assisted Dying in South Africa.

³ See paragraph 6 “Semantics” below.

⁴ Milton, JRL (1996) *South African Criminal Law and Procedure*: 311.

⁵ Burchell, J (2013) *Principles of Criminal Law*: 562.

⁶ See paragraph 3 “Roman-Dutch Law” below.

⁷ Milton (1996) 311.

⁸ Milton (1996) 314.

*parricidium*⁹ and South African murder both consider intentional killing to be “*the intentional and unlawful killing of another living person,*” and this is why we have similar principles in South Africa’s law.¹⁰

The Romans, however, were not ahead of their time in all legal matters. Suicide was considered to be a crime and if a person successfully committed suicide their corpse was dishonoured and their remaining property seized.¹¹ But suicide was not considered a crime if *just cause* existed, such as the desire to escape pain.¹² Meaning even they recognized that sometimes death could achieve what medicine could not: an end to suffering. The “crime” of suicide may seem like an archaic idea and even somewhat laughable, but life has always been considered to be sacred and they wanted to deter people from squandering it. This also serves to illustrate how much the world’s attitude surrounding the matter has changed.¹³ It has even progressed to the point where some countries are actively assisting people in committing suicide.¹⁴

These principles made their way into various other countries and it is especially its influence on the Roman-Dutch law that is significant for South Africa.

3 ROMAN-DUTCH LAW¹⁵

Roman-Dutch Law was practiced in the Netherlands prior to their adoption of the Napoleonic Code in 1809. And it was this that was brought by Jan van Riebeeck and

⁹ From the law of king Numa Pompilius, “*si quis hominem liberum dolo sciens morti duit, parricidia esto,*” (if somebody knowingly and with evil intent killed a free man, let him be a *parricidas*). Milton (1996) 314, footnote 41.

¹⁰ Milton (1996) 314.

¹¹ Burchell (2013): 566.

¹² Burchell (2013): 566.

¹³ Until England’s *Suicide Act* was adopted, suicide was still considered a crime in England up until 1961.

¹⁴ See Chapter 4: Comparative Examination of Assisted Dying in Foreign Jurisdictions.

¹⁵ For more information on the topic read Milton, JRL (1996) *South African Criminal Law and Procedure*: 316 – 317.

the Dutch Settlers in 1652 to what is now the Republic of South Africa. Accordingly, the following discussion will focus on the legal rules and norms brought over, specifically the difference between *dolus* and *culpa*.

The biggest difference between the modern South African “murder” and Roman-Dutch “homicide” is that the latter is an umbrella term, including several sub-categories of the unlawful killing of another human being.¹⁶ Unlike Roman law, Roman-Dutch law held culpable homicide also punishable, the determining factor being if the person had acted with *dolus* or *culpa*.¹⁷ *Dolus* means the intention necessary for murder and *culpa* refers to the negligence used for culpable homicide. But it is important to note that a charge of murder could be reduced to one of culpable homicide, implying that it was not considered two separate crimes as we know it in modern times.¹⁸ *Dolus*, or intentional homicide, was further divided into ordinary- and qualified homicide.¹⁹

There are more similarities – and differences – between the Dutch “homicide” and South African “murder”. The most relevant similarity to this dissertation being the *novus actus interveniens*-theory, meaning a direct causal chain between the act and consequence has to exist.²⁰

These principles were eventually combined with the English common law and from this our modern South African law emerged.

¹⁶ Milton (1996): 316. These categories include intentional homicide – which was further sub-divided into ordinary and qualified homicide – culpable homicide and accidental homicide.

For all intents and purposes “intentional homicide” is the Dutch equivalent of South African “murder”.

¹⁷ Milton (1996): 317.

¹⁸ Milton (1996): 369.

¹⁹ This is similar to the modern concept of competent verdicts, as set out in chapter 26 of the Criminal Procedure Act, 51 of 1977.

²⁰ See Chapter 3: The Criminality of Assisted Dying in South Africa paragraph 3.3 “Causation”.

Milton (1996): 316.

4 ENGLISH LAW

Early English law considered all forms of killing as *prima facie* unlawful, despite defences such as accidental killing or necessity. Despite not escaping liability, these acts received a royal pardon automatically.²¹

During the sixteenth century unlawful homicide was divided into *murder* and *manslaughter*. “In English law murder was committed only if the accused acted ‘with malice of forethought’.”²² Murder, however, came to mean *intentional killing* as the English courts started to focus less on premeditation by widening the scope of murder.²³ English lawyers also realized that not all unlawful killings was deserving of capital punishment, which was the mandatory punishment for the crime. They developed the crime of *manslaughter* as a separate crime for which there was a less severe punishment imposed.²⁴ They also distinguished between *intended* and *unintended* killings, as well as *voluntary* and *involuntary*.²⁵ *Voluntary manslaughter* would typically involve cases of provocation²⁶ and a successful defence would change a charge of murder to one of manslaughter. This concept was adopted in South African law, but of course rather than affecting a person’s *fault* it affects the *unlawfulness* of the act.

5 HOW THIS EVOLVED IN SOUTH AFRICA

South Africa has a hybrid legal system. In other words, different principles from various other systems were taken when our current system was being developed – leading to

²¹ Milton (1996): 317.

²² Burchell (2013): 563.

²³ Milton (1996): 318. This intention could be proven by way of *dolus eventualis* or *dolus directus*.

²⁴ Milton (1996): 318.

²⁵ Milton (1996): 318.

²⁶ Such as mutual combat, sudden affray, certain forms of assault, fear of harm and witnessing adultery by one’s own spouse.

our modern law we know today. For this reason the above systems were discussed and their influence on our criminal law must also be considered.

The South African common law definition of murder is “*the intentional and unlawful killing of another live human being.*” This definition offers such a broad scope of protection to human life, that killing is basically considered to always be unlawful, except in certain circumstances of justification. For example, when a person kills another in self-defence the accused is still prosecuted for murder, but can exclude the unlawfulness of his act through the justification of private defence. This mentality has developed in such a way that killing *per se* is wrong, unless some form of justification exists. In other words, and morally speaking, killing is automatically wrong, unless proven otherwise.²⁷ And this moral conditioning has an impact on our interpretation of law.

This approach to interpretation led to a problem with assisted dying which can be summarized by Burchell as,²⁸ “[i]t is a vexed issue whether the notion of the sanctity of human life is so overriding that it regards as murder the taking of life (or assisting another in taking life) in situations of euthanasia and assisted suicide, whether the motive is to avoid unendurable pain and suffering and bring about death with dignity.” Thus, murder is considered to be a crime against the *sanctity of life*. In other words, it is a crime against the fundamental rights enshrined in the Bill of Rights.²⁹ This realization is significant because the crime is punishable not because it is committed against a specific individual *per se*, but because it is against the universal right to “life” and therefore a crime against the community. It would seem that the wronged individual is added by necessary implication. This is also evident in the fact that the State - and not the family of the victims - prosecutes murderers.

²⁷ There are of course several criminal elements applicable: the act, causation, unlawfulness, capacity and fault. See Chapter 3: The Criminality of Assisted Dying in South Africa.

²⁸ Burchell (2013): 562

²⁹ Read this in conjunction with paragraph 2 “The Constitution” in Chapter 3: The Criminality of Assisted Dying in South Africa.

Based on the above interpretations of *murder* and the rights involved, it is conceivable that assisted dying, and all its forms, could be interpreted within the scope of our definition of murder. This is possible in every instance from causation,³⁰ unlawfulness³¹ and fault.³²

It must be taken into account that the words, phrases and terminology used in the definitions have an impact on the interpretation of a concept and this effect must also be analysed.

6 SEMANTICS³³

It would seem that South Africa has all the different forms of assisted dying due to the fact that our definition of murder is too wide. It is very specific, but yet wide enough to leave room for some creative interpretation,³⁴ with which was taken liberties when assisted dying was placed under the same scope. Burchell put it elegantly with, “[s]o broad is the scope of the law’s protection of human life, that it deems it unnecessary to identify the unlawful method by which life is ended. All types and forms of killing are prohibited.”³⁵ Instead of leaving it open to interpretation, the law should be actively developed by legislation in which euthanasia and physician-assisted dying is either

³⁰ The act of the physician has a direct causal link to the death of the patient.

³¹ The physician’s act is considered unlawful, unless a justification exists. And to date no justification has been successful.

³² The intention of the physician can be established in several ways, be it directly or through *dolus eventualis*.

³³ It must be noted that South Africa uses the term “murder”, whereas other jurisdictions, such as England, use “homicide”. The South African offence of “culpable homicide” should not be confused with the foreign offence of “homicide,” as the forms of intention differ – see paragraph 3 “Roman-Dutch Law” above.

³⁴ It is specific since it must be an unlawful act which causes the death of another person and if the act leads to death, it is almost certainly considered to be unlawful. However, the scope of this “act” – along with the other elements - has evolved and now includes giving a person a prescription for lethal medication or switching off life-support machines. As long as the act is part of the legal and factual causal chain, the physician would most likely be convicted for murder.

³⁵ Burchell (2013): 563.

directly included or expressly excluded. In other words, there should be no doubt in legal and medical practitioners' minds about what the consequences would be if they were to approach such a situation.

The problem, according to the author, lies in the word "unlawful" in the definition of murder.³⁶ It is seldom a contested issue whether the Samaritan had the intention to take the patient's life, yet they try to justify it by saying their intentions were noble. But it still leads to a conviction of murder. There is also legally speaking no issue with any of the other elements of a crime either. The act which led to death could usually be identified and isolated, such as writing a prescription or giving an injection. Furthermore, applying any number of theories to establish the causal chain will indicate the act was the factual and legal cause of the death.³⁷ Rather the "unlawfulness" of the act should be focused on.³⁸ This could be achieved in the simplest way by creating a special defence available only to medical practitioners and their assistants and only in very specific circumstances.³⁹

7 CONCLUSION

Throughout the scope of this dissertation the definition of murder should be kept in mind and also that its interpretation is almost as old as the definition itself. However, the law has not been codified and it can be changed to reflect a modern society's morals. *Murder* is a serious crime and should remain punishable, but a distinction should be

³⁶ See Chapter 6: Recommendations.

³⁷ See Chapter 3: The Criminality of Assisted Dying in South Africa, paragraph 3 "Assisted Dying in Criminal Law".

³⁸ See Chapter 4: Comparative Examination of Assisted Dying in Foreign Jurisdictions, part D "England". The defence of "necessity" was successful in the Netherlands prior to adopting legislation and it was also raised in several English cases. This could possibly be raised in South Africa, however in our criminal law a successful defence of necessity negates the unlawfulness of an act and not the intention, such as in other jurisdictions.

³⁹ See Chapter 4: Comparative Examination of Assisted Dying in Foreign Jurisdictions, part A "Canada".

made when it is committed within the circumstances of assisted dying – along with other requirements – and the law should evolve to reflect his.

CHAPTER 3

THE CRIMINALITY OF ASSISTED DYING IN SOUTH AFRICA

1 INTRODUCTION

It is the general point of view in South Africa that all forms of assisted dying are illegal, except for voluntary passive euthanasia. But it will be made clear in the following chapter of this dissertation that even the law is not a simple black and white canvas, but coloured by emotions and what might seem like a clear and legally unambiguous issue can become very complicated when interpreted from different perspectives. And that is true for all sides of the debate.

In this chapter, the Constitution of the Republic of South Africa, 1996¹ will be analyzed and the rights and obligations of all parties involved will be discussed. In most of the cases it will only include the physician and patient. In some circumstances a third party might also be taken into account.

After the legislation a discussion of existing criminal law principles will follow to establish the foundation for the subsequent analysis of case law. Case law has created the foundation of the arguments used to justify or condemn assisted dying. These cases will each be divided into categories and reviewed within the context of the applicable form of assisted dying² or mercy killing.³ This will serve to understand the development of the

¹ Hereafter, the Constitution or the Constitution of South Africa.

² This will include all forms of assisted dying, meaning: assisted suicide, physician-assisted suicide, passive and active euthanasia.

crime and the arguments surrounding the debate. Each category will contain the fundamental requirements and questions with regards to criminal law and conclude with a summary of the law as it currently stands. Where necessary other

It is prudent to mention at this point that many of the cases which will be discussed were decided in the pre-constitutional era and the arguments raised might have been more appropriate in the old South Africa. This, however, does not make them any less relevant and they are to be re-interpreted from a post-constitutional point of view.

It should be kept in mind at all times that the purpose of this dissertation is to determine the criminal liability of parties and as such there will be a focus on the elements which are the foundations of criminal law. The reader should assume, unless specifically stated otherwise, that all forms of assisted dying occur voluntarily. The hypothetical patient who will be able to make use of this practice must, at the very least, be a mentally competent adult who is also a South African citizen.⁴

2 THE CONSTITUTION

2.1 SECTION 10: DIGNITY

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

Terminally ill patients are usually described in a horrifying manner in order to evoke strong emotions, such as sympathy and mercy. It should be difficult for anyone to imagine who does not deal with situations such as this on a daily basis.⁵ Descriptions could include that the patient “[s]uffers from severe pain, nausea, vomiting, stomach cramps, constipation, disorientation, weight loss, loss of appetite, high blood pressure,

³ For purposes of this dissertation this is not a form of assisted dying, as it happens without the consent of the deceased.

⁴ See Chapter 6: Recommendations.

⁵ Such as physicians, nurses and care workers who by necessity becomes desensitized to a certain extent in order to do their jobs well.

increased weakness and frailty... [inability] to get out of bed... endures anxiety [and] cannot sleep without morphine or other painkillers.”⁶

But *suffering* does not only include terminal pain and extreme discomfort, hence there are other people who would also consider some form of assisted dying. Tony Nicklinson described his own condition as “...*dull, miserable, demeaning, undignified and intolerable. ...it is misery created by the accumulation of lots of things which are minor in themselves but, taken together, ruin what's left of my life. Things like...constant dribbling; having to be hoisted everywhere; loss of independence, ...particularly toileting and washing, in fact all bodily functions (by far the hardest thing to get used to); having to forgo favourite foods; ... having to wait until 10.30 to go to the toilet...in extreme circumstances I have gone in the chair, and have sat there until the carers arrived at the normal time.*”⁷

It is difficult to imagine someone who will not feel sympathy for a person whose daily life has been reduced to something similar as described above. But it must be kept in mind that these are extreme cases and not everyone will react the same to similar situations. “Discomfort” must not be elevated to “excruciating and/or unbearable pain” in order to gain more sympathy for a cause as this will only result in failing to treat legitimate future cases with the seriousness it deserves.⁸

Like all the rights entrenched in the Constitution, the right to dignity is subjective.⁹ First and foremost, this means that every person determines the worth of their own Constitutional rights, such as the right to dignity. What affects one person’s *dignitas* will not affect another’s. Just as what might offend one person will not offend another. Furthermore, this also means that the State has to provide the resources in order for

⁶ *Stransham-Ford v. the Minister of Justice and Correctional Services and Others* 30 April 2015, Case no. 27401/15 (NGHC) (unreported): paragraphs 7.1 to 7.4.

⁷ *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381 (Admin), [2012] MHLO 77: paragraph 13.

⁸ Similar to “crying wolf” one too many times.

⁹ *Carmichele v The Minister of Safety and Security and the Minister of Justice and Constitutional Development* 2001 (3) SA 938 CC: paragraph 54.

people to enjoy these rights, as far as reasonably possible.¹⁰ In the case of dignity, based on the wording of the section, a person inherently has dignity which means that nobody can award it to the holder and certainly nobody can take it away without the holder's permission. Some people might even consider extreme measures to protect their dignity, even if that means some other right might be infringed upon or completely disregarded.¹¹

But this right, like any other, is susceptible to limitation in terms of section 36 of the Constitution.¹² And naturally it would not do to give this right the widest possible protection as this would certainly place obligations on the State which are neither practical nor sustainable. It is however very interesting to note that the Interim Constitution stated that infringement of the right not only had to be justified by reasonableness, but also by necessity, thus awarding it the highest level of protection a right could receive. The wording was changed with the adoption of the final Constitution, since it was implied in the limitation clause.¹³

Thus, the scope of the protection, and limitation, offered by the Constitution deserves the court's attention. Does this protection exceed that granted to other rights, meaning should dignity be protected and promoted first and foremost, even if that meant infringing on another right? It is hard to imagine that someone's dignity places an obligation on another person, unless it is restrictive in nature in order to withhold them from infringing on another's right.

A generous approach and the widest possible protection would not be practical, as the infringement of any other right could mean an infringement on dignity and *vice versa*.¹⁴ The relationship between dignity and the other rights were described perfectly by

¹⁰ Leibowitz D & Spitz D (1999) "Human Dignity" *Constitutional Law of South Africa* (1): 17-4.

¹¹ Such as "waiving" your right to life in order to preserve your right to dignity, which was the case in *Stransham-Ford* footnote 6 *supra*.

¹² See paragraph 2.6 "Section 36: The Limitation of Rights" below.

¹³ Leibowitz & Spitz (1999): 17-1.

¹⁴ Leibowitz & Spitz (1999): 17-6A.

O'Regan J when she said: *“Human dignity ... informs constitutional adjudication and interpretation at a range of levels. It is a value that informs the interpretation of many, possibly all, other rights. This Court has already acknowledged the importance of the constitutional value of dignity in interpreting rights such as the right to equality, the right not to be punished in a cruel, inhuman or degrading way, and the right to life. Human dignity is also a constitutional value that is of central significance in the limitations analysis. Section 10, however, makes it plain that dignity is not only a value fundamental to our Constitution, it is a justiciable and enforceable right that must be respected and protected. In many cases, however where the value of human dignity is offended, the primary constitutional breach occasioned may be of a more specific right such as the right to bodily integrity, the right to equality or the right not to be subjected to slavery, servitude or forced labour.”*¹⁵

The relationship between dignity and the other rights in the Constitution needs to be elaborated on and explained in detail, since *“...recognition and protection of human dignity is the touchstone of the new political order and is fundamental to the new Constitution.”*¹⁶ The courts need to consider whether all rights are created equal or whether some rights are more equal than others?¹⁷

2.2 SECTION 11: LIFE

“Everyone has the right to life.”

It should be kept in mind at all times that even a dying person is still alive and as a legal subject his rights should receive the same level of respect and protection as any other subject's.

¹⁵ In *Dawood v Minister of Home Affairs; Shalabi v Minister of Home Affairs; Thomas v Minister of Home Affairs* [2000] ZACC 8; 2000 (3) SA 936 (CC): paragraph 35.

¹⁶ *S v Makwanyane and Another* 1995 (3) SA 391 (CC): paragraph 329.

¹⁷ Paraphrased from Orwell G (1945) *Animal Farm*, “All animals are equal, but some animals are more equal than others.”

Some thought should be granted to the meaning of *life* within the context of the Bill of Rights. This could either mean that a certain standard of quality is expected or that it is the continuation of organic matter in the form of a human being. It is difficult to imagine that the legislator had the latter in mind when the Constitution was written, since the preamble states that one purpose thereof is to “*improve the quality of life of all citizens*”. This was also the opinion of O’Regan J in the case of *Makwanyane*¹⁸ when she said, “[b]ut the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, not the right to human life: the right to share in the experience of humanity.” Without life there can be no other rights, but it is these others that give life its value and purpose.¹⁹

It can be argued that *life* as meant by the Constitution expects a certain standard of quality living. This quality of a subject’s life will depend upon their circumstances, such as health, environment, financial status, relationships and much more.²⁰ On the other hand it stands to reason that circumstances that are “unbearable” will also differ from one person to the next. This means that a person’s life might no longer be worth living once that quality drops below a subjective level and they might consider changing it for better or worse.

The world is full of tales of extraordinary people who are inspirations to all, despite having all the odds stacked against them.²¹ However, this is not always possible and the release of death could prove more attractive than being sentenced to a life where existence is pain. “*There is of course no duty to live, and a person can waive his right to life.*”²² This implies that the right to life, like all other rights, does not place a positive obligation on the holder and as such it can be waived and limited in terms of section 36

¹⁸ *Makwanyane* footnote 16 *supra*: paragraph 325.

¹⁹ As with people, there should be a sense of community between rights. This is in line with the values of *Ubuntu*.

²⁰ Each person’s criteria of what they consider to be a “quality life” will be unique, and thus the list is not a *numerus clausus*.

²¹ Stephen Hawking, Helen Keller, Christopher Reeve, John Nash and Stevie Wonder just to name a few.

²² *Stransham-Ford* footnote 6 *supra*: page 19, paragraph 14.

of the Constitution.²³ This might be the case where a person has to choose between a dignified death and a life that can barely be called living.

Although they did not specifically mention assisted suicide, the judges presiding over the famous Constitutional case of *Makwanyane* extensively commented on the right to life. O'Regan J again had something of immense value to add,²⁴ “[t]he right to life is, in one sense, antecedent to all other rights in the Constitution. Without life in the sense of existence, it would not be possible to exercise rights or to be the bearer of them... This concept of human life is at the centre of our constitutional values. The Constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society. The right to life, thus understood, incorporates the right to dignity. So the rights to dignity and to life are intertwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity.”

Based on this it is important to keep in mind that both the rights to dignity and life are important and neither should be considered to be on a higher level of the “Constitutional hierarchy”. But they are awarded to people who can choose to do with them as they wish and it is this freedom of choice, which is the foundation of any democracy, which must be protected and respected.

2.3 SECTION 12: BODILY INTEGRITY

12(1)(e) “Everyone has the right to freedom and security of the person, which includes the right not to be treated or punished in a cruel, inhuman or degrading way.”

There comes a time in most terminal illnesses when palliative care is no longer able to achieve what it once did without adverse side-effects.²⁵ This could be due to an

²³ See paragraph 2.6 “The Limitation of Rights” below.

²⁴ *Makwanyane* footnote 16 *supra*: paragraphs 325 - 326.

²⁵ Such as difficulty to breathe when too much morphine is administered.

increased tolerance to pain medication, the illness takes a turn for the worse or the patient no longer wishes to receive opioid-type medication. The patient is then left in pain not knowing when the eventual moment of death will occur. To knowingly subject a person to this can be described as “*cruel, inhuman or degrading*” treatment. Can it then not be argued that by doing nothing a doctor is, perhaps unintentionally but still knowingly, subjecting a person to this ordeal, which directly infringes upon his right to bodily integrity and in turn his right to dignity as well. It can be argued that the patient brings it upon herself by refusing other options, but in some circumstances it is acceptable for a medical worker to treat a patient without the required consent,²⁶ except in cases where a patient explicitly refuses treatment.²⁷

However, this section does not place a positive obligation on any physician to assist with the hastening or causing of the patient’s death²⁸ and therefore this argument should not succeed in court. This is the same approach to abortion²⁹ and the correct one as any other approach will mean that one person’s rights place positive obligations upon others.

In some cases it might be considered to be a mercy and more humane to euthanize someone with the main intent of relieving suffering. This is common practice when working with animals. In fact, the Animals Protection Act places a positive obligation on the owner of an animal that is severely injured or in a similar physical position to put the animal out of its misery by euthanizing it.³⁰ The Applicant in *Stransham-Ford* stated that “*it is universally accepted that to permit an injured or sick animal to suffer is not only*

Teater D (2015) *The Psychological and Physical Side Effects of Pain Medication* available online at www.colorado.gov/pacific/sites/default/files/Psychological%20and%20Physical%20Side%20Effects%20Teater%20NSC.pdf. Accessed 2017/03/07.

²⁶ Section 7 of the National Health Act, 2003.

²⁷ Section 6(1)(d) of the National Health Act, 2003.

²⁸ In *Stransham-Ford* footnote 6 *supra* Fabricius J specifically stated that “*no medical doctor is obliged to accede to the request of the Applicant.*” page 35, paragraph 1.5.

²⁹ The Choice on Termination of Pregnancy Act 92 of 1996 places no obligation upon a medical worker to perform a procedure for an abortion.

³⁰ Sections 12(1)(e), 5(1) and 8(1)(d) of the Animals Protection Act 71 of 1962.

*merciless and cruel but is also a crime.*³¹ This is a strange argument since animals are slaughtered for food and materials, yet it is still generally tolerated to some degree. And when humans are killed by the thousands there is a definitive difference in outrage and disgust compared to animals. On the other hand, pet owners are generally willing to have their pets euthanized when no other option is available. This is an occasion of great sadness and it is usually not the first option, but mercy is the determining factor. So even though humans and animals cannot be treated the same, thought should be granted to the fact that the same concept is considered mercy in one situation and unimaginably inhumane in another.

There is a subtle difference between sub-section 12(1) and 12(2) of the Constitution. The former concerns an individual's right to be free from outside interference. Meaning, no one is allowed to subject you to something without your consent. The latter, on the other hand, concerns being free to do with one's own body as one pleases. Thus, to focus on section 12(1) would be a mistake as it cannot succeed for the above reasons. One would have a higher chance of success if one argued section 12(2) instead.

12(2)(b) *“Everyone has the right to bodily and psychological integrity, which includes the right to security in and control over their body.”*

This section contains two elements:³² The first being “security in”, which means that a person is free from harassment from the outside, either from the state or other individuals. The second is “control over” which means a person should be free to make choices regarding their own body without any outside influence. This protects the rights to self-determination and autonomy. In the times we live the focus has shifted from the rights of the collective to that of the individual, such as the right to self-determination. One need only look at how far abortion legislation has come to see its effect. This was

³¹ *Stransham-Ford* footnote 6 *supra*: pages 21 – 22, paragraph 16.

³² Prinsen L (2016) *An Analysis of Consent with Specific Regard to Stem Cell Therapy and Research* (LLD thesis unpublished, University of Pretoria): 121.

also held in *Phillips v De Klerk*³³ where the court remarked that this might even be more important than the rights to health and living.

According to Ronald Dworkin the value of autonomy, and by necessary implication section 12(2)(b), entails, “[w]e allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values.”³⁴

Intrusion of a person’s bodily integrity, thus refusal of her autonomy, is also justifiable in some cases, such as those of crime prevention where a suspect is searched for illegal substances. However, this justification must be necessary and proportional to the person’s autonomy.³⁵ These justifications can either be moralistic or paternalistic.³⁶ The former being what is considered right and wrong and the latter being to protect people from what is bad for them.

“Right or wrong,” “good or bad” - all of these have to be weighed against the person’s autonomy and bodily integrity and ultimately her decision must be respected. To arbitrarily refuse a person’s autonomy, without legitimate justification, is a sign of a lack of respect for the individual’s rights and their ability to choose.

Should a person not be able to choose, such as when a person is in a persistent vegetative state, then their wishes should be determined through an advance directive, if possible. If one is not available, then the court should determine who will be allowed to make any final decisions.³⁷

³³ *Phillips v De Klerk* 1983 TPD (unreported).

³⁴ Dworkin R (1993) *Life’s Dominion*: 225.

³⁵ *Winston v Lee* 470 US 753 (1985).

³⁶ Currie I & Woolman S (1998) “Freedom and Security of the Person” *Constitutional Law of South Africa* (3): 39-44.

³⁷ Further reading on the topic is encouraged: Jordaan L (2011) “The Legal Validity of an Advance Refusal of Medical Treatment in South African Law (Parts 1 & 2)” *De Jure* (1 & 2).

2.4 SECTION 14: PRIVACY

“Everyone has the right to privacy, which includes the right not to have

- a) their person or home searched;*
- b) their property searched;*
- c) their possessions seized; or*
- d) the privacy of their communications infringed.”*

This section is relevant if demands are made to make the details surrounding the application public. This was the case in *Stransham-Ford* where one respondent stated that the name of the physician and medication used during the procedure should be made known. Privacy also includes that a person cannot be compelled to make his decision public to be assisted to die. This goes hand-in-hand with the principle of doctor-patient-confidentiality and all patient records must be kept confidential after the patient’s death.

The physician’s privacy must also be respected, as failure to do so would not only infringe on his right to privacy, but his right to freely choose his occupation.³⁸ In other words, heavy handed regulation by the State would infringe upon a physician’s right to operate autonomously and also indirectly create hurdles to practice in the medical profession, therefore infringing upon section 22 of the Constitution.

Therefore, the physician and patient’s rights to privacy must be respected. This being said, it is of the utmost importance to have a certain level of transparency when working with something that could be abused and lead to the death of innocents. It would be ideal to have a similar system to that of abortion, meaning physicians do not have to advertise their practice if they do not want to, but records should be available for scrutiny if some form of misuse is suspected.

³⁸ Section 22 of the Constitution, *“Every citizen has the right to choose their trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law.”*

Currently the Health Professions Counsel of South Africa³⁹ has ethical guidelines set out with regards to providing access to patient records.⁴⁰ Among others it states that patient records can be made available without the written consent of the patient or her legal representative if a court orders it or there exists a statutory obligation to do so.

2.5 SECTION 27: ACCESS TO HEALTH SERVICES

(1)(a) *“Everyone has the right to have access to health care services, including reproductive health care.*

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

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

As far as practically possible the State is supposed to provide access to health care services. This should include palliative care for patients who can no longer be treated in another manner. But this ideal is far from a reality in South Africa. Especially among the poorer citizens of the country who can sometimes barely afford the most basic of medicines, not to mention on-going treatment for pain, which will end up in death in any case. The options available to people in these circumstances are too horrible to imagine.

In the case of *Soobramoney*⁴¹ the patient had chronic renal failure, which was treatable and would keep him alive, but it was also expensive and non-curative. Left untreated it would lead to a protracted and painful death. Madala J⁴² correctly asked the question: *“Should a doctor ever allow a patient to die when that patient has a treatable condition?”*

³⁹ See Chapter 5: The Health Professions Council of South Africa. Hereafter, the HPCSA.

⁴⁰ Health Professions Council of South Africa (2008) *Guidelines on the Keeping of Patient Records Booklet* (14): 6.

⁴¹ *Soobramoney v Minister of Health, KwaZulu-Natal* [1997] ZACC 17, 1998 (1) SA 765 (CC), 1997 (12) BCLR 1696 (CC) (27 November 1997), Constitutional Court.

⁴² *Soobramoney* footnote 41 *supra*, paragraph 40.

This question was not specifically answered, but the appeal was denied, which leads the author to believe that were the resources available patients would be entitled to any and all necessary treatment.⁴³ However, in reality this is not practical and sustainable and difficult decisions have to be made which will lead to the death of one person, but save the life of another.

It can be argued that by not providing access to health care to everyone and thus, subjecting them to inhumane conditions and treatment, the State is also infringing upon the person's right to dignity as well, but this limitation is due to practical necessity and justifiable in terms of the limitation clause.⁴⁴

2.6 SECTION 36: THE LIMITATION OF RIGHTS

(1) *"The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all 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."

Since there is no hierarchy of rights in our Constitution it is inevitable that rights will have to battle for preference. It is then important that the losing right should have a justifiable limitation in terms of section 36. However, it is interesting to note that whenever the phrase "human dignity" is used in the Constitution in conjunction with

⁴³ *Soobramoney* footnote 41 *supra*, paragraph 59.

⁴⁴ Section 36 of the Constitution.

other rights that it is always mentioned first and never mentioned along with the right to life. According to the phrasing of the Constitution “human dignity” is the first right that our democratic society is supposed to be based on, but according to O’Regan J⁴⁵ the rights to dignity and life are two sides of the same coin and one without the other is substantially diminished. However, should it not be possible for a person to limit one of her own rights in order to protect another? A terminal patient’s life is forfeit and their quality of life will inevitably decline to the point where living becomes a punishment, yet their dignity does not necessarily have to decline along with their life. In the High Court application of *Stransham-Ford*⁴⁶ the applicant was willing to give up his life in order to protect and maintain his dignity up to the last possible moment.

The wording of the section is naturally open to interpretation and it is of the utmost importance that when this happens, its result must be the least restrictive option available and affect as few rights as possible. The right to life need not necessarily be limited if the quality of the patient’s life could be guaranteed, but that would entail unlimited access to health care for an indeterminate period of time. Something that is the ideal, but impossible to promise in reality as resources are limited and spread thin as it is.⁴⁷

2.7 SECTION 39: THE INTERPRETATION CLAUSE

(1) *“When interpreting the Bill of Rights, a court, tribunal or forum—*

(a) *must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;*

(b) *must consider international law; and*

(c) *may consider foreign law.*

⁴⁵ *Makwanyane* footnote 16 *supra*.

⁴⁶ *Stransham-Ford* footnote 6 *supra*.

⁴⁷ As per the discussion in paragraph 2.5 “Section 27: Access to Health Services” above.

- (2) *When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.*
- (3) *The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.”*

This section is important for purposes of this dissertation as foreign law⁴⁸ will be discussed, specifically the jurisdictions of Canada, the Netherland, the State of Oregon in the United States of America and England. These jurisdictions will be analysed as each of them has some form of legislation with regards to assisted dying. In the case of England there have been several attempts to legalize the practice, but all have been unsuccessful thus far and these arguments against assisted dying will be examined.

The development⁴⁹ of the common law crime of murder is also relevant as this will shed light on how the definition came to be and why it is still applicable in the current discussion.

Lastly, euthanasia and physician-assisted suicide have been interpreted⁵⁰ to fall within the definition of murder, which consequently affects the common law. Furthermore, this interpretation and/or development could lead to problems of legality, depending on its execution.

⁴⁸ See Chapter 4: Comparative Examination of Assisted Dying in Foreign Jurisdictions.

⁴⁹ See Chapter 2: The History and Development of Murder in South African Criminal Law.

⁵⁰ See paragraph 3.1 “Legality” below.

3 ASSISTED DYING IN CRIMINAL LAW

South African Criminal Law originated from the English Common Law and developed further through case law and legislation. The basic elements of Criminal Law can be best explained through the use of a pyramid.⁵¹ Starting from the bottom and working upwards, the fundamental elements are the act, causation, unlawfulness, capacity and fault. But before one starts analyzing an alleged crime in these terms, one needs to determine whether there is legality. In layman's terms: is it a crime?

An initial and basic explanation will follow on exactly why each form of assisted dying is or is not a crime by using the above terminology. A more in-depth analysis will follow by using the facts and circumstances from existing case law, along with the decision of the court.

3.1 LEGALITY

1. The definition⁵² of legality is as follows: “*An accused may not be found guilty of a crime unless the type of conduct with which he is charged:*

(a) *has been recognized by the law as a crime;*⁵³

(b) *in clear terms;*⁵⁴

(c) *before conduct took place;*⁵⁵

⁵¹ Adapted from the version found in Snyman, C.R. (2014) *Criminal Law* (6): 52.

⁵² Snyman (2014): 36.

Collectively known as the *nullum crimen sine lege*-principle.

⁵³ *Ius acceptum*.

⁵⁴ *Ius certum*.

⁵⁵ *Ius praeivium*.

(d) *without the court having to stretch the meaning of the words and concepts in the definition to bring the particular conduct of the accused within the compass of the definition,*⁵⁶ and

2. *after conviction an accused may not be sentenced unless the punishment also complies with the four principles set out immediately above under 1(a) to (d).*⁵⁷

As will be discussed below⁵⁸ the practice of assisted dying was never explicitly criminalized through legislation until the courts decided to interpret⁵⁹ it under the definition of murder. This seemed appropriate at the time as most cases involved one vulnerable party who had to be protected and medical science did not yet provide the same possibilities it does today. The point being that it was the courts that decided the practice should be criminalized and have since then been loath to adopt another approach.⁶⁰ Legislation will be the best way for the state to formally adopt a stance on the matter and settle the old dispute, but care should be applied to make provision for medical and moral changes that will inevitably take place in the future.

This approach of interpretation, however, is *contra* the principle of *nullum crimen sine lege* as it does not fall within the court's authority to create crimes. Even interpretation of crimes with long term effects should be done rarely, if at all, as this is the job of the legislator.

As will be seen below, the courts have been consistent with their sentencing in these matters, if only to postpone sentences if the act was carried out with merciful intentions. However, this is against the second part of legality known as the *nulla poena sine lege*-principle, which states that punishment for a crime should also satisfy (a) to (d) of the

⁵⁶ *Ius strictum*.

⁵⁷ *Nulla poena sine lege*.

⁵⁸ See paragraph 4.2 "Assisted Suicide / Consent to Death" below.

⁵⁹ Relying on *Carmichele* footnote 9 *supra*.

⁶⁰ Not referring to exception of voluntary, passive euthanasia.

definition above. If these requirements are not met, then there is no legality and an accused cannot be convicted for the crime.⁶¹

3.2 THE ACT

The act is defined as any voluntary human conduct or omission. In context of assisted dying, this might occur when the doctor injects the patient with a lethal concoction or switches off life-support machines in order to cause or hasten the death of the patient. It can also include the doctor giving a prescription for a lethal dose of medication or handing a lethal dose of pentobarbital to a patient, knowing the patient will self-administer it in order to die.

This element is rarely in dispute as it is simple to establish that the physician had indeed performed an act which results in the death of the patient.

3.3 CAUSATION

Causation can be split into two requirements: factual and legal causation. Factual causation is easy to determine by using the “but for-test”. With this test you merely need to ask the question, “would the result (death of the patient) still have come to pass but for the act (injection)?”⁶² Should the answer be negative, then the act was the cause of the result. A practical example: would the patient still have died if the doctor had not switched off his life-support machine or given him a lethal dose? No? Then there exists a factual, causal link between the act (switching off or injection) and the result (death). Of course natural persons will die eventually like everyone else, but in these

⁶¹ In *DPP v Prins* (Minister of Justice and Constitutional Development & two amici curiae intervening) (369/12) [2012] 106 ZASCA (15 June 2012) the court imposed its own punishment by reading section 276 of the Criminal Procedure Act into the Sexual Offences Act, as it was then, which was lacking a penalty clause.

⁶² Also known as the *Conditio Sine Qua Non*-theory.

circumstances the death is hastened or caused by external factors,⁶³ which will lead to someone being criminally liable.

Legal causation is used after factual causation has been established in order to rein in the circumstances so as not to become absurd. If one wants, one can argue that if it were not for the patient's parents conceiving her when they did and providing the genes which would result in the condition which took her to the hospital, it is actually their fault and they are criminally liable for her death in these particular circumstances. Obviously this is irrational, but it is also technically correct, since if you think the person's birth away, then she would never have been sick because she would never have been born. In South African Criminal Law policy considerations are mainly used to determine whether there is legal causation.

Several theories have been used to some extent in the past,⁶⁴ but the one still applicable today and which will be the focus of this section is the *Novus Actus Interveniens* theory.⁶⁵ Simply put, if an unexpected, abnormal *and* independent intervening occurrence should take place which breaks the causal chain between the initial act and the result, then there will be no legal causation. For example, the court could decide that even though the factual cause of the patient's death was the switching off of the life-support machine, it would not be the legal cause based on policy consideration.⁶⁶ In another possible scenario a physician providing a lethal concoction to a patient to drink will be the factual cause, but in this case it would have to be decided whether that act was unexpected, abnormal and independent in order to determine whether the legal causation has been established. Most likely courts will decide that it is not a *novus actus interveniens*, thus there will be legal causation.

⁶³ Usually an act as described above.

⁶⁴ The individualisation theories, the theory of adequate causation and the foreseeability theory.

⁶⁵ Snyman (2014): 86.

⁶⁶ See *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) below.

3.4 UNLAWFULNESS

Unlawfulness implies something is against the law. Thus far there is no law criminalizing suicide in South Africa, yet assisting someone to commit suicide is condemned and people have been convicted for murder in the circumstances.⁶⁷ Since no legislation exists regulating the “crime” of assisted dying, courts have interpreted the conduct of people under these circumstances to fall within the ambit of murder and therefore to be unlawful.⁶⁸ It is suggested that most of the issues surrounding these circumstances may be solved if only proper legislation regarding it would be adopted.

The easiest solution would be to create a special defence for a medical practitioner that would, provided he acts within certain parameters, exclude the unlawfulness of his conduct.⁶⁹ Therefore, the option of assisted dying would be available to people, but still allow for the state to charge someone with murder if it is warranted.

It is possible to follow the Dutch⁷⁰ example and use the justification of *necessity* until legislation provides a specific defence. Necessity is raised where a person commits an offence in order to defend another legally protected right. The defence may, however, not be disproportional to the unavoidable evil. In these circumstances the evil would be the undignified death,⁷¹ which would be avoided through killing the patient. The question to consider would then be: is killing a valid and necessary method of protecting a person’s dignity? For this to be answered in the affirmative, it would have to be proven that the physician had no other available option and that it is not disproportional. This of course would depend on the circumstances and would have to be decided on the *ad*

⁶⁷ See paragraph 4.2 “Assisted Suicide / Consent to Death”.

⁶⁸ The common law definition of murder is as follows: “*The unlawful and intentional causing of another human being’s death.*”

See Chapter 2: The History and Development of Murder in South African Criminal Law.

⁶⁹ See Chapter 6: Recommendations.

⁷⁰ See Chapter 4: Comparative Examination of Assisted Dying in Foreign Jurisdictions.

⁷¹ See paragraphs 2.1 “Section 10: Dignity” and 2.2 “Section 11: Life” above. It has already been established that the right to dignity is worthy of protection. However, its importance in relation to the right to life will vary depending on the patient and her unique circumstances.

hoc merits of each case. Therefore this dissertation cannot provide a conclusive answer.

The unlawfulness of a person's conduct is measured against an objective standard which consists of external factors which are unique to each particular crime. However, a person will only be criminally liable if he also meets the subjective standards of capacity and fault.

3.5 CAPACITY

For purposes of this dissertation capacity will not be discussed in great detail, since the focus is on adults who possess the necessary capacity to make decisions regarding their own life and health. This means that children and mentally ill persons are left out of the discussion and unless specifically mentioned, not to be taken into consideration. This is mainly due to the fact that this debate is already controversial enough that to include children and the mentally ill would make it nigh impossible.⁷² Also, children and mentally ill people receive more protection and less decisional capacity⁷³ in our law.

Thus, with regards to the physician and patient, only adult persons with the necessary capacity will be considered for purposes of this dissertation. This is because they can form the necessary intention to kill someone or make decisions regarding their own life and health.

3.6 FAULT

Fault is divided into two aspects: intention (*dolus*) and negligence (*culpa*). There will be a primary focus on intention, as suicide cannot be committed without it. *Dolus directus* is

⁷² Notwithstanding the fact that the protection awarded to these parties will never allow any practice of the sort.

⁷³ Children's Act 38 of 2005.

the form of intention that will be applicable most of the time, but by rephrasing ones argument it is possible that *dolus eventualis*⁷⁴ can also become applicable.

Picture the scene: a doctor is treating a terminal patient for pain by giving her morphine on the patient's request. They have to increase the dosage on each administration of the morphine, otherwise it would no longer be effective. The doctor also knows that if the dosage becomes too high, a side-effect might cause the patient to have difficulty to breathe and, inevitably, die. Nevertheless, the doctor keeps on administering morphine and eventually the patient dies, not from the terminal disease, but from the increased morphine. Yet no one, unless malicious intent is suspected, will question the doctor's actions and decisions which were fundamental to the patient's death. This is a form of *dolus eventualis* seeing that the doctor had a primary motive - treating the pain - but subjectively foresaw that there might be a different result - death - and reconciled him with this possibility anyway.

Imagine a different scenario: a terminal patient is in a lot of pain and asks the doctor to assist her to end her life. Should the doctor acquiesce he could be convicted of murder and sentenced accordingly. Or in the best circumstances he could only lose his license to practice medicine.⁷⁵ The doctor had *dolus directus* as his main goal was to cause the death of the patient and his conduct is still unlawful.⁷⁶ As stated above, this is only unlawful due to legislation not providing for a crime such as assisted dying,⁷⁷ and thus it is interpreted to be a form of murder. Although moved by merciful intentions, the doctor still had the intention to cause the death of the patient and should still be convicted for murder. At most the court can decide that due to the doctor's Samaritan attitude he

⁷⁴ A person incurs criminal liability when he subjectively foresaw that a consequence might happen **and** reconciled himself with the possibility and acted anyway. This test was applied in *S v Sigwaha* 1967 (4) SA 566 (A).

⁷⁵ See Chapter 5: The Health Professions Council of South Africa.

⁷⁶ *S v Hartmann* 1975 (3) SA 532 (C).

⁷⁷ See paragraph 3.1 "Legality" above, specifically the *nulla poena sine lege*-principle.

should be sentenced, which for all practical purposes does not exist. This would naturally still have all the consequences borne from a conviction of murder.⁷⁸

In both scenarios the doctor could be found guilty for the death of the patient, but in the former it is more likely that everyone will agree that the doctor was only performing his duties, unless circumstances such as negligence indicate that that was not the case. Both acts of the doctors are technically unlawful, but the intention at the moment of the alleged crime is the factor that will finalize criminal liability, and also incidentally determine the need for prosecution.⁷⁹ This indicates that there are inconsistencies with interpretations of similar factual bases,

⁷⁸ Such as losing one's license to practice in a certain profession or not being able to inherit if one assisted a family member. See Chapter 5: The Health Professions Council of South Africa.

⁷⁹ If the doctor does not report his intention to kill the patient to the police, it is unlikely the death will be investigated. Unless medical malpractice is suspected.

4 ASSISTED DYING THROUGH CASE LAW

Several categories of assisted dying exist which each in turn will be discussed in more detail and, more importantly, what the criminal law approach to each one is. It is possible for some categories to overlap or even seem exactly the same as another, but these categories are based on technical differences that have come up in case law through the years.

These categories are broadly:

1. Mercy Killing
2. Assisted Suicide
3. Passive Euthanasia
4. Active Euthanasia
5. Physician-Assisted Suicide.

4.1 MERCY KILLING

Mercy killing and *euthanasia* have been used as synonyms in the past, but for purposes of this dissertation the difference between the two practices are that mercy killing is done against or without knowing the wishes of the deceased,⁸⁰ but still with noble intentions. Mercy killing, unlike euthanasia, does not include medical procedures, patients or personnel, although there are cases, especially in the United States, of these so-called Angels of Death where medical personnel, normally nurses, kill patients with noble intent in order to end their suffering.⁸¹

⁸⁰ In other words a more appropriate synonym would be “involuntary active/passive euthanasia”, but this term is not wide enough as it is limited to medical procedures.

⁸¹ Russel, A (2016) “Angel of Death’: A look at health-care professionals charged with killing their patients” *Global News* available online at globalnews.ca/news/3027315/angel-of-death-a-look-at-health-care-professionals-charged-with-killing-patients. Accessed 2017/03/20.

In terms of *mercy killing* the accused takes initiative, but with *assisted suicide* always reacts to a request from the deceased.

Assisted suicide and euthanasia should not be confused with one another based on this section's explanations. See those sections below for a more in-depth discussion.⁸²

In these circumstances the accused satisfies all the fundamental requirements for murder and a conviction is appropriate. The only distinction to be made between this and murder is in the motive and after conviction, sentencing. The court might find a merciful approach to be more appropriate under certain circumstances and then deviate from the minimum sentence as stated by the Criminal Procedure Act.⁸³

Keeping some of the following questions and concepts in mind will make comprehending the case law easier, within the context of this dissertation.

4.1.1 Fundamental Requirements for Mercy Killing:

1. Consent or a request lodged by the deceased is not a valid defence for purposes of a conviction, but it *may* have an effect on the sentencing.
2. The killing is always performed with noble intentions. This would normally be when the accused subjectively believes the deceased no longer wants to suffer.
3. It does not include medical personnel or procedures as it would then fall within the scope of involuntary euthanasia.

4.1.2 Questions Raised by these Cases:

1. What is the effect of noble intentions on a charge of murder?

⁸² See paragraphs 4.2 "Assisted Suicide / Consent to Death," 4.3 "Passive Euthanasia" and 4.4 "Active Euthanasia" below.

⁸³ Section 283(1) of the Criminal Procedure Act, 51 of 1977, which states "A person liable to a sentence of imprisonment for life or for any period, may be sentenced to imprisonment for any shorter period, and a person liable to a sentence of a fine of any amount may be sentenced to a fine of any lesser amount."

2. Should the consent of the deceased make any difference with regards to the conviction or sentence?

4.1.3 Case Law

4.1.3.1 S v De Bellocq⁸⁴

Facts:

The accused, a medical student, gave birth to a premature infant which was soon thereafter diagnosed with toxoplasmosis and determined to be a clinical idiot. Due to De Bellocq's medical training she was fully aware that the child would have a very challenging life. On an impulse she decided suddenly to drown the infant in the bath one day.

Decision:

She was found guilty of murder, but due to the unique circumstances the court decided to be merciful and sentenced the accused in terms of section 349 of the Criminal Procedure Act of that time.⁸⁵ The convicted mother was released on her own recognizance with the condition of returning for sentencing if, and when, called upon to do so. She never was.

4.1.4 Summary in Terms of Criminal Law:

It is clear that:

1. When committing the crime of murder noble intentions might have an effect on the sentence imposed, but none whatsoever, and rightly so, on the conviction.

⁸⁴ *S v De Bellocq* [1975] 1 All SA 6 (T).

⁸⁵ Criminal Procedure Act, 56 of 1955.

2. Consent does seem to indicate that the accused did not act wilfully and only performed a mercy killing due to the wishes of the deceased. It is however not a valid defence for murder and could only affect the sentencing.⁸⁶

4.2 ASSISTED SUICIDE / CONSENT TO DEATH

In these circumstances the accused reacts to a request (most of the time) from the deceased and merely assists with preparation for the final act to be committed by the deceased.⁸⁷

These cases will each have unique circumstances and must be decided based upon their own merit and also with emphasis on the appropriate element, but the cases below might provide guidelines to be followed in future circumstances. Most of the time the causation will need to be examined and interpreted in order to convict the accused.

4.2.1 Questions Raised by these Cases:

1. Is consent a valid defence for murder?
2. Is suicide and/or assistance to commit suicide a crime?
3. What is the difference between assisted suicide and murder?
4. Does the fact that the deceased had done nothing to avoid death constitute a valid *novus actus interveniens*?⁸⁸
5. What effect does the accused's intentions and fault have on the conviction/sentencing?

⁸⁶ See paragraph 4.2 "Assisted Suicide / Consent to Death" below.

⁸⁷ For purposes of this dissertation "assisted suicide" includes the parameters set out in the case of *S v Agliotti*, discussed in paragraph 4.2.2.6 below.

⁸⁸ An independent, abnormal and unexpected act, which breaks the causal chain. See paragraph 3.3 "Causation" above.

4.2.2 Case Law

4.2.2.1 R v Peverett⁸⁹

Facts:

Mr. Peverett concluded a suicide pact with his girlfriend, Mrs. Saunders. He tried to poison them both by having them sit in the car with the windows closed and connecting the exhaust pipe of the car to the interior. This should have led to fatal carbon monoxide poisoning, but instead they both survived.

Decision:

The accused clearly desired for them both to die and had the required intention to cause the death of Mrs. Saunders. Thus, satisfying the requirements of murder. But since she survived it could merely be attempted murder. But for an unexpected result, the accused had done everything within his ability to have the desired result come to pass. It was confirmed that neither suicide, nor the attempt to commit suicide is a crime in South Africa. Furthermore, the judge concluded that consent is not a valid defence on a charge of murder and the fact that the victim is free to prevent their death does not free the accused from criminal liability.

He was convicted for attempted murder.

4.2.2.2 S v Gordon⁹⁰

Facts:

Gordon, the accused, and his girlfriend made a suicide pact, similar to the one in *Peverett* above. But he had a different method in mind. He provided them both with

⁸⁹ *R v Peverett* 1940 AD 213.

⁹⁰ *S v Gordon* 1962 (4) SA 727 (A).

tablets which, once ingested, would cause death. They both consumed the tablets as planned, but only the girlfriend died, while Gordon survived.

Decision:

The court made a different ruling from the one in *Peeverett*. The distinguishing factor, according to the presiding officer, was in the case of *Peeverett* the accused had done everything in his power to cause the death of both parties. In terms of the criminal law elements, his final act (switching on the motor vehicle) would have been the judicial and factual cause of the death of Mrs. Saunders. In the present case of Gordon, the accused merely provided the means with which the desired result could be achieved, but it was the act of the deceased herself which was the cause of death, since her act - ingesting the lethal tablets - was a voluntary and independent one which broke the causal chain between the accused's act and the final result.

The court further said that even though the accused had aided and abetted in the suicide of the deceased, that it was not recognized as a crime in South Africa and it was not a case of *qui facit per alium facit per se*.⁹¹ The accused was acquitted since his conduct fell short of murder and attempted murder in the present circumstances.

4.2.2.3 Ex parte Minister van Justisie: In re S v Grotjohn⁹²

Facts:

Grotjohn, the accused, handed a loaded firearm to his invalid wife along with the words, "*Skiet jousef dan as jy wil, want jy is 'n las.*"⁹³ The deceased aimed the firearm at her face and pulled the trigger with her toes.

⁹¹ "He who acts through another does the act himself."

⁹² *Ex parte Minister van Justisie: In re S v Grotjohn* 1970 (3) SA 355 (A).

⁹³ "Shoot yourself then, because you are a burden."

Decision:

The court held that the end result was not far enough removed to be considered an independent or unexpected act, therefore the causal chain between the accused's actions and the final result of death was not broken.⁹⁴

In terms of fault, the accused could reasonably foresee that the deceased would follow through with her promise and yet he still acted as he did, thus reconciling himself with the end result of his actions. In other words, this is a case of *dolus eventualis*.

4.2.2.4 S v Nkwanyana⁹⁵**Facts:**

The deceased, Heidi Katz, befriended the accused, Alfred Nkwanyana. She suffered from a severe psychiatric disorder and anorexia. She allegedly regularly begged the accused to kill her. At first he refused, but in the end gave in after she threatened to get other people to assist her.

Decision:

He was found guilty of murder, but only received a suspended sentence of five years.

⁹⁴ A *novus actus interveniens*. See paragraph 3.3 "Causation" above.

⁹⁵ *S v Nkwanyana* 2003 (1) SA 303 (W).

4.2.2.5 S v Robinson⁹⁶

Facts:

Mr Jackson had arranged with his wife, a friend and Mr Robinson to kill him, Mr Jackson, in order for his wife to receive money from his life-insurance. Mr Robinson was specifically included so he could commit the act.

Decision:

The court confirmed here that consent is not a valid defence on a charge of murder, once again relying on the decision made in *Peeverett*.

The fact that the deceased had consented to his death was however considered to be extenuating circumstances, but only enough for the court to deviate from the minimum sentence, which was in this case the death penalty, with regards to the deceased's wife and friend.

4.2.2.6 S v Agliotti (South Gauteng High Court)⁹⁷

Facts:

Norbert Glenn Agliotti, the accused, was charged with, among other things, the murder of Brett Keble. His defence was that the deceased had requested him to assist with his suicide in order for his wife to claim on his life insurance policy.

Decision:

The court finally ruled that "*anyone who conspires with, aids and/or abets another to commit suicide, albeit it be called assisted suicide, will also be guilty of an offence(s)*".⁹⁸

⁹⁶ S v Robinson 1968 (1) SA 666 (AD).

⁹⁷ S v Agliotti (SS 154/2009) [2010] ZAGPJHC 129; 2011 (2) SACR 437 (GSJ) (25 November 2010).

In these few words the court declared the practice of assisted suicide as unlawful and also widened the scope of its parameters.

Thus, the court had disobeyed one of its fundamental rules: *ius dicere non dare*.⁹⁹ This is clearly against the principle of legality. Even if the criminalization is justified through section 39 of the Constitution, the court had still not provided a fitting punishment for the new crime. The court most likely felt it was unnecessary to elaborate on that point, since the accused was discharged based on section 174 of the Criminal Procedure Act.¹⁰⁰

The above cases illustrate different problems the courts have had to face in the past and the current position is far from clear. Hopefully clarifying *de lege lata* will help to provide for future clarity.

4.2.3 Summary in Terms of Criminal Law:

1. There is a problem with legality, since suicide itself is not a crime, but assisting, aiding, abetting and/or conspiring with someone to commit suicide is. The accused are convicted for murder. There is also no formal punishment and those convicted of the same crime can receive the lightest or most severe form of punishment depending on how much sympathy the court has for their circumstances.
2. The terminology used is also problematic in terms of legality, since merely conspiring or aiding someone to commit suicide, could warrant a conviction for murder. Courts have to dress assisted suicide in the guise of murder, since - according to *Agliotti* - convicting an accused for *conspiracy to assist someone to commit suicide* is clearly absurd, but technically still valid.

⁹⁸ *Ibid* paragraph 21.

⁹⁹ “*To declare law, not make it.*” See paragraph 3.1 “Legality” above.

¹⁰⁰ “*If at the close of the case for the prosecution at any trial, the court is of the opinion that there is no evidence that the accused committed the offence referred to in the charge or any offence of which he may be convicted on the charge, it may return a verdict or not guilty.*”

3. It is plausible for the causal chain to be broken, but modern courts are loath to do so and thereby setting a precedent. There has been no modern reported case of assisted suicide in which the deceased's own act constituted a *novus actus interveniens*.
4. Consent is not an accepted justification, which could exclude the unlawfulness of a person's act.
5. Lastly, if there is supporting evidence the accused could claim that it was neither his intention nor that he foresaw and/or reconciled himself with the fact that the deceased might commit suicide.

4.3 PASSIVE EUTHANASIA / CESSATION OF MEDICAL TREATMENT

The practice is currently the only one accepted in South Africa and that is mostly based on the *boni mores*, which in turn is justified in terms of causation.

In Estate Stransham-Ford¹⁰¹ the court confirmed that ceasing medical treatment which serve no curative, therapeutic or palliative purpose does not constitute a criminal offence by the physician. As seen below, the disease is considered to be the cause of death in these circumstances.

4.3.1 Questions Raised by these Cases:

1. Does an advance directive constitute consent?
2. What is the double effect and the law's stance surrounding it?
3. How is passive euthanasia justified?

¹⁰¹ *Minister of Justice and Correctional Services v Estate Stransham-Ford* (531/2015) 2016 ZASCA 197 (6 December 2016), paragraph 33.

4.3.2 Case Law

4.3.2.1 Clarke v Hurst¹⁰²

Facts:

The applicant's husband, a medical doctor and a member of the South African Voluntary Euthanasia Society, was in a persistent vegetative state with no prospects of waking up. The patient had concluded an advance directive which stated that should he ever be in a situation of extreme physical or mental disability, such as he was experiencing under the circumstances, he should not be kept alive by artificial means.

The applicant and wife applied to court to be appointed the *curatrix personae* in order to gain authority with which she would then order the removal of the nasogastric tube. This would end the artificial feeding of the patient and cause his death.

Decision:

The court was convinced that the patient had permanently lost all brain function. This, together with the advance directive, led the court to believe that the *boni mores* would allow for the application to be granted. The patient's nasogastric tube was removed and he died.

The court further found that in terms of criminal law, the act of removing the nasogastric tube might be the factual cause of death, but not the judicial cause of death based on policy considerations. This means that the applicant or physician in these cases cannot be held criminally liable as there is no causal link between their act and the unlawful result.

The court also stated that it is acceptable for a doctor to give a patient pain relieving medicine, while knowing full well that the medicine will also shorten the patient's life.¹⁰³ This is referred to as the double effect.¹⁰⁴

¹⁰² *Clarke v Hurst* footnote 66 *supra*.

4.3.3 Points to Ponder

4.3.3.1 The Advance Directive:¹⁰⁵

What would be the case should the patient not have an advance directive? The reasoning would be the same, but in this instance it would be difficult to determine the wishes of the patient with sufficient accuracy. The HPCSA have certain guidelines to assist, but they are sorely lacking in definite conclusions.¹⁰⁶ The guidelines merely state that the senior clinician should attempt to ascertain the wishes of the patient through interviews with the patient's authorised representative and/or those deemed close to him, as well as the rest of the health care team. It fails to say which options are available, but the chosen course of action must be within the best interest of the patient.¹⁰⁷

It would seem that the primary purpose of an advance directive in most cases would be to speed along the process of deciding. The document does not even seem to be crucial to the process, since a decision can be made with only a few extra steps. However, the document will be invaluable in cases where a definite conclusion cannot be made with regards to the patient's wishes. This will most likely be the minority of cases.

¹⁰³ *Clarke v Hurst* footnote 66 *supra* at paragraph 656H – I. Here the court was paraphrasing the statement made in *R v Adams* 1957 Crim LR 365, “a doctor is entitled to do all that is proper and necessary to relieve pain and suffering even if such measures may incidentally shorten life.”

¹⁰⁴ *Estate Stransham-Ford* footnote 101 *supra*, the court confirmed this practice to be lawful at paragraph 34.

¹⁰⁵ Further reading on the topic is encouraged: Jordaan (2011), footnote 37 *supra*.

¹⁰⁶ Health Professions Council of South Africa (2008) *Guidelines for the withholding or withdrawal of treatment* Booklet (7): 5 – 6.

¹⁰⁷ See Chapter 5: Health Professions Council of South Africa, paragraph 4 “The Best Interests of the Patient”.

4.3.3.2 The Double Effect:

The court said it is acceptable for a physician to administer treatment or medication to a patient without incurring any liability, while knowing full well that the patient's lifespan would be indeterminably shortened.¹⁰⁸ What if the patient's life is shortened more than expected and the patient dies? Is this not a case of *dolus eventualis* or at the very least *luxuria*?¹⁰⁹ A physician has to warn a patient of the negative side-effects and/or possible consequences of medical treatment.¹¹⁰ Thus, legally speaking, three options are available to physicians:

1. To be guilty of murder by foreseeing the death of a patient and reconciling himself with it;
2. To be guilty of culpable homicide by unreasonably not reconciling himself with the possibility when the reasonable physician would have and therefore be negligent; or
3. To be possibly guilty of culpable homicide due to negligence compared to the reasonable physician under the circumstances.

None of these options are ideal, but in practice a fourth option has developed and is the most widely used: blame the death on circumstances beyond anyone's control and justify it with policy considerations.

¹⁰⁸ McQuoid-Mason DJ (2015) "Stransham-Ford v. Minister of Justice and Correctional Services and Others: Can active voluntary euthanasia and doctor-assisted suicide be legally justified and are they consistent with the biomedical ethical principles? Some suggested guidelines for doctors to consider" *South African Journal of Bioethics and Law* (8): 36.

¹⁰⁹ *Humphreys v The State* (424/12) [2013] ZASCA 20 (22 March. 2013).

As opposed to *dolus eventualis*, with *luxuria* a person foresees the possibility of a consequence that might come to pass, but unreasonably does not reconcile himself with the possibility while the reasonable person would have.

¹¹⁰ Health Professions Council of South Africa (2008) *Confidentiality: Protecting and Providing Information* Booklet (10): 3 – 4.

Naturally all of this is moot, since the causation requirement has not been met for criminal liability and it needs to be satisfied before fault can be discussed.¹¹¹

In the case of *Castell v De Greeff*¹¹² the doctrine of informed consent was introduced and confirmed by the Supreme Court of Appeal.¹¹³ This emphasized a patient's right to bodily integrity and autonomy so that they may refuse medical treatment even if that would be detrimental to their own health. In these circumstances the unlawfulness of a physician's medical treatment would be excluded, provided that the patient was sufficiently warned of the material risks involved.¹¹⁴

This seems to have created a paradoxical standpoint. A physician is obligated to inform his patient of possible side-effects of medical procedures, for example the continuous administration of morphine. This would exclude any unlawfulness that the physician might incur. Is this not a form of consent? On the other hand the physician can treat the pain of a patient, knowing death is a possible side-effect, yet in terms of the double-effect there seems to be no official obligation to divulge this information.

It would seem the courts have gone out of their way over the years to protect the medical profession from the legal repercussions of the double effect. But to name this practice would shed light on it and force various sectors to acknowledge it and consider how it should be regulated.¹¹⁵

4.3.4 Summary in Terms of Criminal Law:

1. A person can be allowed to die if they are brain dead, in a persistent vegetative state or similar condition.

¹¹¹ Based on *Clarke v Hurst* footnote 66 *supra*.

¹¹² *Castell v De Greeff* 1994 (4) SA 408 (C) A.

¹¹³ Hereafter in this chapter referred to as the "SCA".

¹¹⁴ However, the patient can consent to accepted medical procedures, but not to her own death.

¹¹⁵ Huxley, A (1927) *Proper Studies*, "Facts do not cease to exist because they are ignored."

2. An advance directive is important, but there are ways to get along without one in most circumstances.
3. The patient's condition is deemed to be the judicial cause of death based on policy considerations. Thus, no one incurs criminal liability.
4. The double effect is acceptable if there are no alternatives left and it is deemed to be in the best interest of the patient.

4.4 ACTIVE EUTHANASIA

The main difference between active and passive euthanasia is on the element of causation, since the cause of death will not be due to natural causes.

In these cases there is a final, unlawful act committed by the physician or someone acting under their orders.

The already dying patient's death will be hastened and this hastening might be to such an extent that it happens in mere minutes.

4.4.1 Question Raised by these Cases:

1. Should the hastening of a dying person's death be considered murder even though it is in line with the wishes of the deceased?
2. Is this hastening different from the double effect?
3. Alternatively should a special defence be developed for physicians who perform active euthanasia on consenting, terminal patients? If so, what safety measures should be in place to protect vulnerable patients?

4.4.2 Case Law

4.4.2.1 S v Hartmann¹¹⁶

Facts:

The accused, Dr. Hartmann, was a physician in Ceres whose father, the deceased, was terminally ill. He had suffered from carcinoma of the prostate for years and later developed cancer in his bones, specifically in the ribs. He consistently complained about being in pain. The accused ordered several doses of morphine to be administered to the deceased and later administered a large dose of Pentothal, which had the *intended* effect of death. At the time of death the deceased was on palliative treatment as all hopes for a cure had vanished and he was presumably very close to death in any case.

The accused stated that the deceased had consented to being euthanized, as he had asked him whether he would like to sleep and the accused then vaguely nodded his head. This was contested as it is impossible to know whether the deceased had understood what was asked and even if his conduct established consent.

Decision:

The court determined that at the moment the accused administered the lethal drug he was fully aware of the consequences and thus, had intention - a critical requirement for the crime of murder. However the accused was moved by compassion and the desire to relieve suffering. The court convicted him of murder, notwithstanding the alleged consent nor his noble intentions.

The motive that moves the accused, albeit noble and merciful, is irrelevant for purposes of conviction. It will however impact the sentencing after a successful conviction, as was the result in this case. The court used the mitigating circumstances of this case to impose a sentence as unique as the facts that gave rise to it. The accused was

¹¹⁶ *Hartmann* footnote 76 *supra*.

detained until the rising of the court and the remainder of his one year imprisonment was suspended.

4.4.3 Points to Ponder

4.4.3.1 The Appropriate Terminology:

In *Estate Stransham-Ford* the court stated that the case did not concern active voluntary euthanasia.¹¹⁷ With respect, the author disagrees with this statement as the definition for active euthanasia is the unlawful and intentional causing of death of a person through a direct action, in response to a request from that person.¹¹⁸ The circumstances fit the definition perfectly, unless the court had another definition in mind when they made the statement.

4.4.4 Summary in Terms of Criminal Law:

1. **The ACT:** The accused administered the lethal medication.
2. **CAUSATION:** the autopsy performed determined that the deceased's direct cause of death was the huge amount of Pentothal in his system. Thus, it can be argued that if the accused had not committed his act the victim would have survived or at the very least not have died at that moment.¹¹⁹
3. **UNLAWFULNESS:** as per the definition above of active euthanasia developed through common law the conduct of the accused was unlawful under the circumstances it was performed.

¹¹⁷ *Estate Stransham-Ford* footnote 101 *supra*, paragraph 38.

¹¹⁸ Carstens P & Pearmain D (2007) *Foundational Principles of South African Medical Law*: 203.

¹¹⁹ *Conditio sine qua non*-theory *supra*.

Consent is not a valid defence on a charge of murder, thus it cannot be used as a justification.¹²⁰

4. **CAPACITY:** although presumably and understandably very emotional at the time the accused was in possession of both his cognitive and conative functions.
5. **FAULT:** Depending on the mentality of the accused at the moment of the crime, this could be a case of *dolus directus* or *dolus eventualis*.

If the accused's primary intention was to cause the death, and by extension, relieve the pain of the patient, then it would be *dolus directus*.

If the accused foresaw that the injection would cause the death of the patient and he reconciled himself with the consequence, then it is a textbook case of *dolus eventualis*.¹²¹ No matter which form of fault is proven, the result would still lead to a conviction of murder.

Although not the exact facts of this case, another possible scenario would be if the accused's primary intention was to relieve the pain of patient, but he knew that the only way to achieve this would also cause the death of the patient, without wishing it to happen, then it would be *dolus indirectus*.

This seems eerily similar to the double effect as discussed above. It would appear that the best argument in these cases would be to keep on administering opioid medication, claiming the intention is to relieve pain whilst knowing it would sooner or later lead to the intended death of the patient.

This is of course not ideal nor encouraged. For the practice to work there needs to be a certain level of trust and transparency. Naturally neither of these will be present if physicians have to lie in order to serve their patients. The possibilities for abuse is also apparent and horrifying to imagine. Furthermore, the patient

¹²⁰ See Chapter 6: Recommendations.

¹²¹ *Sigwahla supra*.

might wish to be in full control of his faculties for the last moments of his life. A mercy he would be denied under these circumstances.

According to the above elements of criminal law it is proper and appropriate for a court to convict a physician who performs a procedure for active euthanasia, unless a special defence is developed. However, the consent of the patient and the intentions of the physician can have an impact upon the sentencing.

The fact that voluntary active euthanasia leads to a conviction is the main difference between it and the double effect.¹²² Notwithstanding they are almost identical in practical terms. The physician is technically capable of actively euthanizing the patient by increasing their doses of morphine. Naturally his official intention should be to relieve pain, but an accepted, and possibly intended, side-effect is the death of the patient.

4.5 PHYSICIAN-ASSISTED SUICIDE

For academic and technical purposes *physician-assisted suicide*¹²³ and *active euthanasia* will not be used as synonyms and they each represent different practices. During PAS the physician merely provides the means for the patient with which he can commit suicide himself.¹²⁴ The patient must commit the final act which will be the direct cause of death. As opposed to active euthanasia where the physician commits the final act in reaction to the wishes of the patient.

The distinction might be academic in nature, but the reason is for practical purposes. Some patients might be physically incapable of committing the final act themselves.¹²⁵ Not catering for patients in these circumstances can result in discrimination.¹²⁶

¹²² See paragraph 4.3.3.2 "The Double Effect" above.

¹²³ Hereafter referred to as "PAS".

¹²⁴ McQuoid-Mason (2015): 38.

For example, providing a lethal "cocktail" which the patient will drink himself, knowing it will cause his death.

¹²⁵ Nicklinson *supra*.

PAS must be distinguished from *assisted suicide* in that the person who assists must be a medical practitioner who is acting within his official capacity and follows a medically approved procedure. When working with *assisted suicide* any person can provide assistance in any manner.¹²⁷

4.5.1 Case Law: Stransham-Ford¹²⁸

Facts:

The applicant in this case was terminally ill with a very aggressive form of cancer. He was in constant pain, nauseous and nearing the end of his life and also unable to perform most of his daily tasks, such as personal hygiene. He applied to court for permission to ask a physician to assist him with hastening his death, as he could not bear to live in that state for much longer and palliative care did not provide him with the relief he sought.

4.5.1.1 North Gauteng High Court Decision:¹²⁹

The court granted the application, saying that the physician in this case is free from civil, criminal and disciplinary liability should he administer or provide a lethal agent which would lead to the death of the patient. A practical and procedural problem arose with the court's *ratio*, since the applicant had died before it was delivered and as such the cause for the application had ceased to exist. This was discussed at length in the SCA's decision, but since the focus of this research document is on the material criminal law, the procedural discrepancies will not be discussed further.

¹²⁶ Section 9 of the Constitution, "the right to equality".

¹²⁷ See paragraph 4.2 "Assisted Suicide / Consent to Death" above.

¹²⁸ This section must be read in conjunction paragraph 2 "The Constitutional".

¹²⁹ *Stransham-Ford* footnote 6 *supra*.

The main argument for the court's decision was that the sacredness of life should be protected and taken into account. Not "life" as mere organic matter.¹³⁰ This meant that *dignity* is just as important as *life* and both are rights that are worthy of protection.¹³¹ This being said, the court ruled that there should be a focus on a patient's autonomy and their right to bodily integrity. This, along with case- and foreign law, led to the conclusion that a patient who is terminally ill and of sound mind should be allowed to waive one Constitutional right in order to give effect to another, since a dying person is still alive and can still enforce the rights of a living person.

The main argument against euthanasia and assisted suicide is that of the slippery slope which will lead to the inevitable misuse and abuse and cause the death of many people who do not wish it.¹³² In his decision, the presiding officer negated this argument by explicitly stating that his decision should not be considered a development of the common law. This was a "one-time-thing" due to the unique circumstances of the case and it is still the responsibility of the legislator to create law.¹³³ The presiding officer was merely answering a question which was not readily available in our common law or legislation. Because of this the presiding officer did not feel the need to elaborate on the general safeguards which would be necessary to avoid the potential misuse of the practice.

The applicant raised a point with which the presiding judge agreed, which was that the current legal position regarding euthanasia was established in a pre-Constitutional era.¹³⁴ This ruling was the presiding officer's attempt to provide a modern point of view on the matter of assisted dying.

The presiding officer, Fabricius J, considered as many relevant sources as was permitted with the limited amount of time. There was a thorough examination of

¹³⁰ Quoting O'Regan in *Makwanyane, supra*.

¹³¹ See paragraphs 2.1 "Section 10: Dignity" and 2.2 "Section 11: Life" above.

¹³² See Chapter 6: Recommendations.

¹³³ See paragraph 3.1 "Legality" above.

¹³⁴ *Stransham-Ford* footnote 6 *supra*, paragraph 12.

Constitutional law and the Bill of Rights, as well as relevant case law, reports, foreign law and academic documents.

4.5.1.2 Supreme Court of Appeal Decision:¹³⁵

The SCA based its ruling on three pillars: firstly, the cause of action had ceased to exist, thus it was inappropriate of the High Court to make the order it did. Secondly and partly due to the urgency of the circumstances at the time, there was no proper investigation into the subject, local or foreign, making the court's argument lack the necessary authority. Lastly, the court did not comply with the Uniform Court Rules and all interested parties did not receive equal opportunity to make their concerns heard. This restricted the facts the court based their order on. For purposes of this research document there will be a primary focus on the second pillar of the order, wherein the SCA discussed the applicable legal arguments.

Note that in paragraph 40 the court said that "*I can see no reason for distinguishing their [medical practitioners'] situation from that of a family member or friend who did the same.*" With the current position this might be true for purposes of sentencing, but if active euthanasia and/or PAS should ever be allowed, then this distinction would be of the utmost importance. The procedure should only be carried out by a qualified physician or someone acting under their orders in order to ensure all the correct steps are followed. Also family members and close friends should never be expected to perform the procedure as this could affect other matters, such as inheritance.¹³⁶ Not to mention the possibility of taking matters into their own hands because they do not want to see a loved one suffer, despite the patient's wishes.

¹³⁵ *Estate Stransham-Ford* footnote 101 *supra*.

¹³⁶ *De bloedige hand erft niet*.

Not to mention the psychological effects it might have on an untrained person when asked to actively cause/assist in the death of a loved one.

The court reiterated and once again confirmed that consent to be killed is not a valid defence under any circumstances and the accused should in these cases still be convicted for murder.¹³⁷

The court further said in paragraph 41 that the High Court should not have made such an order which will profoundly change the law's interpretation of murder. However, Fabricius J specifically stated that his order should not be considered to have any effect on the common law crimes of murder or culpable homicide, except insofar it concerned the applicant's case in that particular matter.¹³⁸

4.5.2 Summary in Terms of Criminal Law:

1. The final act, which is the direct cause of death, is committed by the deceased himself.
2. The physician merely provides the means with which suicide can be committed, but this is enough for criminal liability to be established.
3. The *double effect* is not applicable here as all actions taken by the physician and patient are with the sole intent of causing the patient's death.
4. The conduct of the physician is still considered to fall within the common law definition of murder.

5 CONCLUSION

Based on the above discussions it would seem that unless legislation intervenes, the matter will stay unresolved and fluid. Although theoretically able to change, courts seem loath to adopt a modern approach.

¹³⁷ *Estate Stransham-Ford* footnote 101 *supra*, paragraph 38.

¹³⁸ *Stransham-Ford* footnote 6 *supra*, order 4.

Only passive euthanasia is legally justified. But even though PAS and active euthanasia is unlawful, there are ways and means for physicians and patients to circumvent any criminal liability that might possibly be incurred. These however, will create a breeding ground for dishonesty and inconsistency in a system that should be open, transparent and safe.

Courts have to take the initiative and attempt to be open-minded when considering assisted dying in order to adopt a modern approach. This could be accelerated with objective research, done without preconceived notions or hidden political agendas. This would also ensure that arguments are based on solid legal principles and not subjective feelings.

The same argument for abortion is applicable in these circumstances: criminalization does not prevent its practice, it merely prevents the safe practices. By creating appropriate legislation, it would be simpler to regulate assisted dying and impose sensible and practical safety measures.¹³⁹

¹³⁹ See Chapter 6: Recommendations.

CHAPTER 4

COMPARATIVE EXAMINATION OF ASSISTED DYING IN FOREIGN JURISDICTIONS

1 INTRODUCTION

In the previous chapters the legal position of assisted dying, specifically with regards to criminal law, was set out. *De lege lata* was discussed and analysed with some preliminary recommendations made.

This chapter will examine the position of foreign jurisdictions' stance on assisted dying. Jurisdictions examined will consist of Canada, the Netherlands, the State of Oregon in the United States of America and England and Wales. This is to explore other perspectives on the matter in order to see what the possible solutions or pitfalls are that should be taken into account should South Africa decide to take a stance.

A short discussion on the history or development of assisted dying in these jurisdictions will be done initially to create a basis. This will be done by referring to case law, previous or current legislation and any other resources that might be relevant, followed by a critique of the law.

Each discussion will then conclude by making recommendations as to what South Africa may “learn” from each mentioned country and how this might be implemented locally, if at all. It must be kept in mind that other jurisdictions might use the same terminology as South Africa, but interpret or apply it differently. Where this is the case it will be “translated” into South African terms.

PART A

CANADA

1 INTRODUCTION

Recently Canada has made some major changes to its legislation by adopting Bill C-14.¹ This piece of legislation amends the Criminal Code² and it is now legal for physicians to practice assisted dying, as long as they adhere to certain guidelines.³ In other words they can assist in a patient's request to commit suicide or carry out the procedure themselves. Although, at the moment mentally ill persons are not yet explicitly excluded from using this Bill the Canadian government is committed to research future possibilities of allowing mature minors, mentally ill persons and advance requests also to be included in the use of this Bill.⁴ The wording of the Bill will be discussed in more detail below.

Notwithstanding the vocabulary, the spirit of the legislation will be taken into account within in the context of the wording, since the difference in cultures between Canada and South Africa are so fundamental that the phrasing of the Bill, which makes sense in Canada, has major legal *lacuna* if it were to be adopted by South Africa *verbatim*.⁵

¹ An Act to amend the Criminal Code and make related amendments to other Acts (medical assistance in dying). Hereafter and only for Part A, referred to as the "Bill C-14".

² The Criminal Code (R.S.C. 1985, c. C-46, as amended). Hereafter referred to as the "Criminal Code" in Part A.

³ See paragraph 3: New Legislation below.

⁴ Government of Canada (2016) "Legislative Background: Medical Assistance in Dying (Bill C-14)" *Government of Canada* available online at: www.justice.gc.ca/eng/rp-pr/other-autre/ad-am/ad-am.pdf. Accessed 2017/08/16.

⁵ This happened with the adoption of the Consumer Protection Act, 68 of 2008. For more information on the subject read: Barnard J (2017) "Role of Comparative Law in Consumer Protection Law: A South African Perspective (Part 1)" *South African Mercantile Law Journal* (2): to be published.

In the following section of this chapter the development of assisted dying in Canada will be discussed with reference to the history thereof, as illustrated in case law. This is followed by a discussion of the new Canadian legislation on the matter, which will also contain the critique and practical execution thereof. Ultimately, the purpose of this comparison is to investigate the lessons which South Africa might learn from Canada. Canada's stance on the matter of assisted dying is more recent and less encumbered by history than that of other jurisdictions, specifically the Netherlands. But the history of the Canadian debate all started with one specific case, namely *Rodriguez v British Columbia*, which will be discussed below.

2 HISTORICAL DEVELOPMENT

2.1 *Rodriguez v British Columbia*⁶

Sue Rodriguez was a woman suffering from amyotrophic lateral sclerosis⁷ and in 1993 it was concluded that she would not survive another year. She applied to court to have section 241(1)(b)⁸ of the Criminal Code struck from legislation, alleging that it violated her rights guaranteed by the Charter⁹ such as the right to life, liberty and security of the person,¹⁰ protection against cruel and inhuman punishment¹¹ and equality.¹²

⁶ *Rodriguez v British Columbia (AG)* [1993] 3 S.C.R. 519.

⁷ Better known as ALS or "Lou Gehrig's Disease".

⁸ "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."

⁹ The Canadian Charter of Human Rights and Freedoms. Hereafter referred to as the "Charter" in Part A.

¹⁰ *Life, liberty and security*, section 7 of the Charter.

¹¹ *Inhuman punishment*, section 12 of the Charter.

¹² *Equality*, section 15 of the Charter.

The Supreme Court of Canada denied her eventual appeal in a 5 against 4 majority. They conceded the fact that section 241(1)(b) could conceivably deprive her of personal autonomy and decision making concerning her own body, as bestowed upon her by section 7 of the Charter. However, despite the concession, they found that a blanket ban on assisted suicide upheld fundamental principles of justice and therefore did not violate section 7.¹³

Thus, it was deemed necessary to protect the potential victims of misuse, instead of accommodating one individual. However, this policy would change a little more than 20 years later.

2.2 Carter v Canada¹⁴

In this case it was decided that section 241 of the Criminal Code¹⁵ violates a person's section 7 rights of the Charter. The specific section 241(1) was suspended for a period of 12 months in order to allow the government to make the amendments necessary to allow for assisted dying. These amendments are reflected in Bill C-14 below.

On appeal the trial court's judgment was upheld, saying that sections 241(1) and 14¹⁶ of the Criminal Code infringes on a person's right to life, liberty and security of their person.¹⁷ This person, however, has to be a competent adult person who (1) clearly consents¹⁸ to assisted dying and (2) has a "*grievous and irremediable medical condition*" that causes intolerable long term suffering to the individual.

Section 7 in its entirety is applicable as follows:

¹³ *The Criminal Code*, footnote 2.

¹⁴ *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331.

¹⁵ *Section 241(1)(b) of the Criminal Code*, footnote 8 *supra*.

¹⁶ "No person is entitled to consent to have death inflicted on them, and such consent does not affect the criminal responsibility of any person who inflicts death on the person who gave consent."

¹⁷ *Life, liberty and security*, footnote 10 *supra*.

¹⁸ In South African law this is still not considered a valid defence. See Chapter 3: The Criminality of Assisted Dying in South Africa at paragraph 4.2 "Assisted Suicide / Consent to Death".

Life¹⁹ - The court argued that by preventing a person from seeking assisted dying it would indirectly impinge upon their right to life by forcing people to commit suicide while they still felt like they have some semblance of control.

Liberty - The person's autonomy and dignity are also relevant since it is a decision concerning their body and the quality of life they want to enjoy up until the last moment.

Security of their person - Lastly, consigning a person to an unknown period of intolerable suffering infringes on the security of their person.²⁰

The rights to liberty and security of their person – which concern their dignity and autonomy – are also infringed upon by preventing them to make decisions about their own bodies and consequently forcing them to endure intolerable pain.

The blanket ban on assisted dying, which was the official policy after *Rodriguez*,²¹ was not to preserve life, but more to protect vulnerable persons from being motivated to commit suicide against their will. However helpful, the Supreme Court found that the ban is overbroad and does infringe on certain individuals' rights, which makes it disproportionate and against the objective thereof.

The court decided that assisted dying is allowed under the circumstances where a physician – or someone acting under the direct guidance of a physician – may administer lethal medication in order to end a patient's life or provide medication with which a patient may end their own lives.

Once the above was argued and accepted, section 15²² of the Charter by necessary implication included people with physical disabilities, thus, allowing them to make use of the practice as well. Otherwise people who are physically incapable of committing

¹⁹ See Chapter 3: The Criminality of Assisted Dying in South Africa at paragraph 2.2 “Section 11: Life”.

²⁰ See Chapter 3: The Criminality of Assisted Dying in South Africa at paragraph 2.3 “Section 12: Bodily integrity”.

²¹ *Rodriguez* footnote 6 *supra*.

²² *Equality*, footnote 12 *supra*.

suicide would have to rely on another's assistance, who would then be open to potential prosecution.

As stated above, the court allowed the government 12 months to amend the Criminal Code in order to allow for the use of assisted dying.

3 NEW LEGISLATION

Before Bill C-14 was adopted, the Criminal Code's only sections on the matter of assisted dying were sections 14²³ and 241²⁴ respectively. Section 14 remained the same, which indicates that consent to assisted dying is still not a valid defence, except for circumstances that fall within the parameters of the new amendments. The Bill made the following amendments of note to the Criminal Code, by having certain sections now read as follow:

The core concept of section 241(1) was kept the same with a few changes to the wording. This, however, states that any other form of assisted dying, than that mentioned in section 241.2,²⁵ is still a crime.

241(1) Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,

(a) counsels a person to die by suicide or abets a person in dying by suicide; or

(b) aids a person to die by suicide.”²⁶

²³ *Consent*, footnote 16 *supra*.

²⁴ *Section 241(1)(b) of the Criminal Code*, footnote 8 *supra*

²⁵ With Canadian legislation new subsections' numbers are written with a period just before the new number, similar to South Africa's use of capital letters. Thus sections 241(2) and 241.2 are completely different sections.

²⁶ See Chapter 3: The Criminality of Assisted Dying in South Africa at paragraph 4.2 "Assisted Suicide / Consent to Death".

See paragraph 4 "Lessons for South Africa" below.

This section still criminalizes the act of assisting someone to commit suicide. But read together with the sections discussed below will grant medical personnel exemption and will not be committing a punishable offence in terms of this section. It is interesting that from the phrasing it is implied that there is no distinction between passive and active euthanasia and both concepts fall under the act of “*aiding*” a person to die.

Medical practitioners or nurses are granted exemption from prosecution when assisting someone with committing suicide through medical means.

“227(1) No medical practitioner or nurse practitioner commits culpable homicide if they provide a person with medical assistance in dying in accordance with section 241.2.”

“241(2) No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying in accordance with section 241.2.”

The Bill also specified the definition for *medical assistance in dying* within the context of the Criminal Code, and therefore the parameters of the act committed by the physician:

“(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or

(b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.”

The phrasing in subsection (b) could pose a problem, since it states a person should *self-administer* the substance. However, section 15 of the Charter would require that physicians are allowed to take a more direct hand with assistance in the instances where a patient is unable to self-administer the medication, such as in cases of severe disabilities.

From the above excerpts it is clear that aiding, abetting or counselling for suicide is still a criminal offence. Section 241.2, however, grants a special defence to medical practitioners under these circumstances as long as all the material requirements are met. These material requirements are as follow:

“241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:

(a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;

(b) they are at least 18 years of age and capable of making decisions with respect to their health;

(c) they have a grievous and irremediable medical condition;

(d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and

(e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.”

A person is considered to have a “grievous an irremediable medical condition” if:²⁷

“(a) they have a serious and incurable illness, disease or disability;

(b) they are in an advanced state of irreversible decline in capability;

(c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

(d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.”

²⁷ As per section 241.2 (2) of Bill C-14.

The requirements of “advanced state of irreversible decline” and that “death has become reasonably foreseeable” were not included in the original *Carter*²⁸ decision and are considered to be possibly unconstitutional.²⁹ Pro-euthanasia advocates argue that they are too restrictive and that patients will be at the mercy of physicians’ discretion who would rather err on the side of caution. On the other hand anti-euthanasia advocates state the requirements are too vague, which leave it open for misuse.³⁰ Cases such as amyotrophic lateral sclerosis³¹ or Parkinson’s disease are used as examples where a patient might be suffering, but denied the use of this Bill since their deaths might not be “reasonably foreseeable”.

As yet there have been no court decisions on the constitutionality or practice of the Bill and only time will tell whether this will truly create as many issues as claimed or be a success.

4 LESSONS FOR SOUTH AFRICA

An important lesson South Africa can learn from the Canadians is that to over-define the different phrases - such as assisted dying, passive and active euthanasia and physician-assisted suicide - only serves to complicate matters. The distinctions are necessary for academic purposes, but practically speaking it is sufficient to use one term in legislation under which all the rest will fall. The differences are, as put in Stransham-Ford,³² “*intellectually dishonest*” and only serve to limit progress. As seen in Canadian law, passive euthanasia, or anything remotely similar, is not even mentioned once in their legislation. It is almost as if the Canadians could not fathom this to be a

²⁸ *Carter* footnote 14 *supra*.

²⁹ Dying with Dignity (date) “Get the Facts: Assisted Dying in Canada” available online at www.dyingwithdignity.ca/get_the_facts_assisted_dying_law_in_canada. Accessed 2017/09/28.

³⁰ Laurence L (2016) “Breaking: Canadian Senate Passes Euthanasia Bill” *Life Site* available online at www.lifesitenews.com/news/breaking-canadian-senate-passes-euthanasia-bill. Accessed 2017/08/29.

³¹ Commonly referred to as “ALS”.

³² See Chapter 3: The Criminality of Assisted Dying in South Africa at paragraph 4.5.1 “Case Law: Stransham-Ford”.

problem and never even thought of raising it as a possible concern. They also make no practical distinction between physician-assisted suicide and active euthanasia, at least not in those exact terms. Yet, they provide for both these circumstances when exempting it from the crime of murder.

This being said, it is necessary to explicitly state the liability, or lack thereof, of each party that could possibly participate in the practice. This includes the physician, nursing staff, pharmacists and family member who assist the patient in any way. There should be no confusion as to what actions will incur criminal liability.

Just as with the Dutch legislation, Canada decided to keep assisted suicide a crime, but provided a defence for justification if it should happen within certain parameters. It is suggested that should South Africa decide to adopt legislation on the matter, the act of assisting someone to commit suicide, outside of accepted parameters, should incur criminal liability. But before any new practices are started, perhaps it would be wise to improve existing ones.

It is interesting to note that some countries which have allowed the practice of assisted dying did not suffer a decline in palliative care as many thought would be the case. A study has shown that in fact the opposite is true.³³ Since proper palliative care is such a fundamental part of assisted dying, the governments in the study - Netherlands and Belgium - have increased their budgets for the development of proper palliative care.³⁴ The South African parliament should focus on improving the overall health and healthcare of its citizens, before taking on new endeavours. This would also, incidentally, give weight to a person's argument that palliative care is no longer sufficient for their purposes, provided that they have exhausted that option.

³³ Bernheim J, Chambaere K, Theuns P, Deliens L (2014) "State of Palliative Care Development in European Countries with and without Legally Regulated Physician-Assisted Dying" *Health Care Volume* (2 (1)): 10 -14.

³⁴ End-of-Life: Law and Policy in Canada "Euthanasia" *End-of-Life: Law and Policy in Canada* available online at eol.law.dal.ca/?page_id=238. Accessed 2017/08/29.

5 CONCLUSION

Just as with the Dutch legislation, South Africa cannot afford to plagiarize the Canadian Bill, no matter how full proof it might seem. It would be prudent to observe and analyse the effects of the Bill, while working on our own version. We should attempt to reproduce or improve the positive results, while avoiding less desirable outcomes.

PART B

THE NETHERLANDS

1 INTRODUCTION

The Netherlands are arguably the most famous jurisdiction in terms of assisted dying. This makes sense if one considers their overall liberal position on many controversial topics, such as drug-use and prostitution. The following discussion will analyse the historical background and current legislation on the matter, referring to case law and legislation. However, practice is almost always considerably different from theory and these differences will be examined and critiqued. This section will be concluded by making recommendations for South Africa.

2 HISTORICAL DEVELOPMENT³⁵

The Dutch Criminal Code³⁶ sought to codify euthanasia when it was adopted in 1886. In terms of this Act euthanasia deserved a separate penalty clause³⁷ from that of murder³⁸ and manslaughter.³⁹ The reasoning for this was that the latter were crimes against the right to life, whereas euthanasia⁴⁰ did not violate this right of the deceased individual

³⁵ De Haan, J (2002) "The New Dutch Law on Euthanasia" *Medical Law Review* Volume (10): pp 57 -75.

³⁶ Act of 3 March 1881. Hereafter in Part B referred to as the "Criminal Code".

³⁷ Article 293 of the Criminal Code. See paragraph 3 "Legislation" below.

³⁸ Article 289 of the Criminal Code.

³⁹ Article 287 of the Criminal Code.

⁴⁰ The Dutch definition for euthanasia is, "*termination of life on request.*" Therefore it is always voluntary and euthanasia and assisted suicide are mostly dealt with together.

due to the deceased consenting to the act. It was still criminalized because of the substantive rule, “*thou shalt not kill*” and violated the *respect* for life.⁴¹

The Dutch approach to euthanasia had developed over 30 years’ time and mainly rested on three pillars,⁴² namely:

1. Jurisprudence through Supreme Court decisions in case law;
2. Legislation;
3. Prosecutorial policy.

All three pillars played its own important role and each will be discussed below.

3 OLD LEGISLATION

Specific reference to articles 40⁴³ and 293 of the Criminal Code as it was at the time of the case law will be made. These sections were paramount to the decisions made by the court in the case law mentioned below.

Before the current legislation was adopted assisted dying in the Netherlands was regulated by article 293 of the Criminal Code. It read “[a] person who takes the life of another person at that other person’s express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine of the fifth category.” However, as stated above and will be seen below, the courts accepted the defence of necessity.

⁴¹ The explanatory note accompanying article 317 of the first draft of what later became the Criminal Code explained it as: “*He who complies with another person’s explicit and serious wish to take his life is to be subjected to a punishment considerably lighter than he who has been found guilty of plain murder. The consent cannot remove the punishability of taking another person’s life, but it does completely alter the character of the act – the law, so to speak, no longer punishes the assault against a certain person’s life, but the violation of the respect due to human life in general – no matter what the motive for the act may be. Crime against human life remains, crime against the person is absent.*”

⁴² De Haan (2002): 60.

⁴³ English translation: “*Any person who commits an offence under the compulsion of an irresistible force shall not be criminally liable*”

Unlike in South Africa, where necessity is merely a justification⁴⁴ for unlawfulness, necessity also excludes a person's culpability.

This combination of articles, along the case law, paved the way for what is now the current legal position of assisted dying in the Netherlands.

4 CASE LAW

In the *Schoonheim*, *Chabot* and *Kadijk* cases⁴⁵ the court had ruled that a physician could successfully raise a defence of necessity in terms of article 40 of the Criminal Code.⁴⁶ However, the *Kadijk* case will only be mentioned for its historical context as this case concerned a minor whose parents decided to euthanize her, and thus falls outside the parameters of this dissertation.

⁴⁴ A "defence" in South African law is a general term used to indicate a counter to an argument or charge and can impact any of the criminal law elements. Whereas a "justification" refers to a specific counter which only affects the unlawfulness of a person's act, such as necessity.

⁴⁵ Griffiths, J, Bood, A & Weyer, H (1998) *Euthanasia and Law in the Netherlands*.

Schoonheim, Supreme Court of the Netherlands, Criminal Chamber, 27 November 1984, nr 77.091. *Nederlandse Jurisprudentie* 1985, no. 106. As translated by Griffiths (1998): 322.

Chabot, Supreme Court of the Netherlands, Criminal Chamber, 21 June 1994, no. 96.972. *Nederlandse Jurisprudentie* 1994, no. 656. As translated by Griffiths (1998): 329.

Kadijk, Court of Appeals, Leeuwarden, Second Full Criminal Chamber, 4 April 1996. As translated by Griffiths (1998): 341.

⁴⁶ *Compulsion*, footnote 42 *supra*.

These cases are discussed in more detail below.

4.1 SCHOONHEIM⁴⁷

Facts:

Ms. B had been suffering for years and regularly made requests for the physicians to assist her to die. Her condition(s) were irreversible with no prospect of improvement. Eventually her physician successfully applied a medical method in order to end her life.

Decision:

The defendant had three arguments and they in turn were considered by the Court of Appeals:

1. He was not “taking another person’s life” as meant by article 293 of the Criminal Code

To understand this argument the phrasing of the article in Dutch should be considered. The article specifically reads “*een ander van het leven beroven*”, and a more accurate translation will be to say that the defendant had *robbed* another person of their life. His argument, thus, was that since the patient had consented and given permission to the act, he could not *rob* her of it. It is more difficult to phrase this argument in a logical manner in English, due to semantics. In English the phrase “to take another person’s life” is used and it does not have the same emotional impact as saying a person was “robbed of their life”. If this should be translated into accepted South African criminal law terms, the argument is essentially that she had consented. In South Africa this argument won’t even be considered as it has been established time and again that consent is never a valid defence on a charge of murder.⁴⁸

⁴⁷ *Schoonheim*, footnote 45 *supra*. Griffiths (1998): 322 – 328.

⁴⁸ See Chapter 3: The Criminality of Assisted Dying in South Africa at paragraph 4.2 “Assisted Suicide / Consent to Death”.

The court stated that the article cannot be interpreted restrictively⁴⁹ and it should simply be interpreted as *taking another person's life*. The defendant's conduct was deemed to fall within this interpretation and consequently this argument was rejected.

2. There was no substantial violation of the law.

The defendant argued that the right to self-determination has become so important and accepted as correct in society that it removes any unlawfulness the act⁵⁰ would otherwise have had under article 293. This argument was also rejected on appeal by stating that euthanasia is not generally accepted by society.

3. Necessity⁵¹

The defendant found himself in circumstances of conflict of duties where he was forced to make a decision between alleviating his patient's suffering and saving her life. This means that he objectively balanced the relevant duties and interests at hand, which justified his eventual decision.

The arguments made by the court are confusing and somewhat contradictory, but in the end, based on the facts established by the court, they accepted the defence of necessity.⁵²

However confusing it might have been, it set the precedent for future cases based on similar circumstances.

⁴⁹ Botha, C (2012) *Statutory Interpretation: An Introduction for Students*: 173. In South African terms the court interpreted the provision extensively, meaning the opposite of restrictive interpretation. The objective of the provision was broader than the textual meaning and the court widened the meaning to give effect to the purpose. In *Ex parte Dow 1987 (3) S.A. 829 (D)* the court also used this method of interpretation and found that the word "in" merely served to prevent clandestine marriages.

⁵⁰ Based on the *boni mores* the act is acceptable and therefore lawful.

⁵¹ *Compulsion*, footnote 42 *supra*. Article 40 of the Criminal Code states that a person is not criminally liable if he commits an offence due to a force he could not be expected to resist. This "*overmacht*" can be divided into two separate forms, the first being comparable to duress and the second necessity. The latter was the focus of the defendant's argument.

⁵² Further reading on this particular subject is encouraged, as argued by Griffiths in Griffiths (1998): 326 – 328.

4.2 CHABOT⁵³

Facts:

The defendant was a psychiatrist who had supplied his patient, Ms. B, with lethal medication, knowing she would use it to end her life.

After her two children's deaths and her divorce, the thought of suicide had come to dominate her mind and she attempted, but failed, to commit suicide. She was terrified of a second failure which would have her committed to a mental institution and/or leave her severely disabled.

She had no somatic illness and her pain was purely psychological. According to the defendant he had diagnosed her with an adjustment disorder "*consisting of a depressed mood, without psychotic signs, in the context of a complicated bereavement process.*"⁵⁴ He had only assisted her because there was no "*concrete treatment perspective*" and he was afraid she would not relent and continue to use increasingly violent means to commit suicide.

Decision:

The defendant relied on a defence of necessity. The test for necessity as the court applied it required the defendant to choose between two conflicting duties and in the end to choose the one with greater weight. In these circumstances the two duties would be that of preserving life and relieving unbearable pain.

The Court of Appeals found the defence on *necessity* well-founded and the defendant's only oversight to be that the consulted experts had not examined the patient personally.⁵⁵ They further stated that "unbearable suffering" need not be physical and the patient should simply be experiencing pain and loss of bodily functions. This ruling

⁵³ *Chabot*, footnote 45 *supra*. Griffiths (1998): 329 - 340.

⁵⁴ According to the Diagnostic and Statistical Manual for Mental Disorders, 3rd edition.

⁵⁵ These experts allegedly included 4 psychiatrists, a clinical psychologist, a GP and a professor of ethics.

opened the floodgates for patients with non-somatic illnesses to ask for assistance to commit suicide.

In hindsight, these rulings should have been an omen that the acceptance of assisted dying was escalating and becoming more liberal.

4.3 KADIJK⁵⁶

Facts:

The Defendant had assisted in the termination of an infant's life. The baby had been born with a chromosomal defect trisomy-13. This defect led to difficulty to breathe, eat and later developed to a consistent state of pain. All the physicians who had examined her concurred that she had a very short time to live and death was inevitable.

The defendant was requested by the parents if he would be willing to end the baby's life in order to end her suffering. He stated that he was and approached the local prosecutorial authority for more information on the subject and possible consequences.

The baby's life was ended on 26 April 1994 at 10 'o clock, while she was being held by her mother.

Decision:

The defendant was acquitted, even though his conduct satisfied the technical requirements of "murder". The court was, however, satisfied that the defendant's conduct in the circumstances were justifiable on the grounds of necessity. They took into account the facts that there was no doubt as to the prognosis of the baby, the physician had consulted with other physicians whom all agreed and active termination was only considered when the parents had requested it as a last resort.

⁵⁶ *Kadijk*, footnote 45 *supra*. Griffiths (1998): 341 - 351.

By interpreting the Criminal Code articles as they did, the three above cases created the precedents necessary for changes to be made. One of these changes consisted of the *rules of due care*.

5 PROSECUTORIAL POLICY

The Public Prosecution Service had adopted the policy not to instigate proceedings against a physician who had reported themselves after performing euthanasia and had met certain criteria that required special attention.⁵⁷ These criteria mostly correspond with what is now referred to as *rules of due care*.⁵⁸

The Rotterdam Court, in 1981,⁵⁹ set out the guidelines which is the foundation of the *rules of due care* in article 2 of the Termination of Life Act. These guidelines were formally accepted by the Royal Dutch Medical Association in 1998 and can be summed up as follow:⁶⁰

- a. *“The physician must be convinced the patient's request is voluntary and well-considered.*
- b. *The physician must be convinced the patient is facing unremitting and unbearable suffering.*
- c. *The patient does not have to be terminally ill. The patient must have a correct and clear understanding of his situation and prognosis.*

⁵⁷ Van der Maas, PJ, Van der Wal, G, *et al.* (1996) “Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands” *The New England Journal of Medicine* Volume (355): 1699. These included a checklist regarding the patient’s medical history, request, the medication used and another physician’s report. They also had to report the death to the coroner and was not allowed to classify it as a natural death, but as a physician-assisted death.

⁵⁸ See paragraph 6 “Current Legislation” below.

⁵⁹ Gomez C (1991) “Regulating Death” *New York: Free Press*: 32.

⁶⁰ Richbug K (2000) “Dutch Euthanasia Law Guidelines” *The World Federation of Right to Die Societies* available online at www.worldrtd.net/dutch-euthanasia-law-guidelines Accessed 2017/08/03.

- d. *The physician must reach the conclusion, together with the patient, that there is no reasonable alternative that is acceptable to the patient. The decision to die must be the patient's own.*
- e. *The physician must consult at least one other independent doctor who has examined the patient.*
- f. *The physician must carry out the termination of life in a medically appropriate manner.”*

Even though euthanasia and assisted dying was still technically illegal, prosecutors stopped prosecuting physicians as long they had satisfied all the above requirements. It will be seen below that these are in essence the same as what was eventually formally adopted by the Termination of Life Act.⁶¹

6 CURRENT LEGISLATION

It is interesting to note that according to Dutch law it is still illegal to terminate the life of a person due to the deceased's express wishes. This means that saying euthanasia or physician-assisted suicide is “legal” in the Netherlands is a misnomer. It has merely been *decriminalized* by article 293(2) of the Criminal Code, which is also the most significant material change to this Act. Decriminalizing, as opposed to legalizing, means that the act is still a crime, but the person who assists in the suicide cannot be prosecuted by the relevant authorities provided they satisfy all the necessary requirements⁶² in article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. The requirements are as follow:

“The requirements of due care, referred to in article 293 second paragraph Penal Code mean that the physician:

⁶¹ See point (a) – (f) in paragraph 6 “Current Legislation” below.

⁶² Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 1 April 2002. Hereafter in Part B the Termination of Life Act.

- a. *holds the conviction that the request by the patient was voluntary and well-considered,*
- b. *holds the conviction that the patient's suffering was lasting and unbearable,*
- c. *has informed the patient about the situation he was in and about his prospects,*
- d. *and the patient hold the conviction that there was no other reasonable solution for the situation he was in,*
- e. *he has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a - d, and*
- f. *has terminated a life or assisted in a suicide with due care.”*

Along with these requirements the acting physician has to notify certain parties, such as the prosecuting authorities, who then have the discretion to investigate the conduct of the physician.

However thorough legislation may seem, strict requirements will inevitably become guidelines and eventually decline to mere suggestions. Human nature guarantees this and it will become apparent when examining the current practice of assisted dying.

7 IN PRACTICE

The Termination of Life Act came into effect in 2002. This is a good thing for South Africa since it provides us with more than a decade of data to analyse without having to do a lot of guesswork. This, together with the practice starting in the 1980's, provides a long enough timeline for one to investigate possible short-, medium- and long term consequences.

Statistics indicate that although there has annually been an increase in the use of euthanasia since the Act came into effect, the increase itself has been slowing down

and it is suspected that a decrease in its use is inevitable.⁶³ Another interesting statistic from the same report indicates that 99.93% of all euthanasia cases comply with all the legal requirements. However, this could be misleading since a study conducted in 2012 claimed that 23% of all euthanasia cases are not reported as they should be.⁶⁴ This could indicate that some predictions against assisted dying may have some merit.

One of the most common arguments against the practice of euthanasia and assisted suicide is that of the slippery slope; meaning it would inevitably lead to abuse and misuse with a less stringent approach to the requirements.⁶⁵ Advocates in the Netherlands claim that this is not a problem as long as the safeguards in place are met, but it is hard to argue with statistics indicating otherwise.⁶⁶ This drastic increase seems to be due to the allowance of mentally ill, physically disabled and elderly people to undergo euthanasia or assisted suicide without them meeting all the relevant criteria, such as unbearable pain.

Many of the studies show different interpretations of the data available, but there seems to be a general consensus that:

- 1) There is a definite increase in the annual euthanasia and assisted suicide cases;
- 2) More or less 23% of these cases go unreported;

⁶³ Dying for Choice (2016) "Netherlands – 2015 euthanasia report card" available online at www.dyingforchoice.com/resources/fact-files/netherlands-2015-euthanasia-report-card. Accessed 2017/04/24.

⁶⁴ Life Site (2012) "Euthanasia is out of control in the Netherlands – New Dutch Statistics" available online at www.lifesitenews.com/blogs/euthanasia-is-out-of-control-in-the-netherlands-new-dutch-statistics. Accessed 2017/04/24.

⁶⁵ This argument states that legal exceptions are followed by more exceptions to the law up to the point where what has become common practice would not initially have been acceptable.

Pereira J (2011) "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls" *Current Oncology* Volume (18): e38 – e48.

⁶⁶ Life Site (2016) "Dutch euthanasia deaths up again in 2015: jumped 50% in five years" available online at www.lifesitenews.com/news/dutch-euthanasia-deaths-up-again-in-2015-jumped-50-in-five-years. Accessed 2017/04/24.

- 3) Not all the patients who undergo euthanasia or assisted suicide used it as a last resort; and
- 4) There has been an increase in the allowance of mentally ill, physically disabled and elderly people to undergo assisted dying with less strict adherence to the criteria set by law, although many cases are justified for numerous medical reasons, some reasons are allegedly cited as “loneliness,” “tired of living” and “not wishing to be a burden on family.” This is clearly unacceptable.

Adjusting these statistics to accommodate South Africa’s massive population would indicate staggering amounts of assisted death, and inevitably, abuse. Ideally the available data and its conclusions should be applied in order to try and pre-empt some of the less favourable consequences inherent in such changes.

In theory the codification of the practice of euthanasia and assisted suicide in the Netherlands should have been sufficient to prevent abuse and misuse, but human nature would not allow an indefinite, strict adherence to the law and the practice has since become careless. The fact that it is considered, and also informally accepted, to extend the practice to parties such as infants born with disabilities and the mentally ill should be a strong indication that the enforcement of the rules has to be revisited and become a high priority. This could potentially involve being more strict when investigating possible cases of non-adherence.

If a first-world country such as the Netherlands cannot maintain the healthcare services required by those citizens who need it most, it cannot be expected for a country such as South Africa which has neither the resources nor the infrastructure to do so.

8 CRITIQUE

Clearly there are cases where psychological suffering is on the same level or even worse than any form of physical suffering borne from a terminal illness. But

unfortunately it is, at least currently, impossible to determine with absolute certainty whether a person who is severely clinically depressed is untreatable. And naturally the will to die might be a direct result of the mental state of anguish. It seems there are three paths to take: first, mental illnesses should be treated the same as any somatic illness which causes great physical pain and discomfort, and therefore patients should also have the option of assisted dying. Second, more research should be done on treating mental illnesses or at least determining the scope of the illness with greater accuracy, but not making assisted dying an option and make treatment the only option available. Last, do nothing, which would move some people to take drastic measures in order to opt out. The options are either impractical, cruel or both.

Severe penalties for not adhering to the Criminal Penal Code and/or not meeting all the relevant requirements should be imposed and executed. The last thing any advocate for assisted dying is to have to admit that the slippery slope argument was right all along.

However, if South Africa truly wants to make an informed decision, all possibilities and available information, good and bad, should be examined. There are countless studies and data available in different formats that can and should be analysed before any kind of decision is made. Some practical lessons that can be taken away from a rudimentary study is discussed below, and South Africa would do well to heed these lessons.

9 LESSONS FOR SOUTH AFRICA

If South Africa were ever to adopt this practice it should only be available to citizens of the Republic. Along with all the requirements the Dutch have, some form of written consent/agreement should be signed by the patient. If this is not possible then perhaps a recording of the patient consenting to and/or the procedure being carried out. This is to at least make sure it was voluntary and provide material which can be reviewed afterwards. An independent physician and psychologist should *always* perform their own examination of the patient's health and/or mental state and provide a report on the

possible alternatives to assisted dying or agree that it is the only sound and reasonable choice to make.

Proper training with regards to palliative and end-of-life care should become a high priority in all medical care centres. Not only should this be of the highest possible standard, it should also be available to all people. Living without pain should not be a luxury reserved for the financial elite and this is an ideal to be strived towards. However, currently this is a naively optimistic demand to place on the State, but it should not prevent people from fighting for it.

10 CONCLUSION

The Netherlands, being one of the countries with the oldest legislation on this subject, should be examined and scrutinized. But ultimately, South Africa cannot plagiarize another country's legislation on any matter due to factors such as demographics, culture, traditions, religion and *boni mores* and many more. All we can do is learn from their mistakes and attempt not to repeat them. Successful legislation can be used as a guideline to create our own, tailor-made act, which should provide for our own, culturally unique circumstances.

PART C

UNITED STATES OF AMERICA

1 INTRODUCTION

There are several States whom have accepted the practice of assisted dying in the last few years.⁶⁷ The discussion in this section will focus on the state of Oregon, since the Oregon Death with Dignity Act⁶⁸ is the oldest. But all the states' legislation are more or less similar. However, specific mention will be made if any of the other states have a relevant and different approach.

Oregonian legislation refers to "physician-assisted suicide," however in this context it only makes provision for the physician to prescribe medication, which the patient has to be able to ingest themselves. The physician is not allowed to take more direct action than this. In other words active euthanasia is still illegal and it does not seem that this position will change in the foreseeable future, through legislation or otherwise.

2 LEGISLATION

For purposes of this section the focus will be on the state of Oregon, as their legislation on the matter is the oldest and to take all states into account would needlessly complicate the discussion. Section 163.005(1) of the Oregon Revised Statutes of 2015⁶⁹

⁶⁷ Washington, Oregon, California, Colorado and Vermont have legislation for assisted dying. Montana allows the practice through the court's decision in *Baxter v. Montana*.

⁶⁸ This is found in the Oregon Revised Statutes 127.800 to 127.900, but is commonly referred to as the Oregon Death with Dignity Act.

Hereafter in Part C referred to as the "DWDA".

⁶⁹ Hereafter in Part C referred to as "2015 ORS".

defines criminal homicide⁷⁰ as “... *without justification or excuse, the person intentionally, knowingly, recklessly or with criminal negligence causes the death of another human being.*”

Assistance to commit suicide is also a crime in terms of section 163.193(1) of the 2015 ORS. This section states “*a person commits the crime of assisting another person to commit suicide if the person knowingly sells, or otherwise transfers for consideration, any substance or object, that is capable of causing death, to another person for the purpose of assisting the other person to commit suicide.*” However, this does not include a person acting within the parameters of the DWDA, which provide for certain qualifications for lawful assisted dying. To qualify a patient⁷¹ must be –

1. A resident of the State in which she wishes the procedure to be performed.
2. A major person – in other words, 18 years or older.
3. Mentally competent and capable of making and communicating decisions about her health care.
4. Terminally ill and expected to die within six months based on sound medical judgment.
5. Able to self-administer the medication.

⁷⁰ “Criminal homicide” is the umbrella term used to include all forms of unlawful killing and also the equivalent for South African “murder”.

⁷¹ This is a simplified version of the legislation provided by the organization, Death with Dignity in the USA. This is a non-profit organization dedicated to the promotion of assisted dying laws and the development of end-of-life care. The organization’s objective is to advocate for the adoption of similar legislation in as many states as possible based on the framework of the DWDA.

Death with Dignity (2017) “How to Access and Use Death with Dignity Laws” *Death with Dignity* available online at www.deathwithdignity.org/learn/access/#Going_Through_the_Process_of_Obtaining_Medications. Accessed 2017/09/05.

Furthermore, a person will not be allowed to apply for physician-assisted death if any of the above requirements are not met and at least two physicians have confirmed this. Also a person will not be allowed to make use of the legislation should their sole motivation be age or disability.⁷² This is because the patients have to be deemed to be “terminal” for purposes of the DWDA, meaning their death should be reasonably expected to happen within six months of the request. This indicates a willingness to accept controversial ideas, but would still rather err on the side of caution. In contrast, the approach to physical and mental disabilities are more conservative. These disabilities disqualify a person from using the legislation,⁷³ unlike the Netherlands and possibly Canada.

3 CRITIQUE

Unlike in the Netherlands intolerable suffering is not a requirement for the DWDA and research indicates that the most common reasons for applying for assisted dying are loss of dignity, autonomy and no longer being able to participate in enjoyable activities.⁷⁴ Another concern is that even though legislation requires a physician to inform a patient of potential palliative care options, it does not require any of the participating physicians to be an expert in the field.⁷⁵

⁷² Section 2.01(2) of the DWDA.

⁷³ A person with physical disabilities could still apply for the procedure, provided all the other requirements have been met.

⁷⁴ Cavalo J (2017) “Examining the impact of ‘Death with Dignity’ Legislation: A Conversation with Charles D. Blanke, MD, FACP, FASCO” *The ASCO Post* available at www.ascopost.com/issues/march-25-2017/examining-the-impact-of-death-with-dignity-legislation. Accessed 2017/09/05.

⁷⁵ Ganzini L (2016) “Legal Physician-Assisted Death in Oregon” *QUT Law Review* Volume (16): 76 – 83.

A physician who is not up to date with the latest advances in palliative care and procedures could ignorantly lead a patient to believe that palliative care would be less effective than it would be in reality. At the very least the patient should be referred to an expert if the physician unable to inform the patient thoroughly.

The requirement that the patient should be expected to die within six months of the request is also unreliable. Research shows that many patients who receive prescriptions outlive the predicted six months, which indicates that the physicians' judgment is not an accurate indicator for the future.⁷⁶

These concerns with the legislation should give South Africa insight into problems that are likely to crop up and help any legislator to anticipate them and provide potential solutions.⁷⁷

4 LESSONS FOR SOUTH AFRICA

In the opinion of the author one of the most important lessons to be learned from the USA on the topic is arguably the importance of end-of-life-care. This includes proper training in the latest medical advances, facilities and research in order to improve the overall standard in South African hospitals and hospices. If affordable and state-of-the-art palliative care is available to anyone seeking assisted dying, then the applicants would be limited to patients who have exhausted palliative care as an alternative and are now seeking assisted dying as a last resort. The consulting physician should also be an expert in the field of whatever illness the patient has. It would not be appropriate to have a paediatrician to deliver a prognosis on a cancer patient.

Also, intolerable suffering should be included and expressly stated whether it only provides for physical pain or mental anguish as well. If "intolerable suffering" is not a requirement for application then it could widen the scope to people who are physically disabled, but not terminal, as someone could then cite "tiredness of life" as a valid reason for applying.

⁷⁶ Ganzini L (2016): 81.

⁷⁷ For example that time limits are not a reliable requirement and this limits the application of such legislation to people who are terminally ill – which was the objective of the DWDA. However, if physically disabled people are to be included, then a time limit would effectively exclude them from the scope of the legislation.

5 CONCLUSION

Even though their legal system is fundamentally different from South Africa's, all the states that legally allow assisted dying, especially Oregon, should be properly researched. They possess both a proper length of time and research⁷⁸ during this period, which would be invaluable as empirical data, enabling South Africa to make accurate predictions, despite the differences in demographics. And similar to South Africa, the USA has a very diverse population in terms of race, culture and religion which would make any research more applicable for South Africa's purposes.

All of the previously mentioned jurisdictions had pro-assisted dying legislation. In order to gain a better understanding all arguments have to be considered. The most applicable jurisdiction to South Africa which is against assisted dying is England and Wales and their arguments for not allowing the practice must also be analysed.

⁷⁸ Further reading is encouraged at Death with Dignity (2017) "For Researchers" *Death with Dignity* available at www.deathwithdignity.org/learn/researchers. Accessed 2017/09/06.

PART D

ENGLAND & WALES

1 INTRODUCTION

South Africa's history is full of English influence and the law is no different. It played a significant part in the development of our common law and how we interpret some principles still used today.⁷⁹ It has been established that English and Welsh law⁸⁰ refuses to allow any form of assisted dying.⁸¹ However, it has been challenged numerous times and this part of the discussion will focus on the reason those challenges failed.

2 LEGISLATION

2.1 Suicide Act of 1961

Prior to this act suicide was a crime in England and Wales, but this was changed with the adoption of the Suicide Act.⁸² Yet conduct that leads to another person committing suicide has been formally criminalized by the following section:

Section 2: Criminal liability for complicity in another's suicide.

“(1) A person (D) commits an offence if -

⁷⁹ See Chapter 2: The History and Development of Murder in South African Criminal Law.

⁸⁰ England and Wales has the same legal system, so when the author speaks about “English law” it is implied that Wales is included.

⁸¹ Suicide Act of 1961.

R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) (Respondent) v The Director of Public Prosecutions (Appellant) [2014] UKSC 38 On appeal from [2013] EWCA Civ 961.

⁸² Section 1 of the Suicide Act.

(a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and

(b) D's act was intended to encourage or assist suicide or an attempt at suicide.

...

(4) [N]o proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions."

Thus, unlike South Africa, England has an Act that explicitly criminalizes assistance to commit suicide. However, there is no legislation that provides for a justification in certain circumstances. There was an attempt by Lord Falconer to provide one, but unfortunately it was unsuccessful and voted down in 2015.

2.2 LORD FALCONER'S ASSISTED DYING BILL⁸³

The proposed Assisted Dying Bill was based on the Oregon Death with Dignity Act.⁸⁴ According to this Bill⁸⁵ a person would be able to apply for assistance to commit suicide if they were (1) a mentally competent adult and resident of England or Wales for the past year. (2) The patient would have to be able to self-administer the lethal medication, which the physician would provide. (3) Furthermore, the patient should be terminally ill and reasonably expected to die – in other words, within six months after the request has been made. (4) Lastly, the patient would have to provide a written statement, also signed by two physicians, confirming that all the requirements have been met.

⁸³ Hereafter in Part D referred to as the "Bill".

It must be noted that a similar draft bill was given to parliament to consider by Lord Rob Morris in 2015. This draft was based on Lord Falconer's Bill and the principles thereof and critique against it are the same. Therefore only Lord Falconer's Bill will be discussed in this dissertation.

⁸⁴ Dignity in Dying (2014) "Lord Falconer's Assisted Dying Bill (2014)" *Campaign for Dignity in Dying* available at www.dignityindying.org.uk/assisted-dying/the-law/lord-falconers-assisted-dying-bill-2014. Accessed on 2017/09/12.

⁸⁵ Care Not Killing (2015) "Lord Falconer's Assisted Dying Bill" Care Not Killing available at www.carenotkilling.org.uk/public/pdf/falconer-bill---overview,-arguments,-problems.pdf. Accessed on 2017/09/12.

Not adhering to these requirements would result in prosecution in terms of the Suicide Act. These requirements were heavily criticized⁸⁶ and the Bill was ultimately voted down by parliament. One of the main, and expected, reasons for not legalizing assisted dying is the protection of vulnerable persons. The organization, *Care Not Killing*, contends that a right to die will inevitably become a duty to die and most applicants would only make use of the Bill in order to avoid becoming a burden on family members.⁸⁷ Their arguments are based on the premise that the law should not be changed to accommodate a few individuals and possibly endanger a lot more. In other words, the loss of the right to dignity of a few individuals is an acceptable restriction if it protects other vulnerable parties.

The article specifically critiques Lord Falconer's Bill on the vagueness of several phrases,⁸⁸ stating "*terminal illness*", "*mental capacity*" and "*clear and settled wish*" are hard to determine with certainty even by experts. This uncertainty will ultimately lead to more extreme cases being included in the participation of the practice⁸⁹ and to limit it to certain categories of people will make the Bill automatically discriminatory.

This stance is hypocritical since they can accept the restriction on individuals' right to dignity, but to restrict the use of this Bill to mentally competent people or people capable of self-administering the medication would be discriminatory.⁹⁰ However, even such arguments and "soft reasons" must be taken into account when creating such a piece of legislation.

Lord Falconer's Bill would only have allowed people to die by self-administering the medication, which naturally excludes any person disabled to such a point that they cannot even take their own lives, such as Tony Nicklinson.

⁸⁶ Care Not Killing (2015) online.

⁸⁷ Care Not Killing (2015) online.

⁸⁸ Care Not Killing (2015) online.

⁸⁹ The classic "slippery slope" argument.

⁹⁰ They would like the reader to think that within a short time of amending the law, all disabled and elderly people will be marched off to gas chambers, such as in Nazi Germany.

3 CASE LAW

Tony Nicklinson was paralyzed from the neck down after suffering a severe stroke in 2005 and was unable to do anything for himself. Despite his condition he was considered to be “healthy” and expected to live for several years. He was given leave by the court to apply for a declaration stating a doctor may assist him to commit suicide based on the grounds of necessity,⁹¹ or alternatively that section 2 of the Suicide Act and his right to private life in terms of the European Convention for the Protection of Human Rights and Fundamental Freedoms⁹² were contradictory. The defence of necessity would only be available if –

- a) It has been confirmed that the defence will be applicable on the facts of the case;
- b) The patient is suffering from a medical condition with no available alternatives for alleviation and has made a “*voluntary, clear, settled and informed*” decision to end his life; and
- c) The physician who is to perform the procedure is satisfied that the duty to respect the patient’s autonomy outweighs the duty to protect and preserve life.

⁹¹ Stephen J (1883) *The History of the Criminal Law of England*.

In English Law the defence of necessity is rarely successful and according to Sir James Stephen there are four requirements:

1. There were no alternatives available to avoid the consequence;
2. The consequence was an inevitable and irreparable evil;
3. No more was done than reasonably necessary to avoid the evil; and
4. The lesser crime committed was not disproportionate to the consequence avoided.

⁹² Hereafter referred to as the “Convention”. Article 8 of the Convention reads as follows:

“Right to respect for private and family life

1. *Everyone has the right to respect for his private and family life, his home and his correspondence.*
2. *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”*

Unfortunately the Divisional Court rejected both of his applications and Nicklinson died of pneumonia a week later after refusing all foods, fluids and medical treatment. Lords Dyson and Elias LJ of the Court of Appeal stated that to allow the doctrine of necessity to succeed in some circumstances of assisted suicide would be incompatible with legislation and recent judicial decisions.⁹³ After his death his wife continued with the application and the Supreme Court stated that it would be more appropriate for parliament to deal with the issue and that a “blanket ban” on assisted suicide is not incompatible with article 8 of the Convention.⁹⁴

4 CRITIQUE⁹⁵

According to section 2(4) of the Suicide Act a person cannot be charged under this act without permission from the Director of Public Prosecutions. However, the Suicide Act does not state which criteria will be considered when deciding whether to prosecute a person who assists someone to commit suicide.⁹⁶ This uncertainty was challenged in the cases of *Pretty*⁹⁷ and *Purdy*⁹⁸ respectively, but only the latter’s appeal was

⁹³ *Nicklinson* footnote 81 *supra*, paragraph 130.

⁹⁴ *Nicklinson* footnote 81 *supra*, Lord Neuberger at paragraph 148.

⁹⁵ See Part C: United States of America, paragraph 3 “Critique” above. As Lord Falconer’s Bill is based on Oregon’s Death With Dignity Act the critique against them are naturally the same. Therefore it will not be discussed again here.

⁹⁶ The most common scenario was the prosecution of family members who helped a person to travel to Switzerland in order the commit suicide at one of the infamous “suicide clinics”. This was the circumstances in both *Pretty* and *Purdy*, below.

⁹⁷ *R (on the application of Pretty) v Director of Public Prosecutions* [2002] 1 All ER 1.

⁹⁸ *R (on the application of Purdy) v Director of Public Prosecutions* [2009] 4 All ER 1147.

successful. Purdy wished for the Director of Public Prosecutions to establish a policy⁹⁹ for guidelines with regards to the application of section 2(4).¹⁰⁰

The problem with the above approach is that it does not stop people from committing suicide. It merely limits the safe – and unlikely to be prosecuted – alternatives available to the people who are financially capable.¹⁰¹ Everyone else should continue to suffer or consider more violent means of committing suicide. In South Africa the majority of people would fall in the latter category.

5 LESSONS FOR SOUTH AFRICA

The fact that people are still committing suicide despite the criminalization of active euthanasia and physician-assisted suicide indicates that there is a definite demand for such a procedure. People will always find a way around legislation, however a more desperate person would consider frightening alternatives. But it must be kept in mind that the mere existence of the crime does not mean it will always lead to prosecution as it will depend on the discretion of the prosecutor whether to charge the physician.

This prosecutorial policy is similar to South Africa's unofficial position regarding the *double effect*,¹⁰² wherein a physician is not charged with murder if death occurs as an unfortunate side-effect of pain relieving medication. Thus, South Africa must also adopt

⁹⁹ The Crown Prosecution Service (2014) "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" *The Crown Prosecution Service* available online at www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html. Accessed 2017/05/10.

¹⁰⁰ As opposed to *Pretty* who applied for her husband's immunity from prosecution if he assisted her to travel to Switzerland in order to commit suicide at a Dignitas clinic.

¹⁰¹ Such as travelling to Switzerland.

¹⁰² See Chapter 3: The Criminality of Assisted Dying in South Africa at paragraph 4.3.3.2 "The Double Effect".

Although, in England this policy is primarily applied when a family assists a person to travel to another jurisdiction in order to commit suicide. Whereas in South Africa the circumstances surrounding the *double effect* happen much more often.

This is also similar to The Netherlands' initial approach to the problem. See Part B: The Netherlands, paragraph 5 "Prosecutorial Policy" above.

a prosecutorial policy concerning assisted dying in order to provide clarity if no legislation is to be adopted.

6 CONCLUSION

Criminalizing assisted dying definitely has an effect on the number of assisted deaths that occur. However, this number could be misleading as some cases are probably not reported. Taking into account their meagre 243 assisted deaths at Dignitas over the last 11 years,¹⁰³ not one family member has been charged with assisting a loved one to commit suicide in England. It is clear that the Suicide Act is merely a deterrent, but it is strange that it has never been used.¹⁰⁴

It would seem that England has found a comfortable spot on the high road from where they can deny their citizens the liberty of dying in the comfort of their own home, but do not oppose them from seeking it in other countries. As stated earlier, this is discriminatory as only a small number of citizens would then be able to have the procedure performed.

¹⁰³ Care Not Killing (2015) online. In their booklet they cite the few cases of “suicide tourism” that happen in England as opposed to the number of assisted deaths which happen in The Netherlands and Belgium.

¹⁰⁴ Most likely because people travel abroad to die.

CHAPTER 5

THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA¹

1 INTRODUCTION

The medical profession is regulated by legislation, subject to the Constitution of the Republic of South Africa and applicable common law principles. In terms of the HPCSA the relevant act is the Health Professions Act,² which establishes the HPCSA.³ Together with the Act the HPCSA regulates the medical profession and this chapter will focus specifically on their disciplinary function in cases of unprofessional conduct. The HPCSA is “...ultimately responsible to ensure quality health standards for all South African citizens, to protect the public and to guide the medical profession,”⁴ and this chapter will seek to determine whether assisted dying is plausible within the parameters of these objectives.

First it has to be established what is considered to be “unprofessional conduct” and what authority the HPCSA has in such matters.

¹ Hereafter referred to as the “HPCSA”.

² 56 of 1974 as amended by Act 89 of 1997. Hereafter, and only for this chapter, referred to as the “HPA”.

³ Section 2(1) of the HPA, “There is hereby established a juristic person to be known as the Health Professions Council of South Africa...”

⁴ Carstens P & Pearmain D (2007) *Foundational Principles of South African Medical Law*: 251.

2 UNPROFESSIONAL CONDUCT

The HPA defines unprofessional conduct as “*improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy.*”⁵ This is a very ambiguous – and possibly problematic – definition. But Taitz⁶ stated that “improper or disgraceful conduct” would fall into at least one of four categories, such as they are:

a) Medical malpractice;

This is medical treatment which could be considered negligent, improper or against tenets of good medical practice, which would typically include experimental or unlawful medical procedures.

b) Improper or disgraceful behaviour concerning patients;

Examples of this would include breach of doctor-patient-confidentiality or improper relationships with patients.

c) Improper or disgraceful conduct concerning fellow practitioners; or

Intentionally taking another physician’s patients, touting or discussing colleagues with a third party in a defamatory manner.

d) Other improper or disgraceful conduct unbecoming to a medical practitioner.

This includes any other conduct not directly associated with the medical profession, such as conviction for a common law or statutory crime, for example murder or rape.

⁵ Section 1 of the HPA.

Further reading on what is considered “unprofessional conduct” is encouraged in Carstens footnote 4 *supra*: 262 – 264.

⁶ Taitz J (1998) “The Disciplinary Powers of the South African Medical and Dental Council” *Acta Juridica*: 46.

For purposes of this dissertation numbers (a) and (d) above are the most relevant as assisted dying could constitute medical malpractice – an unlawful medical procedure, such as active euthanasia or physician-assisted suicide – which would lead to a conviction for the common law crime of murder. The questions at hand are what the HPCSA’s authority is in a case of assisted dying, the consequences it could hold for the physician, and if and how this would change should assisted dying become lawful.

3 DISCIPLINARY POWERS OF THE HPCSA

How the law currently stands is thus: a physician can be investigated and tried for unprofessional conduct by a professional board for medical and dental practitioners with authority provided by the HPA. If a person is found guilty for unprofessional conduct then one or more of the following penalties can be imposed:⁷

- a) A caution or reprimand and a caution;
- b) A suspension for a specified period from practising;
- c) Removal of his name from the register;
- d) A fine;
- e) A compulsory period of professional service;
- f) The payment of the costs of the proceedings or a restitution or both.

Removal from the register will mean that a person who was registered in terms of the HPA can no longer lawfully practice that profession. Thus, a person would not necessarily receive a punishment in terms of law, but could receive a penalty from the board due to a conviction from a court of law. This is exactly what happened in the case

⁷ Section 42(1) (a) – (f) of the HPA.

of *Hartmann*⁸ who, for all practical purposes, received no legal punishment, but was struck from the register and could no longer practice as a physician.

If prosecutorial policy becomes similar to that of the Netherlands⁹ before adopting legislation, meaning deciding not to prosecute physicians under certain circumstances of assisted dying, then the board could still find the physician guilty of unprofessional conduct and impose a penalty. The other option is to adopt legislation on the matter, which would preclude the criminal prosecution of physicians under certain circumstances. However, it should be stated that the HPCSA could possibly still institute disciplinary proceedings against a physician, as these are civil proceedings and are not automatically unavailable when *criminal liability* is excluded. These matters will have to be decided on an *ad hoc* basis on their unique circumstances, although it might be difficult to interpret this procedure to fall within the interpretation of “unprofessional conduct”. Be that as it may, the HPCSA could be prevented from their own disciplinary proceedings if the adopted legislation explicitly excludes said conduct from the definition of “unprofessional conduct” as meant in the HPA.¹⁰ As a statutory being, the HPCSA would be subject to the Constitution and by extension the new legislation.

Until new legislation is adopted on the matter, it would fall to the legal and medical practitioners to interpret the law as it stands, while doing what is best for the patient and also for the future of the medical profession.

4 THE BEST INTERESTS OF THE PATIENT

Ethical considerations when discussing medicine and law is necessary, but also virtually unending. The following section will take into account the “soft law” regarding the matter, such as the various ethical guidelines where it is not regulated by law. Notwithstanding its relevance, the discussion will be limited to the ambit of the

⁸ *S v Hartmann* 1975 (3) SA 532 (C). See the full discussion on this case in the chapter on “South Africa”.

⁹ See the chapter on “Foreign Jurisdictions: The Netherlands”.

¹⁰ See Chapter 6: Recommendations.

dissertation's main objective. With this in mind, the "best interests" of the patient is a subjective concept and will be different depending on the patient and the unique circumstances, thus they are established via guidelines.

The HPCSA provides booklets on the guidelines of certain matters - such as good practice, informed consent and withdrawing treatment just to name a few - on their website.¹¹ As the name suggests these are merely guidelines and not fast rules, however non-compliance in certain instances could lead to disciplinary proceedings against the practitioner if he acted without sufficient justification. The Guide to Good Practice booklet¹² specifically refers to *non-maleficence*¹³ and *beneficence*,¹⁴ both of which specifically refers to the "best interest" of the patient. The difference between these two definitions is a subtle one: the physician is not allowed to act *against* the best interests and must act *in* the best interests of the patient. This could be interpreted to mean the physician may not obstruct these interests, but must also seek to actively achieve them. Most of the time the same conduct would fall within the ambit of both definitions as not *actively promoting* the interest could be deemed to *obstruct* the achievement thereof. But it does not state what the best interests are.

It would seem that the ethical dilemma lies within the interpretation of the "best interest" of the patient. In the booklet on informed consent¹⁵ the HPCSA provides criteria the

¹¹ The Health Professions Council of South Africa "Professional Conduct and Ethics" available online at www.hpcs.co.za/Conduct/Ethics. Accessed 27/09/2017.

¹² Health Professions Council of South Africa (2016) *Guidelines for Good Practice in the Healthcare Professions* (1): 2.

¹³ "Healthcare practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest." Own emphasis added.

¹⁴ "Healthcare practitioners should act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest." Own emphasis added.

¹⁵ Health Professions Council of South Africa (2016) *Seeking Patient's Informed Consent: The Ethical Considerations* (4): 11.

The factors that should be taken into account are:

1. Whether options for investigation or treatment are clinically indicated;
2. Advance statements by the patient;
3. The patient's background, such as culture, religion and employment;

physician must take into account to establish the best interest where a patient lacks the capacity to make a decision. These are, however, a far cry from what is necessary where a patient does have capacity. What should be considered is if it could be in the best interest of the patient to die.¹⁶

The best interest of the patient would depend on the circumstances, for example with a simple disease the best interest would be to cure it. However, with terminal diseases or those that have progressed beyond medical intervention, the best interest would shift to palliative care. Thus, it is conceivable that there is another stage beyond that of palliative care, where medical intervention cannot cure a disease and also cannot provide comfort to the patient without robbing her of her awareness and appreciation of her surroundings.¹⁷

Unfortunately this discussion will entail research into other disciplines and will not provide a satisfactory answer in any case. The legal problem at hand is whether this conduct could become lawful and the answer would render the discussion on ethics, for purposes of this dissertation at least, moot. Even if the practice should become lawful, a physician would still be allowed to refuse to perform the procedure based on any number of factors, thus the question of ethics will need to be answered by the physician personally.

5 RECOMMENDATIONS

It would seem that, in accordance with recommendations made in prior chapters, the most effective answer to assisted dying in law would be to adopt legislation on the matter. In doing so the problem of “unlawfulness” would be solved and practitioners

-
4. Whether a third party may shed light on the patient’s wishes;
 5. Where more than one option is available, which option restricts the patient’s future the least.

¹⁶ Assuming all other requirements have been met. See the chapter on “Recommendations”.

¹⁷ Continual administering of certain medicines could lead to death as a secondary effect, while pain is being treated. See the discussion on “The Double Effect” in the chapter on “South Africa”.

would be safe from other possible consequences, such as proceedings instituted by the HPCSA. But it should be explicitly stated that compliance with the hypothetical act would not constitute “unprofessional conduct” as meant in the HPA, and therefore the chances that a practitioner would have disciplinary proceedings instituted against him are significantly diminished.

The HPCSA should also provide guidelines on proper end-of-life care and the physician’s conduct leading up to the moment of death of the patient. This would be to ensure adherence to legislation and prevent resources being spent unnecessarily on every case of assisted dying. Thus, leaving disciplinary proceedings only for the cases that warrant it. In other words, the HPCSA might consider taking a different approach and adapt to changing societal norms.

6 CONCLUSION

It is clear that the HPCSA has an important part to play in protecting the medical profession and its practitioners. However, the increase in applications for assisted dying is an indication that societal norms are changing and when change is resisted one of two things normally happen: stagnation or replacement. This being said, it might be more efficient to guide change, instead of countering every opportunity for it and having change inevitably forced upon you.

CHAPTER 6:

RECOMMENDATIONS AND CONCLUSION

1 INTRODUCTION

This chapter will contain recommendations based on the research in the previous chapters. Short mention will be made with regard to relevant principles, but for a complete understanding the corresponding chapter must be studied.

Canada, the Netherlands and some states of the United States of America each went through a unique process of decriminalizing assisted dying – or at least some forms of it. Eventually each of them adopted legislation on the matter and these have had varying levels of success, depending on a person's interpretation thereof. England on the other hand has explicitly criminalized the practice through legislation. Currently South Africa is at a crossroads and has to make a decision: whether to unambiguously allow or criminalize assisted dying. But it is clear that the current position will be challenged until some type of resolution is reached.¹

Be that as it may, each of these abovementioned positions owes its existence to people challenging the status quo and receiving their day in court.

¹ At the time of the writing of this dissertation a new application to the High Court of Johannesburg was made by two parties for assisted dying.

2 THE JUSTIFICATION OF NECESSITY

As has been established several times, consent cannot negate the unlawfulness of the physician's conduct. Burchell states that “[t]raditionally the common law has been interpreted as insisting that Y’s consent to being killed by X cannot purge the homicide of its unlawfulness.”² And this is correct, since consent, as important as it is, on its own cannot be sufficient for the purposes of assisted dying as this only indicates that it was voluntary. The conduct needs to be necessary as well in order to have any chance of success.

Many of the court cases that were catalysts for change in their respective jurisdictions applied their own version of the defence of necessity.³ However, *necessity* was only used until formal legislation was adopted on the matter. In South Africa *necessity* is a justification and excludes the unlawfulness of a person’s conduct.⁴

In *Adams*⁵ the court considered the justification of necessity within the criminal law. For this justification to exclude the unlawfulness of a person’s conduct, the following requirements have to be met:

- The accused must have a legal interest which is being threatened;
- The threat must be imminent or have already commenced;
- The accused must not be responsible for the threat;
- It must be necessary for the accused to prevent the danger; and

² Burchell, J (2013) *Principles of Criminal Law*: 207.

³ See Chapter 4: Comparative Examination of Assisted Dying in Foreign Jurisdictions.

⁴ It can exclude a person’s culpability as well according to Snyman CR (2014) *Criminal Law* (6): 116.

⁵ *S v Adams* 1979 (4) SA 793 (T).

The definition according to Snyman is: “A person acts in necessity, and her act is therefore lawful, if she acts in protection of her or somebody else’s life, bodily integrity, property or other legally recognized interest which is endangered by a threat of harm which has commenced or is imminent and which cannot be averted in another way, provided the person is not legally compelled to endure the danger and the interest protected by the protective act is not out of proportion to the interest infringed by the act.”

- The means used to avert the danger must be reasonable in the circumstances.

In layman's terms: *necessity* is raised when a person commits an unlawful, yet proportional, lesser offence in order to avoid an inevitable evil or protect a worthy interest. In the circumstances of assisted dying the inevitable evil would be the undignified death and intolerable suffering caused by a terminal illness and the lesser offence would require causing the death of the patient upon her request.

According to Snyman⁶ the requirements for a successful plea of necessity entails whether -

1. The threatened right is a legal interest worthy of protection;

In this case it would be several rights, such as dignity, bodily integrity, life, etc.⁷

2. The evil has already started and is inevitable;

The evil would be the suffering and undignified death caused by a terminal illness.

3. The evil cannot be repelled in any other way than the lesser condemned act;

In other words, the patient is in the final stages of her illness and palliative care is no longer an alternative. This could be due to an array of reasons such as increased tolerance to pain medication, lack of available medical resources, finances and much more. This should be considered carefully as any number of potential applications could lead to discrimination against the poorer citizens of the Republic.

4. The offence cannot be out of proportion of the evil; and

This will probably be the hardest requirement to justify as it has to be proven beyond a reasonable doubt that between killing the patient and leaving her to suffer indefinitely, the former would be the lesser of the two evils. This can also only be proven if the third requirement has been met. This establishes the relationship between necessity and the lack of intention on behalf of the physician.

⁶ Snyman (2014): 118. There are other aspects to this defence, however they are less relevant.

⁷ See Chapter 3: The Criminality of Assisted Dying in South Africa, paragraph 2 "The Constitution".

5. The physician or patient are not compelled to tolerate this evil.

The physician might not be compelled to tolerate the suffering of the patient, but he cannot be forced to take direct action in order to end it, beyond what he considers morally and medically acceptable.

The success or failure of this justification will solely depend on the circumstances of each case, since it would be as unique as the patient themselves. Factors that would influence the application will include the type of illness and its progression, alternative care, whether palliative care has been exhausted as an option – thus, indirectly a patient's finances will also be a factor – how long the patient is reasonably expected to live and the quality of life that could be expected during the period. This does not even take into account the patient's subjective factors such as religion, morals, culture, education and age.

It goes without saying that this justification – or any common law defence – should only be used until legislation provides a special defence for the specific circumstances. As discussed in the chapter 3 of this dissertation, this justification will exclude the unlawfulness of the physician. However, the intention which accompanies the conduct will still be of the utmost importance, considering that one of the fundamental requirements will be that the physician's intention is to still treat the patient, which coincidentally entails the causing or hastening of her death. Therefore, without the proper intention, the physician will not be allowed to make use of the defence or justification, thus his conduct will be unlawful and he should be convicted for murder.

3 GUIDELINES FOR POSSIBLE LEGISLATION

By studying other jurisdictions that have adopted legislation with regards to assisted dying it is apparent that all of them, although achieving it in various manners, still criminalize assisted suicide to some degree. Yet they provide a special defence which will release a physician from liability if he satisfies all the necessary requirements, with the exception of England. It seems the simplest solution for South Africa would be to

have legislation which would set out the parameters of the defence in no uncertain terms. Even if legislation is adopted with the sole purpose to unambiguously declare all forms of assisted dying unlawful – with the exception of voluntary, passive euthanasia – it would still resolve many arguments before they begin.

3.1 SAFETY GUIDELINES

Canada, the Netherlands and the state of Oregon each have their own unique piece of legislation. No act or bill can be perfect, but it would be wise to study the safety measures they implemented and whether those have been successful or not. Apart from the requirement of consent, there are a variety of other requirements that are equally important should active euthanasia and physician-assisted suicide be decriminalized. Certain safety measures are important in order to avoid abuse, such as:

1. The patient must be a competent adult.
 - a. Children and mentally ill people are the most obvious parties who would need protection.
2. The patient must be a citizen of the Republic of South Africa.
 - a. This would avoid phenomena such as “*suicide tourism*”.⁸
3. The patient must be terminally ill without any prospects of a cure and also be in a constant state of pain.
 - a. Why palliative care is not chosen should be well justified. Naturally the subjective reasons and circumstances of the patient should be taken into account.
 - b. If “intolerable suffering” is a requirement then it must be properly defined. Furthermore, it must clearly state whether only physical pain will be taken into account or if mental anguish will also be considered. Every person’s pain threshold is different and will have an effect on their circumstances.

⁸ See Chapter 4: Comparative Examination of Assisted Dying in Foreign Jurisdictions.

This is arguably one of the more difficult aspects to regulate through legislation as pain is mostly determined by subjective factors. This is also the condition that could be challenged more often if certain people feel that they are excluded from the application of the legislation because of their “type” of pain. If this part is challenged then eventually it could lead to amendments or looser adherence to the regulations in order to include more categories of people, such as the children, mentally ill and elderly people who are “tired of living”. In other words we will see the slippery slope argument as it takes effect.

- c. The elderly who are “tired of living” should not be allowed to practice assisted dying. There is always the possibility of them being pressured or not wanting to be a burden on family members. Even though these people might be mentally competent adults, they are not terminally ill or suffering in the medical sense. It could be argued successfully that they have several medical problems due to their age, which would only become more severe over time, but the deciding factor should be persistent suffering and not age.
4. The application by the patient should be considered by independent experts.
 - a. The ideal would be to have an independent physician, who is an expert in the medical field applicable to the patient’s condition, perform his own examination. He should report his findings and only if they are in agreement with the initial physician’s report,⁹ should assisted dying be considered as a last resort.
 - b. Furthermore, a psychologist/psychiatrist must examine the patient and determine that the patient is competent and has made an informed choice free from any outside influence. It is unlikely that a physician would proceed to carry out the procedure if a psychiatrist has a dissenting report about the patient’s capacity or doubts the patient’s wish to die is genuine.
 - c. This might include interviews with- and examinations of the patient. Ideally they would all arrive at a similar conclusion. This would allow for more comprehensive conclusions

⁹ In other words assisted dying is contingent thereon that both physicians agree about the patient’s condition, treatment options and alternatives and life expectancy. Only once palliative care is exhausted as an alternative should other measures be considered.

to be drawn about the circumstances of the case and comment on the viability of assisted dying as a treatment option and last resort.

5. The physician's conduct should be limited to only what is absolutely necessary.
 - a. In terms of physician-assisted suicide he must only provide the lethal medication which the patient has to drink herself.
 - b. Some jurisdictions include writing a prescription for the patient, but the fewer parties participate during the procedure, the simpler it would be to monitor.
 - c. In terms of active euthanasia this might extend to giving a lethal injection. This would be the case if the patient is physically incapable of taking the lethal medication herself. However, this could be a more humane option and would ideally be available even to patients who are capable of committing the act themselves.
 - d. If physician-assisted suicide and active euthanasia are both legal then the academic and technical difference of who committed the final act should not pose a major hurdle in the execution of the practice.
6. The assistance may only be provided by a medical professional registered in terms of the Health Professions Act.¹⁰
 - a. This is in order to avoid family members or anyone else taking matters into their own hands.
 - b. The hypothetical act must explicitly state that the physician's conduct in these circumstances would not be considered "unprofessional conduct" as meant by the HPA, and therefore could not be tried by a disciplinary panel.
 - c. It would be prudent for the physician to submit their report to the HPCSA. They should then have the discretion to initiate an investigation with the right to take disciplinary steps if deemed necessary and unprofessional conduct is suspected.
7. There should be an obligatory waiting period of a few days or weeks.

¹⁰ 56 of 1974 as amended by Act 89 of 1997.

- a. The patient retains the right to withdraw from the proceedings at any point. A waiting period before the procedure is carried out would give the patient time to reconsider or harden her conviction.

3.2 GENERAL GUIDELINES

Canada and the Netherlands, whose legislation is somewhat more liberal than Oregon's, allow for physician-assisted suicide **and** active euthanasia. For the sake of simplicity without sacrificing clarity, it would be best if one term is used to refer to the procedure, and all the accepted conduct is defined within its parameters. For example, using the phrase "lawful assisted dying" which includes conduct where –

1. death is hastened through withdrawing or suspending medical treatment;¹¹
2. a prescription for a lethal dosage of medicine is provided to a patient which would allow her to self-administer at a place and time of her choosing;¹² or
3. the physician, or someone acting under his orders, injects the patient with a lethal substance which causes death.¹³

Naturally the different forms of assisted dying are relevant for academic purposes, but for practical purposes it would be redundant, unnecessary and perplexing. This will be good practice regardless of the legislation adopted.¹⁴

Even if legislation is not adopted the Director of Public Prosecutions should set out the official policy regarding the prosecution of parties under these circumstances. This would be especially helpful if a patient decides to request the assistance family members in order to travel to one of Switzerland's suicide clinics.

¹¹ Passive euthanasia.

¹² Physician-assisted suicide.

¹³ Active euthanasia.

¹⁴ In other words, even if only voluntary, passive euthanasia is allowed then only that conduct should fall within the definition of the term used in the legislation.

4 ARGUMENTS AGAINST ASSISTED DYING

4.1 THE SLIPPERY SLOPE

The “slippery slope” argument entails that an exception to a law will be made at some point, which will inevitably be followed by increasingly more liberal exceptions. In a discussion about assisted dying the argument could state that passive euthanasia would be followed by active euthanasia and physician-assisted suicide, which in turn would be followed by involuntarily euthanizing children, elderly people and the mentally ill. It need not be so dramatic and could be more subtle, taking place over the course of years or decades. The procedure might become less of a last resort and more of a quick fix to a complicated problem, with little or no prosecution happening in debatable situations.

An article by Pereira¹⁵ indicates that the cases of assisted dying in certain jurisdictions are not limited to the small number of patients it was originally created to help. The majority of these cases, which are now considered common practice, would not have been accepted in the beginning. He argues that this non-adherence to legislation and the lack of prosecution in these circumstances prove the *slippery slope*. He proposes that proper palliative care could provide enough relief which would cause most patients to reconsider assisted dying. The author is inclined to agree with this conclusion, however there will be an extremely small number of people for whom this would not be sufficient and it is these people for whom the practice should be made an option. Pereira further observes that this becomes an issue when there is no terminal disease to treat and for these people proper psychological treatment should be provided.

In the same article Pereira¹⁶ sets out statistics indicating the non-adherence to legislative requirements. It would seem the problem is not that the requirements are insufficient, but that people tend to ignore them which makes them superfluous. A very important requirement that cannot be neglected is that of palliative care.

¹⁵ Pereira J (2011) “Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls” *Current Oncology* volume (18(2)): e38.

¹⁶ Pereira J (2011): e39 – e42.

4.2 PROPER PALLIATIVE CARE

According to Zyllicz¹⁷ there are five reasons why patients would seek assisted dying and he explains them with the abbreviation “ABCDE”. These patients –

- Are **afraid** of what could happen in the future.
- Experience **burnout** from a ceaseless illness.
- Seek to regain **control** over their lives.
- Experience **depression**.
- Experience **extreme** suffering and pain.

Most patients do not necessarily think in these terms and summarize it as a loss of dignity. But when it is broken down into different components such as above, it is less an unnamed evil existing in the ether and starts to become individual issues which may be treatable. Thus, even if the terminal illness to which all the other problems can be attributed can no longer be treated, the secondary effects, such as depression, can be treated by other means.¹⁸

Thus, training and financial resources in end-of-life care should become a high priority and exhausting this possibility should be a requirement, within the subjective circumstances, before assisted dying is considered.

5 FINAL REMARKS

It is the author’s conclusion that there is a definite lacuna in the law and the common law must be amended to reflect a modern society’s values. Seeing as South Africa’s Constitution is based on “*dignity, freedom and equality*” patients who wish to commit suicide with the assistance of a physician should be allowed to do so. And said

¹⁷ Zyllicz B (2002) Palliative Care and Euthanasia in the Netherlands: Observations of a Dutch Physician. In Pereira J (2011): e43.

¹⁸ In other words, the definition of palliative care: treating the symptoms and not the cause.

physician should not be held criminally liable based on a justification of necessity – provided all the requirements are met. However, this justification’s relevance must be assessed on a case-by-case basis until legislation provides a solution similar to foreign law. In other words, parliament must adopt legislation which will regulate the matter. The ideal would entail decriminalizing conduct in certain circumstances if a physician wishes to avoid any criminal liability when assisting a patient with suicide in any manner.¹⁹ The other option is that legislation at least unambiguously settles the matter and only decriminalizes voluntary, passive euthanasia. However, foreign jurisdictions such as those studied in this dissertation can be examined for possible solutions.

Foreign legal systems have proven to be a wellspring of information on the topic and one can learn a lot from all of them. They have also shown that the success of the chosen approach is determined by the country’s *boni mores*. Thus, what is considered “common practice” in one country could be unimaginable in another. However, personal autonomy means that the terminally ill individual’s rights cannot necessarily be determined by the opinions of the healthy masses.²⁰

It must be kept in mind that pro-assisted dying legislation does not mean people will be marched off to the gas chambers the very next day. This will be a last resort for people who qualify for *and* wish to make use of it. Similar to any other medical procedure, a patient cannot have the procedure forced upon them and a physician is not obliged to perform the procedure if it goes against his professional or personal opinions. The lack of faith in humanity of people who say otherwise is disturbing to say the least.

It is unlikely that the necessary legal and societal reform will happen soon and there are many battles to be fought – in court and in the hospitals – before assisted dying is available to those who so desperately wish it. But nothing worth having ever comes easy and it is hoped that this dissertation might play a small part in the changes to come.

¹⁹ Within reason.

²⁰ Similar to men deciding what a woman’s options should be in the case of an unwanted pregnancy, without considering the woman’s opinion.

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1 EXPLANATORY NOTE ON REFERENCING METHOD

In the following explanatory note regarding the referencing method used throughout this dissertation the numbering indicates:

- 1 : Reference used in first relevant footnote of chapter.
- 2 : Subsequent references to same source.
- 3 : Reference as it appears in the Bibliography.

It must be noted that each chapter may be regarded as its own entity in relation to the references used in the relevant chapter. For this reason, references start anew and footnotes begin with “1.”

No table of abbreviated journal titles has been provided as the full title of the journal is provided

Suggested further reading is provided throughout the course of this dissertation for persons interested in certain aspects mentioned in the relevant discussions.

1.1 BOOKS

- Where more than two persons are authors, only the surnames of the first two authors are used in subsequent reference. The remainder of the authors are referred to as “*et al.*”

¹ The reference method used in this dissertation is based on and adapted from the method developed and used by Prinsen L (2016) *An Analysis of Consent with Specific Regard to Stem Cell Therapy and Research* (LLD thesis unpublished, University of Pretoria): 562 - 567.

- Where a person has authored more than one publication in the same year, an abbreviated title of the publication is provided in order to distinguish.
- Publications authored by institutions make reference of the full name of the institution as author in the first reference thereof and the recognised abbreviated name of the institution in subsequent references.

1.1.1 Books by single of multiple authors

- 1 : Author(s) Surname Initial (year) *Title of book*: relevant page.
- 2 : Author Surname (year): relevant page.
- 3 : Author(s) Surname Initial (year) *Title of book* Volume/Edition Publisher: Place of Publication.

1.1.2 Books compiled by editor

- 1 : Editor(s) Surname Initial (year) *Title of book*: relevant page.
- 2 : Editor(s) Surname (year) relevant page.
- 3 : Editor(s) Surname Initial (year) *Title of book* Volume/Edition Publisher: Place of Publication.

1.1.3 Books, booklets or guidelines authored by institutions

- 1 : Full name of institution (year) *Title of book/booklet/guidelines*: relevant page.
- 2 : Abbreviated name of institution (year) relevant page.
- 3 : Full name of institution (year) *Title of book/booklet/guideline* Volume/Edition Publisher: Place of Publication.

1.2 DISSERTATIONS AND THESES

- 1 : Author Surname Initial (year) *Title of dissertation/thesis* (LLM/LLD dissertation/thesis unpublished, University where obtained): relevant page.
- 2 : Author Surname (year): relevant page.
- 3 : Author Surname Initial (year) *Title of dissertation/thesis* (LLM/LLD dissertation/thesis unpublished, University where obtained).

1.3 ARTICLES

- Where more than two persons are authors, only the surnames of the first two authors are used in subsequent reference. The remainder of the authors are referred to as “*et al.*”
- Where a person has authored more than one publication in the same year, an abbreviated title of the publication is provided in order to distinguish.
- Publications authored by institutions make reference of the full name of the institution as author in the first reference thereof and the recognised abbreviated name of the institution in subsequent references.

1.3.1 Articles by single or multiple authors

- 1 : Author(s) Surname Initial (year) “Title of article” *Name of Journal* Volume (number): relevant page.
- 2 : Author(s) Surname (year) relevant page.
- 3 : Author(s) Surname Initial (year) “Title of article” *Name of Journal* Volume (number): first page of article.

1.3.2 Articles or essays as contribution in books compiled by editor

- 1 : Author(s) Surname Initial (year) "Title of contribution" in Editor(s) Surname Initial *Title of book*: relevant page.
- 2 : Author(s) Surname (year) in Editor(s) Surname relevant page.
- 3 : Author(s) Surname Initial (year) "Title of contribution" in Editor(s) Surname Initial *Title of book* Volume / Edition Publisher: place of Publication.

1.3.3 Articles, essays or guidelines authored by institutions

- 1 : Full name of institution (year) "Title of article / essay / guideline" *Name of Journal* Volume (number): relevant page.
- 2 : Abbreviated name of institution (year): relevant page.
- 3 : Full name of institution (year) "Title of article / essay / guidelines" *Name of Journal* Volume (number): relevant page.

1.4 ONLINE SOURCES

1.4.1 Online sources authored by person in form of booklet

- 1 : Author Surname Initial (year) *Title of booklet* available online at full URL. Accessed /da/te/.
- 2 : Author Surname (year) online: relevant page.
- 3 : Author Surname Initial (year) "Title of article" *Name of website*
Full URL.

1.4.2 Online source authored by person in form of articles

- 1 : Author Surname Initial (year) "Title of article" *Name of website* available online at full URL. Accessed /da/te/.

- 2 : Author Surname (year) online relevant page.
- 3 : Author Surname Initial (year) "Title of article" *Name of website*
Full URL

1.4.3 Online sources authored by institution

- 1 : Name of Institution (year) "Title of article" *Name of Institution / website*
available online at full URL. Accessed /da/te/.
- 2 : Abbreviated name of institution (year) online.
- 3 : Name of institution (year) "Title of article" *Name of institution / website*
Full URL.

1.4.4 Online sources in the form of magazine or newspaper article

- 1 : Author Surname Initial / Magazine / Newspaper (year) "Title of article"
Name of Magazine / Newspaper, date available online at full URL.
Accessed /da/te/.
- 2 : Author Surname / Magazine / Newspaper (year) online.
- 3 : Author Surname Initial / Magazine / Newspaper (year) "Title of article"
Name of Magazine / Newspaper
Full URL

1.5 SOUTH AFRICAN LEGISLATION

1.5.1 Acts

- 1 : Name of Acts, Act number of year.
- 2 : Name of Act year.
- 3 : Name of Act, Act number of year.

1.6 SOUTH AFRICAN CASE LAW

- 1 : *Full name of case reported citation.*
- 2 : *Abbreviated case name supra.*
- 3 : *Full name of case reported citation.*

1.7 INTERNATIONAL INSTRUMENTS

A table of international instruments is provided for in the text of the relevant chapter pertaining to international instruments. The table provides the creator of the instrument, the name of the instrument and the date thereof. As such, a brief form of referencing was used.

- 1 : Name of instrument (abbreviated name).
- 2 : Abbreviated name.
- 3 : Name of instrument year.

1.8 FOREIGN LEGISLATION

It must be noted that each jurisdiction referenced have a separate manner of referencing certain legislative documents. A complete explanatory note on the citation of United Kingdom legislation has been provided and this section therefore merely explains the referencing method used in the text of this thesis for sources repeatedly referenced.

1.8.1 Acts

- 1 : Name of Act year (chapter/aspect). Hereafter referred to Abbreviated name.
- 2 : Name of Act year OR Abbreviated name.
- 3 : Name of Act year (chapter/aspect).

1.9 FOREIGN CASE LAW

- 1 : *Full name of case reported citation.*
- 2 : *Abbreviated case name supra.*
- 3 : *Full name of case reported citation.*

2 EXPLANATORY NOTE ON THE CITATION OF FOREIGN LEGISLATION

2.1 CANADA

With Canadian legislation a new subsection is added in between existing subsections and indicated with the use of a period, similar to South Africa's use of a capital letter. For example if there already exists sections 241(1) and 241(2), but in the meantime a subsection has been added between these subsections, the new subsection will be numbered as 241.1. Thus, these will indicate two different subsections.

2.2 THE NETHERLANDS

In Dutch legislation the term "article" is used instead of "section" and for the sake of accuracy when referring to Dutch legislation in this dissertation the author will also refer to "articles". Furthermore, the Dutch court cases are referenced as they appear in the source it was cited from.

2.3 UNITED STATES OF AMERICA, STATE OF OREGON

In the United States of America's Oregon legislation and statutes receive a formal citation and informal name. In this dissertation both will be given, but an abbreviated form of the informal name will be used for subsequent referencing.

2.4 ENGLAND AND WALES

The English and Welsh case law referred to will be referenced in full as it appeared in the final court where it was heard, but an abbreviated name will be used for subsequent referencing. If there is reference made to an earlier court in the text the author will specifically state the court's name and that it is a different court.

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6 SOUTH AFRICAN CASE LAW

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7 INTERNATIONAL INSTRUMENTS

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