Euthanasia as the Right to Life: An African Philosophical Perspective

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Abstract

This dissertation philosophically investigates the concept of euthanasia and traces the potential impact of legalisation thereof in South Africa. A lacuna in this context is the formulation of euthanasia as a Right to Life from the basis of the Constitution and relating this legal precedent to local African thought. Indeed, euthanasia as a Right to Life has not been a widely explored idea from a Southern African perspective, and its intersection with African thought is explored even less commonly. In this study I draw inspiration from both Western and African sources, since both converge in the South African milieu (the Western approach is particularly relevant in terms of legal frameworks, and the African approach in terms of the broader social context). On the one hand this dissertation explores the idea of euthanasia as a Right to Life from a legal-philosophical perspective, whereby I evaluate and critically analyse South African law and how it may accommodate the legalisation of euthanasia. On the other hand, this dissertation examines African thought in relation to euthanasia to highlight the importance of African concepts such as dignity, quality of life, and personhood, for paving the way for the societal acceptance of euthanasia after possible legalization. By following the intersection of these two lines of thought I investigate our views as a nation with regard to what it means to be a person who can freely make end-of-life decisions in contemporary South Africa. It is highly unusual for a pro-euthansia position to be taken in an African philosophical perspective. A few African thinkers such as Menkiti, Gyeke, and Molefe who have taken up the task of writing on euthanasia, take in a relatively anti-euthanasia perspective. This project therefore aims to set itself apart from other modes of thinking on the subject matter.

Key concepts

Euthanasia, Constitution, Right to Life, Existentialism, Right to Death, Dignity, Quality of life, African philosophy.

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To my family and my academic supervisor, thank you for your unending support.

Chapter 1 – Introduction

The COVID-19 pandemic brought into sharp focus existential questions regarding death, with which the concept of euthanasia forms an important point of dialogue. The pandemic, declared as such by the World Health Organization (WHO) on 11 March 2020, was an unprecedented event in global history and saw 6 927 378 confirmed deaths worldwide (World Health Organization, 2023). Cyril Ramaphosa, the President of South Africa, declared a national state of disaster on 15 March 2020, and unveiled a set of measures that included immediate travel restrictions and the shutdown of schools from 18 March 2020 onwards. Only on 22 June 2022 were all health regulations related to COVID-19 lifted in South Africa.

Resultantly, many South Africans had lived three years (2020-2022) in the shadow of the COVID-19 pandemic. The daily lives of many individuals were condensed to living in an isolated bubble, which resulted in increased existential fear and anxiety against the backdrop of a global pandemic that saw the vast majority of countries in the world impacted and many lives lost. Societies saw a shift away from being mostly interconnected and individuals became almost completely isolated in a short space of time due to the global lockdowns and national shutdowns which were put in place to ensure the containment of Covid-19. These conditions reveal how one's situation could drastically and quickly change to confront one (as individual or as part of society) with one's existential limitations – all people will eventually succumb to death.

More specifically, the COVID-19 pandemic revealed the fragility of human beings in the face of biological contaminants, such as viruses, and brought to the forefront of South African society the reconsideration of questions regarding sickness and death. While South Africans experienced unprecedented levels of fear and anxiety during this time, it also brought into focus the terrifying idea that a single event (such as shaking someone's hand) could have severe and irreversible consequences. Further reflection, conducted in a similar vein, allows one to realise that any person could – in a moment – be involved in an automobile accident and become a quadriplegic, or that one could be diagnosed with

a life-threatening terminal illness, or that an infection could cause permanent harm, and that this event could completely change the course of one's life. Life could change and never be the same again. Such scenarios, and particularly the global COVID-19 pandemic, led to questioning among the general populace of their daily existence and the potential to be confronted with end-of-life issues. I use Covid-19 was a starting point, to contextualise the arena, in South Africa, relating it to healthcare and social issues over the past few years. Although many individuals recovered from the disease, others lost family members, colleagues, etc. and others became very ill. Although not terminally ill, it did bring light to the reality that today one can be here, living and breathing, and gone tomorrow. I do not doubt that such circumstances can bring one to think in depth about their existence. I still believe that it is relevant to use Covid-19 as contextualisation because its rapid impact on society reflected a range of existential and social concerns.

In this study I will embark on a discussion of such end-of-life issues, specifically by evaluating the decision to die (euthanasia), from the basis of the South African constitution and through the lens of an African philosophical perspective.

Euthanasia, suicide, and cultural views on death

Euthanasia is understood as a good death (from the Greek word *eu* meaning good, and *thanasia* meaning death). More specifically, it is the decision to end one's life in a painless and dignified manner (Oosthuizen et *al.*, 1978: 8). Dying in a "painless and dignified manner" seems a paradoxical and potentially contradictory statement, however, because death is often seen as wasteful and tragic by the community, particularly in the African community. Amzat et al., in their scoping review of euthanasia in Africa, suggest that "the majority of Africans hold the duty of care and preservation of life as the hallmark of medical practice" (2023: 10). Euthanasia is therefore often rejected socially, and it is rarely considered a good act in and of itself in this context. Indeed, speaking openly about death may even be considered a taboo – one may be considered overly gloomy and a-social.

Consider, for example, the social exclusion and communal ostracization of those who have attempted suicide, or the stigmatisation of an individual after they had committed suicide. From a more conservative perspective, euthanasia may be considered a form of suicide because it entails ending one's life prior to the time that one's life was meant to come to an end naturally. So, how may one differentiate between euthanasia and suicide? Suicide is often an act that the individual executes on their own without the help of another individual, and in most cases it is motivated by an individual's struggles with untreated mental health issues such as depression. In contrast, euthanasia is in most cases performed by a medical practitioner based upon specific and legally determined prerequisites that must be fulfilled in order to undergo the medical procedure (Gorsuch, 2006: 5). These prerequisites usually entail that the patient is dealing with a life-threatening terminal illness and/or persistent vegetative state (such as a coma) that hinders their quality of life. Important considerations that relate to euthanasia therefore include both the formal prerequisites for performing the act and a lessened or deteriorating quality of life.

The legal status of euthanasia can differ significantly from one country to another, but most countries globally do not legally recognize euthanasia as a viable medical and end-of-life intervention. This is especially true in Africa, since no African country has legalized or decriminalised euthanasia (Amzat, et al., 2023: 1). It is also no surprise that euthanasia is illegal in most countries around the world, since discussing death, especially death that is seen as unnatural, is a taboo topic in many cultures and may therefore not be discussed for this reason. Furthermore, Amzat et al suggest that not many people in a society have close contact with terminally ill individuals, which often renders healthcare professionals with a more positive disposition to the question of euthanasia than the general populace (2023: 10). Many countries have dominant cultural and religious beliefs that shape public opinion and resultantly legislation around this topic, with more conservative perspectives often viewing the act of euthanasia as morally unacceptable. Euthanasia may therefore be a socially and politically divisive issue, and politicians may avoid debating its legalization due to concerns about losing support or creating controversy (since there exists no legal framework for discussing or regulating euthanasia in many countries).

Lastly, and perhaps crucially in South Africa, the general public may not be well-informed or have not been exposed to the concept of euthanasia, which results in a lack of public discourse (particularly in comparison to healthcare professionals).

Fewer than 10 countries in the world have legalised euthanasia, with the Netherlands being the "model country" for legalisation. Other countries include Belgium, Luxembourg, Colombia, and Canada.[1] Important to note here is that none of these are African countries. Active voluntary euthanasia, which entails "intentionally administering medications to cause the patient's death at the patient's request and with full, informed consent" (Manning, 1998: 3), is the most discussed form of euthanasia when it comes to legalisation. While several countries have already legalised active voluntary euthanasia, such as the Netherlands (Gorsuch, 2006: 2), the current legal stance in South Africa is that active voluntary euthanasia is unlawful (McQuoid-Mason, 2015: 34) but that it may be legally justifiable under certain circumstances (as determined on a case-by-case basis).

The illegality of euthanasia in South Africa (except under specific circumstances) confronts both the sick and the healthy with a troubling proposition when faced with the prospect of painful terminal illnesses. In countries where euthanasia is legally barred, such as South Africa, people often cannot consider options outside of extending their life when faced with severe health predicaments – the only options for such patients are extended hospital care, endless medications and treatments, or being placed under palliative care in terminal cases. These options form the horizon of the possible, since all other avenues are legally barred. However, such interventions often only serve to extend patients' state of pain and suffering. The alternative option – that one might choose to no longer undergo treatments to extend one's life – is rarely taken into account because of the assumption that in all cases people would wish to live longer lives (which supports the societal status quo that sees euthanasia as unlawful, often for religious and cultural reasons). I argue that euthanasia being illegal in South Africa serves to deny citizens

[1] Additionally, Switzerland and several U.S. states (Oregon, Washington, California, Vermont, Colorado, Hawaii, and the District of Columbia) have made allowance for physician-assisted suicide.

access to a wider range of viable end-of-life options (beyond life-extending practices) in a manner that runs counter to the Constitution, while also disregarding African values of personhood, dignity, and quality of life.

This problematic situation is very pronounced in those societies where openly speaking about death is considered a taboo subject, such as South Africa. However, the issue of legalising euthanasia is especially important as we consider shifting attitudes towards death. As a society, or as human beings in general, there is a constant fear of the end of life, which serves to illustrate the continued focus placed on the wide array of measures that are taken to extend life, be it medical procedures, religious practices, or holistic approaches. The aim is, in each case, to preserve life. But why is so much importance placed on preserving life? Should the focus not rather be on living a full life and accepting once one's time has come to depart the planet? This existential question is why quality of life is relevant in this study (beyond the prominent place of dignity in the South African Constitution), and why quality of life will be related in the framework of African thought to personhood and dignity.

Humans appreciate or respect life because it is the only thing that is "given" to us, and we have the right and responsibility to preserve that life and have those around us preserve it as well. This right is emphasised in Sections 10 and 11 of the South African Constitution (1996), which I wish to counter with the proposal that the Right to Life can be seen as a Right to Death – the right to a dignified death. Since post-Apartheid South Africa is arguably typified (to a greater or lesser extent) by African thought (in the postcolonial context), we must consider how the ending of one's life through euthanasia may be intertwined with and impact one's local community. Contrary to what may be seen as an individualistic act and an act that is focused on a personal choice for one's own death, I will argue in this dissertation that the decision to end one's life (under the appropriate circumstances) can positively impact the family or community as well. I will evaluate what euthanasia could constitute in a postcolonial African society – specifically in the South African context – and then discuss how this society's relation to human rights

(specifically the Right to Life and how the subject of death is approached) allows us to rethink the question of euthanasia in the Global South.

Statement of personal interest

In addition to the aforementioned discussion regarding the academic relevance of dealing with the question of euthanasia, this topic is also of personal importance to me. Not only because I am a young African and South African scholar who wishes to broaden philosophical engagement with this subject matter from an African scholarly perspective, but also because of a deep desire to understand the concept of the quality of life as it is ratified in our legal frameworks. I have witnessed close family members suffer from dementia and Alzheimer's, and this has piqued my academic curiosity significantly. Beyond personal considerations, the question of euthanasia has also prominently re-emerged after this country's experience of the COVID-19 pandemic, which has caused the demise of many of South Africa's citizens.

As a scholar residing in South Africa, the South African context is my direct point of reference. It provides an avenue for contributing to broader society through reflecting on the issue of euthanasia. Importantly, South African society is a complex and dynamic one in which to explore the divisive subject of euthanasia. South Africa is a post-Apartheid country with remnants of the former Apartheid government's influence still affecting the socio-economic factors of the country – with economic inequality being a salient example of this. There is still a large gap between the rich and the poor, low education levels, and poor service delivery, even in terms of health care. A philosophical reflective analysis is needed to consider such social factors in relation to decision-making entailed by life-ending or life-extending situations. It is certainly a privilege to be afforded the luxury to reflect philosophically upon a subject matter such as euthanasia; and studies such as my own, if conducted well, may in turn assist people from all walks of life to be educated on the options with which they may be presented should euthanasia be legalised in the

future. Such discussions may also directly impact increasing societal support for such legalisation.

Study approach and overview

In this study I will explore the legalisation of euthanasia in South Africa from a philosophical perspective. While euthanasia is primarily a bioethical issue, in this study I will also consider the subject from a legal-philosophical and societal perspective. If we take the legal stance as reflective of the beliefs of a large number of people in a democratic society, the Constitution of South Africa can shed light on current societal views regarding euthanasia. Chapter 1 of the Constitution of South Africa (1996) lists several values upon which the Republic of South Africa is founded. Amongst these values, as stated in Section 1 of the Constitution (1996), the value of human dignity has specific and crucial implications for the euthanasia debate. It is the concept of human dignity that leads me to question the making of life-or-death decisions with which one may be faced in cases of terminal medical conditions.

The aim of the study is to argue for the legalisation of euthanasia from a South African perspective, based on the ideas that (a) the Constitution of South Africa allows for such legalisation and that (b) an African philosophical account provides a reflective space for such legalisation. This will entail an examination of euthanasia from the dichotomous Western perspective, that cultural engine that generates difference and separation, which in turn will provide a counterpoint for our navigation towards an African perspective. Western accounts of euthanasia cannot adequately theorize the concept in our local concept. This is a particularly important point since euthanasia itself is generally accepted to be a predominantly Western subject matter, and the countries where euthanasia is legal are primarily Western countries (Amzat, et al., 2023: 10). The call in this study is to adopt African perspectives and modes of thinking when discussing euthanasia. I argue that the Western discussion on euthanasia has reached a stalemate, since the majority of the arguments nowadays centre around the antagonistic interplay of supremely rational

arguments for and against legalisation, thereby leaving out of play specific contextual societal considerations. An African perspective on this subject matter allows us to explore euthanasia as a Right to Life in the South African context, and thus to generate novel perspectives. I argue that we should consider euthanasia as a right that is owed to every living individual who is mentally capable of making the decision to end their life, should the necessary medical circumstances and safeguards that would need to be put in place, are fulfilled.

As mentioned earlier, euthanasia is currently considered to be an illegal act in South Africa. In fact, it is classified as a form of murder (McQuoid-Mason, 2015: 34). This fact should not dissuade our philosophical exploration, however, since this law has been challenged in the past. There have been several instances and cases where individuals have gone against this law by assisting people with ending their lives, as in the case of Sean Davison (Martin, 2021: 336). Furthermore, there have also been others who have put forward requests in court to receive legal permission to undergo euthanasia or physician-assisted suicide, as can be seen in the case with the late Robin Stransham-Ford and the ongoing Diethelm Harck cases (Martin, 2021: 337). These cases have allowed laws to be challenged and have also brought to light a range of end-of-life issues in South Africa. I will critically analyse these cases alongside Western examples of a similar nature, to examine the differences in legislature and to illustrate the differences in thinking as it relates to existential concepts such as dignity and personhood (as part of quality of life). The intention is to examine the potential future for legislation in South Africa from the perspective of African thought, in comparison to the West and distinctly Western ways of thinking.

Continuing the critical examination of the legislature, I wish to propose that the Right to Life as described in the Bill of Rights (Section 2 of the South African Constitution), can – and needs to be – re-examined and reformulated as the Right to Death. I will do this by dissecting the meaning of the Right to Life and its implications for one's existence, dignity, and quality of life as understood in an African framework, which forms the crux of the philosophical portion of the study. My interpretation of the Right to Life as the Right to

Death suggests that I have the right to decide when I no longer deem my life as one of quality, thus allowing me the right to decide a way forward for my life, even if that includes the decision to end my life through euthanasia. To avoid a slippery slope, I must emphasise that this quality of life must be in relation to a terminally ill individual and how much the quality of that individual's life diminishes as the illness progresses and their human dignity begins to be compromised (i.e. needing to bed, bathed, clothed, etc.).

Of course, understanding euthanasia in this way (the Right to Life as a Right to Death) brings up the question of how and what determines quality of life. I will examine the concept of quality of life through the lens of (1) those physical boundaries that terminal illness and others can impose on one's general well-being and (2) those social boundaries that arise around the individual, namely those of family and community. I may have a Right to Life, but what happens once quality of life has been compromised? The simple answer is that that one's "life" must be re-examined. However, problematising this approach is the question of what the notion of quality of life entails – it is a broad, complex and highly subjective ideal. Therefore, it might be a difficult tool of measurement for circumscribing one's right to life – and thus entails already from the start a concept that must be critically unpacked and evaluated. An inherent aim in this study is to explore an African formulation of a quality of life and its accompanying concepts (dignity and personhood) to discover how one may deem life as being of a quality or standard to continue living, specifically in cases of the terminally ill. How much of a quality of life am I afforded in a vegetative state? And how can I make the decision to continue living before I enter such a state? I postulate that these questions can be answered by examining the requirements for a quality life (which will be done throughout the study and emphasised in chapter 4 of this study), especially in a post-COVID-19 South Africa. I draw attention to the pandemic, since it entailed a real-world scenario or situation whereby the quality of life of a large number of people (both nationally and internationally) were affected. It affected how South Africans went about their daily lives, and during this period life became focused on survival rather than thriving.

In light of the foregoing, this study will employ a critical philosophical analysis to elucidate the question of voluntary active euthanasia in the context of South Africa. This study serves to make a general contribution to the euthanasia debate which continues to develop in Western countries according to specific presuppositions and biases, and which continues to be discussed primarily from a Western perspective (which will be the focus in chapter 2). Importantly, I argue that the development of different and diverse non-Western perspectives in approaching the subject of euthanasia is crucial for the progression of the legalisation discussion in the Global South, and for communicating the concept of euthanasia to the general public. The Global South requires a context-specific development of the euthanasia debate – there is a need for development that is not merely socio-economic and political, but also academic, in nature. Such a discussion requires ideas from different disciplines to merge, such as philosophy, medicine, law and politics (as will be done in this study). Additionally, this study serves to evaluate the impact of the changes that have occurred in contemporary South Africa, particularly in the wake of the COVID-19 pandemic, that have affected the everyday life of citizens and which have led to a re-evaluation of life in general. Lastly, this study aims at exploring euthanasia in a context that is both complex and reconstructing its identity post-Apartheid and post-Covid-19, but which seems to lean towards a community-based society built around what may be considered (arguably) African ways of thought. Such an investigation will reveal the close relation between philosophical ideas, such as quality of life, dignity, and personhood (which will receive focused attention later in this study, in chapter 4), and the legal aspects of euthanasia (in chapter 3).

I also wish to state that an aim of this study is to educate members of society regarding euthanasia. As stated earlier, members of the public may not be well-informed with regard to euthanasia, which makes open public discourse on such topics exceedingly difficult. The objective of this study is to give South Africans who are terminally ill a chance to explore their options (even if only philosophically), and to provide family members of ill or vegetative-state patients the opportunity to know that their feelings regarding the situation are valid. Public engagement will show members of society that there is another side of life, which differs from the norm, and that discussions of death and euthanasia should not be considered taboo. Being ill, or being in a position where you have no control over your own life, is a position that strips one of one’s dignity and personhood. It reduces one’s

quality of life, which has legislative implications. My hope is furthermore that by recognising euthanasia as a Right to Life, individuals can be afforded the potential of regaining their dignity and taking back control of their life – and thus to existentially determine their own lives in conversation with their community.

1.1. Problem statement

In what manner can the re-interpretation of euthanasia as the Right to Life in a South African context entail the restoration of an individual's dignity and personhood?

1.2. Hypothesis

There are specific challenges to Western arguments for and against euthanasia in the context of African thought, and in terms of the legal framework of South Africa. I argue for the legalisation of euthanasia in South Africa by focusing on the concept of quality of life specifically. I argue that if the South African constitution grants one the right to life, then that Right to Life can also be seen as a right to make a decision on when to end that life – it is a right to death, or alternatively the right to a dignified death. I furthermore argue that there are specific implications for the Right to Life as a Right to Death in terms of how an individual is understood in African society, which is primarily informed and embodied by the idea of community. I will focus on dignity and personhood in relation to quality of life to further argue for the legalisation of euthanasia, since these are foundational features in African thought for establishing one's quality of life.

1.3. Sub-questions

The following sub-questions will be addressed in the corresponding, following chapters:

1. What are the problems with the euthanasia debate?

2. How can the Right to Life be framed as the Right to Death in the South African constitution?
3. How can the Right to Life as the Right to Death be viewed from an Ubuntu perspective?
4. What does an African perspective on euthanasia look like?

1.4. Goals

The following goals will be achieved in the corresponding, following chapters:

1. Euthanasia will be circumscribed in relation to its formulation as a Western problem.
2. The Right to Life as the Right to Death through legal frameworks in South Africa will be explored.
3. The impact of legalising euthanasia in a country that is considered to be an Ubuntu society will be discussed.
4. An African view on the future of euthanasia in South African society will be proposed.

1.5. Method and Exploration of Literature

This study will employ a critical philosophical analysis to elucidate the question of voluntary active euthanasia in the context of South Africa with specific reference to African thought. The proposed study is a desktop study, and no ethical risk is identified.

Sources to be referenced include, but are not limited to, EBSCOhost, Academic Search Premier, African-Wide Information, Philosopher's Index, Literary Reference Centre, JSTOR, and Google Scholar.

Chapter 2 – Contextualising euthanasia: The problems of the traditional debate

2.1. Chapter introduction

In the first chapter euthanasia was described as entailing the intentional ending of a patient's life. It was stated that this study will focus primarily on voluntary active euthanasia which occurs when a patient actively participates in the end-of-life decision, and which is the form of euthanasia that is most prominently discussed in legal conversations (Oosthuizen *et al*., 1978: 8). Furthermore, focusing on voluntary euthanasia will serve to emphasise the idea of euthanasia as a Right to Life, which will be developed in chapter 3. The Right to Life grants an individual the space to freely evaluate their quality of their life, also in cases where the individual is experiencing negative health circumstances that are highly unfavourable and which affect their ability to live a decent life, such as terminal cancer.

Before engaging with the legal aspects of the euthanasia debate in South Africa, however, the academic debate about the topic must be explored. It is problematic for the Global South, however, that academic writing on the topic of euthanasia has predominantly been Western in terms of scope and underlying presuppositions, to the point that discussions regarding euthanasia have often become considered to be a predominantly Western subject matter. This is supported by the fact that the vast majority of countries that have legalised euthanasia, are Western (De Wachter, 1989; Gorsuch, 2006:1). Over and above geographic considerations, I argue that the Western treatment of the subject of euthanasia has reached a stalemate due to its roots in Western discourses, with the majority of arguments centring on the reasons for and against legalisation – as logically constructed seemingly in a seemingly purely rationalistic vacuum – leaving out of play specific contextual societal considerations (which I will endeavour to address in this study). I argue that there is a need to explore euthanasia as a Right to Life in the specifically South African context, which I argue suggests a right that is owed to every living individual who is mentally capable of making a rational decision to medically end their life if there is a personal need to do so, and if the medical circumstances comply with the requirements. The aim of this study is therefore to adopt an African perspective in

relation to the discussion of euthanasia in the academic space, in contrast to the overly Western perspectives often found in this context.

This study is therefore not only aimed at advocating for euthanasia, but also at developing critical thinking about euthanasia, outside of the dualistic “should we, or should we not” thinking that surrounds ethical and moral discussions from the Western perspective. Thinking about euthanasia from another viewpoint will allow us to examine it from a more human, and perhaps African humanist, perspective. In this chapter, I will be discussing the development of the concept of euthanasia, starting with the meaning and types of euthanasia. I will be differentiating between physician-assisted suicide (PAS) and Euthanasia, and I will also be tracing the history of euthanasia to highlight arguments for and against euthanasia. I will be circumscriptively illustrating the debate from a Western perspective and I will then suggest how the debate can develop towards an African perspective, which will be discussed in more detail in subsequent chapters (particularly in chapter 4). It must be made clear that focusing on voluntary euthanasia is specifically to avoid the slippery slope that might come with advocating for all forms of euthanasia. A possible contradiction arises in the study comes through in focusing on studies that advocate for involuntary euthanasia such as Cruzan. I realise that in the case of bringing that particular case up, it was to outline the benefits of viewing euthanasia from a communitarian perspective and how it can be of benefit to the individual and those surrounding the individual. However, this presents a loophole in itself because of my mention of relieving burden of the family of a terminally ill patient. The loophole lies ztherein that it does not take into consideration situations where parents have special needs children or where people are disabled. In such cases those individuals may also be considered to be burdensome, and the argument I present seems to open them up to possibly become candidates of euthanasia (this is not the intention, and such considerations are assumed to be out of play for the rest of the study for reasons of human dignity (supported both by the law and by philosophical thinking).

2.2. Euthanasia as a philosophical and ethical problem

Prior to discussing euthanasia as an ethical problem, it is important to outline the connection between philosophy and medicine, since euthanasia is primarily a biomedical issue. In the chapter “Ethics and Philosophy” of his book *Medical ethics, law and human rights* (2011), A.A. van Niekerk explains that ethics has been around since the developmental stages of the philosophical discipline and formed a significant part of the thinking of philosopher such as Socrates, Plato, and Aristotle. But it was Hippocrates who took ethics into the bioethical realm (Moodley, 2011: 7). Hippocrates is the founder of Western Medicine and inspired the Hippocratic oath, which is one of the central ethics documents in the medical world.[2] The Hippocratic oath is a medical ethics document that deals with important ethical issues in the medical realm, such as abortion and euthanasia. However, philosophy as the discipline concerned with thinking (reflecting on how we think about things and why we think of them the way that we do) is indicated as important for medicine because it allows us to critically examine medical practices with the intention of improving those practices.

2.2.1. Euthanasia and physician-assisted suicide

In discussing euthanasia as biomedical issue, it is first important to circumscribe the concept. Euthanasia is the act of intentionally ending a patient’s life to relieve pain and suffering, and it is derived from the Greek words *eu*, which means “good” and *Thanatos*, which means “death”; thus the original meaning of euthanasia entails the notion of a “good death” (Merriam Webster, 1998: 179). In practice, euthanasia involves the intervention of another individual assisting the patient by speeding up the process of dying, aiming to alleviate the patient's continuing pain or suffering.

The intention behind the act of euthanasia is what separates it from being termed *murder*, since the intention of euthanasia should be to save an individual from their suffering (i.e. there should be no malicious intent behind the act). In addition, the intention should be to bring about a safe and painless transition from life to death for an individual. However, it

[2] See Hippocratic Oath on page 353 of *Medical ethics, law and human rights: a South African perspective*.

is crucial to establish certain criteria for allowing euthanasia, ensuring that it may only be considered under specific circumstances. One fundamental requirement is that an individual must be terminally ill to be considered a candidate for euthanasia. While proponents argue for the right to die with dignity and for the relief of unbearable suffering on the one hand, opponents express concerns about the potential for abuse, the sanctity of life, and the slippery slope it may create on the other hand. Euthanasia therefore entails complex ethical dilemmas, intertwining considerations of personhood, autonomy, and the value of life.

Euthanasia is sometimes used interchangeably with physician-assisted suicide (PAS), though there are some important distinctions between the two concepts (Battin, 2000; Elliot, 1996). The two concepts might be said to be different sides of the same coin, in that they bring about the same outcome but entail distinct differences. The main difference between physician-assisted suicide and euthanasia is the role of the doctor. Euthanasia is the act of intentionally ending a patient's life, usually performed by a doctor, who directly administers a lethal drug or performs an intervention to bring about the patient’s death (such as withholding life-saving treatment or switching off life-saving machines to end the patient’s life) (Rachels, 2019).

PAS, on the other hand, refers to a situation in which the doctor does not perform the act themselves but merely assists the patient by, for example, providing the means or substances for a patient to end their own life – they may write a prescription for a lethal drug that the patient can use for ending their life. In addition, the patient is actively involved during PAS in terms of the decision to end their own life, as well as actively participating in the act that brings about the death (by taking the lethal medication or drug themselves, which has been prescribed by the physician). Physician-assisted suicide is always voluntary, as it requires the explicit sanction and participation of the patient.

The crucial difference between euthanasia and physician-assisted suicide lies in who ultimately performs the act that leads to the patient's death. In euthanasia, another person

– usually a healthcare professional such as a doctor – directly administers the lethal substance or intervention, while in physician-assisted suicide, the patient themselves self-administers the prescribed medication. Physician-assisted suicide is the act of a doctor/physician providing the means for a patient to take his or her own life (Moodley, 2011: 270). This is an intentional act at the request of the patient. The patient plays a bigger role than the physician in that the patient will for example drink the pills prescribed by the physician, and the physician does not have to directly administer the lethal drugs or unplug the ventilator to end the patient's life.[3]

As it stands, euthanasia and PAS are both illegal in South Africa. However, the Draft Bill on the Rights of Terminally ill (South African Law Commission, 1998), which was compiled by the South African Law Commission, refers to physician-assisted suicide and euthanasia under the same umbrella, as "active euthanasia" (Moodley, 2011:277). This is problematic because, as the foregoing has illustrated, there are distinctions between these two acts and the conflation of these two terms may muddy the waters on public discussions concerning this legislation.

The Draft Bill contains prerequisites for active euthanasia, which are as follows (Moodley, 2011:277):

1. The patient must be suffering from terminal illness.
2. The patient must be subject to extreme suffering.
3. The patient must be mentally competent and over the age of 18 years.
4. The patient must be adequately informed of the nature of the terminal illness, the prognosis, and any available treatment.
5. The patient must make an informed and well-considered decision regarding euthanasia.

[3] Note that these are merely basic examples. There are other forms of active euthanasia that a physician can undertake to end a patient's life. The key word in PAS is the word *physician* because the person who assists in the procurement of the means to commit suicide, is a doctor. In cases of euthanasia, an individual who is not a doctor may also assist in ending an individual's life. Euthanasia differs from PAS in that it may be characterised as an act that involves a bigger role from the physician.

6. The patient must have the opportunity to re-evaluate his or her request and yet still persist with the request.
7. The patient must be in such a position that euthanasia is the only way in which he or she can be released from suffering.

The outlines in the Draft Bill also include stipulations for any doctor who should be involved, highlighting their prescribed role. The Draft Bill was submitted to the Minister of Justice in 1999 and contained the following three options (Moodley, 2011:277):

1. Euthanasia could remain illegal in South Africa.
2. Euthanasia could be legalised, with the doctor making the final decision relating to its appropriateness in a particular situation.
3. Euthanasia could be legalised with an ethics committee deciding on the appropriateness of the request.

As will be indicated in the discussion in this chapter and the next, there has been little progress as regards the further legalization of euthanasia in South Africa, although some cases are challenging the *status quo*. These will be discussed in chapter 3.

2.2.2. Types of euthanasia

As introduced in the previous section, two distinct forms of euthanasia shed light on the actions and intentions involved in the act of ending a patient's life. These are passive and active euthanasia. I will discuss each of the categorisations in turn, and then describe the subdivision of active euthanasia into various groupings.

Passive or indirect euthanasia is brought about when medical treatment is withheld or withdrawn, or life-sustaining interventions are removed with the intention of allowing a patient to die naturally. In other words, passive euthanasia is when an individual is "left" to die (McDougall & Gorman, 2008: 1). One example entails individuals who have little to

no chance of survival and are not provided the necessary life-saving care – the doctor might refrain from taking extraordinary measures to prolong the patient's life, for example. Passive euthanasia is grounded in respect for the natural process of dying, aiming to relieve the patient from unnecessary suffering, with no deliberate actions taken that are aimed at causing the patient's death (Garrard & Wilkinson, 2005).

Another example of passive euthanasia is a case where medical resources are scarce in a hospital and where a person cannot be provided medical treatment, in order to sustain the resources for others who have a higher chance of survival (a major consideration during the COVID-19 pandemic). During the COVID-19 pandemic, hospitals were flooded with patients who were all in a very dire condition and in need of ventilators and other life-saving treatments. However, many people suffered due to the public hospital system in South Africa not having enough beds, enough medication, or enough ventilators. Patients were unfortunate casualties due to the lack of medical resources and were inadvertently subjected to passive euthanasia, although these cases were not described as such. I would argue, however, that in due consideration of the definition of passive euthanasia and upon analysing the decisions that were taken by physicians in those circumstances, the resultant acts can be considered as passive euthanasia (Bannon, 2020).

Passive euthanasia entails withholding and/or withdrawing treatment from a patient: even instances where treatment is withheld or not started by physicians, could fall into the category of passive euthanasia. Withholding treatment is a decision that could be based on the severity of the situation, and it could be argued to be more ethically permissible (Moodley, 2011: 270; Rachels, 2019). It can also be argued that a patient's refusal of potentially life-saving treatment is a form of suicide. This also entails consideration of what form of treatment the patient might prefer, for example chemotherapy, radiation or surgery; and consideration of the benefits and disadvantages of different forms of treatment. Furthermore, what might work for one patient, may not work for another and different patients might prefer different approaches (Moodley, 2011: 271). However, the legality of withholding or withdrawing treatment is unresolved in South Africa, and withdrawing or withholding treatment that could potentially prolong life for a patient, may

be permitted under certain circumstances. This is included in South Africa's Draft Bill, in the South African Law Commission (Moodley, 2011: 272).

Contrary to passive or indirect euthanasia, active or direct euthanasia entails the intentional act of causing the death of a patient in order to relieve their suffering through direct intervention of the physician. This would for instance involve the physician injecting a lethal drug into the patient's intravenous drip to end the patient's life (Rachels, 2019). Such intentional acts may include administering a lethal drug, a lethal dose of medicine, or otherwise directly causing the patient's death in the medical context (Brock, 2019). With active euthanasia, there is no intervention by the sick person.

Three sub-categories of active euthanasia have been identified, namely voluntary euthanasia, non-voluntary euthanasia and involuntary euthanasia. I will discuss each of these in the sections below.

2.2.2.1. Voluntary euthanasia

Voluntary euthanasia is carried out with the permission of the patient: explicit and voluntary consent is given. The patient actively and autonomously participates in the decision to terminate their own life (McDougall & Gorman, 2008: 2; Rachels, 2019). Promoters of voluntary euthanasia argue that voluntary euthanasia respects the individual's autonomy and right to make decisions about their own life, especially when faced with inevitable and prolonged suffering.

2.2.2.2. Non-voluntary euthanasia

Non-voluntary euthanasia is conducted without the consent of the patient, such as when the patient is in a vegetative state, unconscious, or unable to communicate their wishes

(McDougall & Gorman, 2008: 2). It takes place when the patient is not able to provide explicit permission for their death, for example in cases where they are unable to provide unambiguous consent or have not expressed a preference regarding their own death (Yount, 2007: 4). It is a controversial practice and it is only considered when a person has a significantly diminished quality of life or is experiencing extreme suffering, and their death is deemed to be in their best interest even without their explicit consent. Non-voluntary euthanasia involves patients who are deemed incompetent, as they cannot consent to euthanasia due to their state. An example of this is an individual in a persistent vegetative state (Cohen-Almagor, 2002; Moodley, 2011: 277). It is important to note that a terminally ill patient who was once competent to request euthanasia can become incompetent due to their condition worsening, while having the original consent stay in place.

2.2.2.3. Involuntary euthanasia

Non-voluntary euthanasia involves ending a person's life without their explicit consent because they are unable to provide it and have not previously expressed their wishes in this regard. Involuntary euthanasia, in contrast, is conducted against the will of the patient or without their knowledge, even if they have expressed a desire to live (Cohen-Almagor, 2002; McDougall & Gorman, 2008: 2). Involuntary euthanasia can also be termed *mercy killing*, because it is intended to relieve the suffering of a patient. However, there is historical precedent for killing undesirable individuals under the auspices of certain regimes, such as homosexuals and physically disabled individuals in Nazi Germany, under the ambit of involuntary euthanasia. This position is exceptionally problematic but falls well outside the framework of this study.

2.2.2.4. Other groupings

Other forms of euthanasia exist, and the sections below will provide additional clarification regarding the actions and intentions involved in the act of intentionally ending a patient's life. These forms involve both passive and active euthanasia (which were discussed in

sections 2.2.1 and 2.2.2 above) and may be subdivided into various categories. Voluntary, involuntary and non-voluntary euthanasia may be delineated as either passive or active forms of euthanasia. The various categories of euthanasia that are identified, are therefore voluntary active euthanasia, voluntary passive euthanasia, non-voluntary active euthanasia, non-voluntary passive euthanasia, involuntary active euthanasia, and involuntary passive euthanasia.

The focus of this study will be on voluntary active euthanasia (VAE). Voluntary active euthanasia occurs when the physician directly intervenes in the death of the patient, such as administering a lethal drug at the request of the patient to end the patient's life (Ogunbajo & van Bogaert, 2008: 38).

2.2.2.5. Voluntary active euthanasia (VAE)

Voluntary active euthanasia (VAE) involves a situation where a clearly competent individual (with emphasis on the word *competent*) makes the decision to end their own life – thus, it is the intentional act of ending a patient's life with the patient's explicit and voluntary consent (Brock, 2019). VAE is often sought by competent individuals who are suffering from an unbearable or incurable state and who seek medical assistance to end their own life.

What constitutes this act as 'voluntary', is the voluntary nature of the patient's request. It is a conscious and informed decision whereby the individual, being of sound mind, makes the decision to end their life and is assisted by a competent individual – preferably a physician (Young, 2022). What constitutes this act as 'active' is the administration of a lethal substance or intervention with the explicit aim of ending the patient's life by a doctor (as discussed in the above sections).

Both voluntary and non-voluntary euthanasia fall under the category of active euthanasia. When voluntary euthanasia occurs, a patient who is “competent” – meaning terminally ill but of sound mind, etc. – requests for their life to be ended medically in a painless and harmless way. The doctor plays a bigger role here than in physician-assisted suicide. Cases where the patient directly requests euthanasia, are referred to as *voluntary active euthanasia* or VAE (Moodley, 2011:276).

2.2.3. Eligibility criteria

For euthanasia to be carried out, a patient must meet certain requirements, the minimum of which are described in the list below:

Incurable or terminal illness: Typically, a patient must have a terminal or incurable medical condition which is projected to cause unbearable suffering and lead to their death in the near future. Examples of such conditions include suffering from stage 4 cancer or degenerative quadriplegia.

Unmanageable or unbearable suffering: The patient must be experiencing severe physical or psychological suffering that cannot be alleviated through medical treatment, palliative care, or other means. Other examples of such suffering include the patient being in a vegetative state, or having no ability to take care of themselves in their day-to-day activities.

Informed and voluntary request: Euthanasia must be requested voluntarily, without any coercion or external pressure from outside parties. A patient must be mentally and emotionally stable (i.e. of a sound mind), or be determined to be mentally competent, to provide the said informed consent. A person might be depressed from being ill and from undergoing major life changes due to that illness, but the reason for wanting to end their

life should not only be an intermittent state of depression but rather due to the difficulty they experience because of the incurable medical state.

Consultation with medical professionals: A request for euthanasia often involves consultations with multiple healthcare professionals, including physicians, psychiatrists, and palliative care experts, to assess the patient's condition and suffering. These professionals often provide a crucial verdict as regards the patient's request for euthanasia. A key consideration of VAE is that the person who performs the act should be doing so to benefit the individual seeking euthanasia (Young, 2022). The individual assisting must act outside of themselves (and even their own interests and wishes) to benefit the individual seeking euthanasia. Due consideration must be given to the mental competence of the individual who is seeking to undergo VAE. They must undergo psychological evaluation prior to and after the assistance in the act of euthanasia, as will be discussed in more detail in the next section.

In summary, the patient must be able to prove that the medical condition is affecting their life in terms of day-to-day activities in line with the listed criteria. The financial and psychological implications for one's life, and even one's family members or caretakers, may also be taken into account. For example, the patient must have undergone psychological evaluation before making the decision to end their life through euthanasia.

The Draft Bill (Moodley, 2011), mentioned in section 2.2.1, proposes the following criteria for a mentally competent person, which I argue serves to further indicate the eligibility (or lack thereof) of an individual to request euthanasia, specifically in a South African context. The Bill states the following (South African Law Commission, 1999: XII):

A "mentally competent person may refuse treatment 3.(1) Every person -

- (a) above the age of 18 years and of sound mind, or

- (b) above the age of 14 years, of sound mind and assisted by his or her parents or guardian, is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.
- (2) Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in subsection (1) is, that such a person's refusal is based on the free and considered exercise of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.
- (3) Care should be taken when taking a decision as to the competency of a person, that an individual who is not able to express him or herself verbally or adequately, should not be classified as incompetent unless expert attempts have been made to communicate with that person whose responses may be by means other than verbal.
- (4) Where a medical practitioner as contemplated in subsection (2) does not share or understand the first language of the patient, an interpreter fluent in the language used by the patient must be present in order to facilitate discussion when decisions regarding the treatment of the patient are made."

The Draft Bill conforms with the eligibility criteria mentioned in this section, illustrating that close monitoring and checking would be closely related to the legalisation of euthanasia in contemporary times.

2.3. The history of euthanasia

This next section aims to delve into the philosophical development of the idea of euthanasia by examining its historical evolution from Ancient Greece, through the Medieval Ages to the Modern Era. In Ancient Greece, philosophers such as Plato and Aristotle contemplated the ethics of a "good death" and the moral responsibility of physicians. In the Medieval period Judeo-Christian influences placed emphasis on the sanctity of life, however, leading to a more generally negative view of euthanasia. The

Modern Age saw significant shifts in thought, especially since the Enlightenment produced rationalist philosophers like John Locke and David Hume, whose early ideas on personal autonomy set the stage for future debates on individual rights and the permissibility of euthanasia. Through an examination of these historical periods, the current discussion aims to illuminate the philosophical perspectives that have shaped our understanding of euthanasia into the contemporary era (Dowbiggin, 2007).

2.3.1. Ancient Greek perspectives

The reason for going as far back as Greece to explore the history of euthanasia is not only because the concept has Greek origins but also because the Greeks are the Western founders of philosophy, which is the main disciplinary lens of this study. It therefore does justice to the analysis of this subject matter, while highlighting the Western biases in which the debate is rooted. Furthermore, exploring the distant past not only provides us with valuable insights into the potential trajectory of the euthanasia discourse in the future, but also sheds light on the contemporary state of the argument, which is the main focus of this study. By exploring historical Greek foundations with regard to this topic, we can gauge the extent to which this argument has evolved and identify its development in present-day discussions.

As mentioned earlier in the chapter, the word *euthanasia* is of Greek origins. However, suicide – as seemingly related to euthanasia – was not always received with a positive attitude in Greek society, and earlier it was considered an act worth condemning (Gorsuch, 2006: 23). Athenians were therefore not always progressive concerning this topic; they expressed their condemnation of suicide by cutting off the corpse's right hand and denying these dead a dignified burial (Gorsuch, 2006: 23; Miles, 2001). One of the founding fathers of philosophy, Plato, condemned suicide multiple times, arguing that philosophers should embrace natural death when it comes, because it is freeing the individual from human existence to bring the individual in contact with truth (Gorsuch, 2006: 23; Miles, 2001). In addition, Plato argued that it is wrong to seek out death. He compared it to a soldier running away from their duties and he claimed that choosing

death was an act of selfishness and cowardice (Gorsuch, 2006: 23, Miles, 2001). Plato identified three exceptions to justify suicide, however: judicial order, excruciating misfortune, and moral disgrace.

There were other exceptions to this attitude towards suicide in Greek culture as well, as Athenian residents were at one point permitted to take doses of poison which would allow them to choose death (Gorsuch, 2006: 24). This reveals that there were divergent arguments for and against euthanasia even in these initial stages. Like Plato and other Athenians, Pythagoreans condemned euthanasia and based their argument on religious views (Gorsuch, 2006: 24). The Romans, too, did not punish individuals who attempted or committed suicide unless their reasons were considered to be irrational (Gorsuch, 2006:25).

2.3.2. Mediaeval conceptions

Similar to the views of Pythagoreans, the Christian view shunned people who committed suicide on a religious basis. The Christian view during this era "linked suffering with spiritual growth by citing the spiritual virtues of martyrdom" (Gorsuch, 2006: 26). Therefore, embracing suffering instead of choosing death was more admirable than the purported cowardly act of taking one's own life. In earlier Christian practices, people who committed suicide were denied a dignified burial, while their family members were shunned from the community and left impoverished since the deceased individual's worldly possessions would be confiscated after their death (Gorsuch, 2006: 26).

In comparison, there has been a shift in attitudes towards suicide in modern day Christianity. Although still a taboo act, churches and church members are now able to congregate and give a dignified burial to an individual who has committed suicide. These burials often provide the opportunity for Christian groups to raise awareness for the importance of religion in one's life and how religion and religious practices may have provided an alternative to ending one's life (Potter, 2021).

Significantly, there is no specific passage in the Bible that forbids the act of taking one's own life, though Christianity continues to teach against the practice (Gorsuch, 2006: 25). At the start of the Medieval Ages, "Augustine argued that intentional self-destruction generally constitutes a violation of the Sixth Commandment" since there is a distinction between intentional and unintentional self-destruction (Gorsuch, 2006: 25). He argued that if self-destruction is permitted, this would lead to a slippery slope, because if suicide is permitted to avoid temporary troubles (such as illness), then it could potentially open up a space for suicide to be permitted to avoid trouble or future sins (Gorsuch, 2006: 27). Augustine's fears have been actualised to some degree, in that we have seen individuals commit suicide on the basis of escaping justice after committing a crime.

2.3.3. Modern perspectives

In pre-revolutionary America, the suicide laws were drawn very much from contemporary English common law and norms (Gorsuch, 2006: 29). In American colonies of the 17th and 18th centuries, forfeiture and ancient pagan practices were endorsed, which included dishonouring the corpse of the individual who committed suicide. They also often buried the corpse at a crossroads where it was assumed that the dead person's spirit would be lost, thus leaving the spirit unable to find its way home – a superstitious practice that set out to discourage individuals from committing suicide (Gorsuch, 2006: 29). However, forfeiture laws were ultimately abolished in the late 1900s.

Furthermore, during the Enlightenment it was realised that the abuse of the dead and their families was of no use, especially in terms of seizing all assets of the dead person. This practice ultimately left those close to the family member at a much greater disadvantage (Gorsuch, 2006:30). This brings about an especially important question of how an individual's family might be affected in the event that a patient opts for euthanasia as opposed to life-extending practices. What is the impact of euthanasia for those left behind? Is euthanasia then completely an individual decision? I will explore this in chapter

4, where I discuss the intention of the individual receiving euthanasia from a view of Dignity.

These shifts in the attitudes towards euthanasia throughout history reveals that there has always been a divide in perspectives. The differences through history underlie the development of the arguments for and against euthanasia, as well as the justifications behind the ongoing arguments. This divide in attitudes towards euthanasia persists to the modern day. This further reveals how important euthanasia is as a subject matter for society at large, and makes it clear that the topic is an evolving one, with much room for development in a society such as South Africa.

2.4. Western and African debates

In contemporary society, and especially in those societies that have not legalised euthanasia, suicide continues to be regarded as a stigmatised act that is predominantly taboo, and continues to be closely related to euthanasia. This is especially true for those areas that are more politically conservative. However, in contemporary times people have grown to be more sympathetic towards victims of suicide. Similarly, attitudes are shifting towards euthanasia, as may be seen in the rise of Right to death groups that support the legalisation of euthanasia globally, such as Compassion and Choices (US) and Dignity in Dying (UK).

It is important to note again that those countries where euthanasia has been legalised are mostly Western – Belgium, Luxembourg, Canada, New Zealand, Spain, The Netherlands, and so on (Amzat, 2023: 10). This further underscores the main argument put forward in this study, namely the need to expand the discourse on the legalisation of euthanasia to encompass a more comprehensive African perspective. It is important to move beyond exclusively Western perspectives (and the related ‘for and against’ types of argumentation) to embrace a more inclusive and diverse approach that considers the ethical, cultural, and socio-political contexts specific to African societies. Expanding the

study of euthanasia in an African framework allows us to develop a comprehensive understanding of the complexities and unique considerations associated with end-of-life decision-making in this context, while acknowledging the diverse beliefs, values and practices that shape perspectives on this subject in African communities.

2.4.1. The Western debate

Previous and current studies concerning euthanasia mostly relied on perspectives that were developed from a Western point of view. Such studies have been very similar in nature, in the sense that they centre around the rational arguments for and against euthanasia. While it is important to discuss the legalisation of voluntary euthanasia from the Western perspective, it is crucial for the development of the euthanasia debate in South Africa that such discussions should also be viewed through a different lens, and in particular an African lens. A typification of the ‘for and against’ type of argumentation that is distinctive of the Western euthanasia debate is founded in the topics of the Slippery Slope and the Sanctity of Life arguments, which are archetypal for many of the claims against the legalisation of euthanasia promulgated in the West.

2.4.1. Slippery slope

The Slippery Slope is a logical fallacy that describes a particular action or decision as leading to a series of increasingly undesirable or harmful consequences. Prominent arguments against euthanasia are based on the slippery slope fallacy, stating that if euthanasia were to be legalised it would lead to an unstoppable chain of events that would result in negative outcomes, particularly in the law, because the conditions for legalising the act might become blurred and its ethics might be easy to compromise. This criterion therefore also encompasses arguments that are centred around the potential for abuse of the legalisation of euthanasia.

Suicide based on mental health struggles, such as bipolar or depression, could be argued to be exclusive to the Slippery Slope argument, as such acts are in essence not an escape from one's lived reality but instead take place under circumstances which are not in the individual's full control. The Slippery Slope argument also states that if PAS and/or VAE are legalised, doctors would abuse their power to end the lives of patients who are considered to be more vulnerable. Patients could in some cases even be coerced into opting for VAE or PAS. According to the Slippery Slope, the worst-case scenario is that such legislation could lead to the practice of involuntary euthanasia and the killing of many patients who did not request for their lives to be ended (Moodley, 2011: 279). Such claims are telling of a Slippery Slope logic and are flawed from the outset, however.

2.4.2. Sanctity of life

The other typical argument in the Western perspective is that of the Sanctity of Life, which states that life is sacred and is not to be taken by an individual (even by oneself through suicide). This argument presents as its basis the inherent value and inviolability of human life, often from a Judeo-Christian perspective, and also relates to arguments for the value of suffering. In the context of the Western euthanasia debate, the Sanctity of Life argument asserts that human life possesses an intrinsic worth and dignity that should be protected and preserved, regardless of quality of life or circumstances. This argument also states that God has the authority to start and end an individual's life. Therefore, when doctors assist patients in such decisions, they take on this authoritative role by "playing God". Because of this, it is concluded that participating in VAE and PAS is morally wrong because an individual or doctor essentially deposes God from His authoritative seat as the almighty powerful entity (Moodley, 2011: 279).

2.5. Towards the African debate

These arguments are contrasted by the arguments for euthanasia, which will also form a basis for the argument in this study from an African perspective, namely that concepts such as dignity and personhood should be placed central. I argue that euthanasia should

take a direction towards an African philosophy perspective. This is central in my study because it is a study based on South Africa and written by a South African scholar, but also because I believe that the African perspective can make important contributions to the global discussion. Such a contextual approach enables me to draw inspiration from the South African constitution to argue my point, specifically in terms of rethinking the Right to Life. Therefore, translating euthanasia as the Right to Life is my primary focus in this study.

An example of an alternative perspective is provided by Ogunbanjo and van Boagaert I. They delve into the complex meaning of euthanasia in their article *Voluntary Active Euthanasia: Is there a place for it in modern medicine?* (2008:38), where they propose three interpretations of the term *euthanasia* – that of a quiet death; a means of procuring death; and the action encompassing this process. Nonetheless, they highlight a significant omission in the discussion: the consideration of the well-being of the person whose death is in question and their underlying motivation for desiring death. Ogunbanjo and van Bogaert (2008: 38) assert that:

> What is missing here is the exclusion of the good of the person whose death is in question and the fact that the death is desired for that person's sake. Euthanasia cannot be morally justified unless it benefits the person who dies.

They therefore contend that euthanasia cannot be justifiable on ethical grounds unless it serves the best interests of the person who ultimately undertakes it. In the context of African thinking, as will be posited in chapter 4, these considerations need to be balanced with the community's views on these issues.

2.6. Chapter conclusion

In this chapter, I explored the meaning of euthanasia by circumscribing the term. I explored the origins of the concept, discussed the different forms of euthanasia, and how they may contribute to the argument that I am attempting to build with regard to the legalisation of euthanasia in a South African perspective. Furthermore, I have traced the history of euthanasia and how the attitudes towards the subject matter have shifted over time, despite there still being a dichotomy in the arguments for and against euthanasia, to present the general theme.

This has led me to conclude that the argument is primarily Western in nature due to the historicity of the debate, but has the potential to develop towards a more African perspective. Doing so will allow me to explore the future of euthanasia in the world and specifically in the South African context, where euthanasia is still not legal or widely discussed amongst the general population. Before developing this philosophical perspective further in chapter 4, however, I first need to sketch the legal framework for this question in South Africa to illustrate (and contrast) formal structural considerations with cultural and societal aspects.

Chapter 3: “The Right to Life, The Right to Death”: Legal aspects

3.1. Chapter introduction

In the previous chapter I have sketched a map concerning the Western philosophical debate around euthanasia. In the current chapter I will investigate the legal frameworks concerning euthanasia in South Africa, before introducing African philosophical aspects into the discussion in this specific context. I will also illustrate how the claim of a Right to Life in the Constitution may be translated as a Right to Death that would suggest the legalisation of euthanasia in this milieu. What does the legal context in South Africa look like?

Euthanasia is currently illegal in South Africa: it is still considered to be murder and an unlawful act (McQuoid-Mason, 2015: 34). However, there exists legal precedent for euthanasia (or physician-assisted suicide) to be justifiable under certain circumstances, as was determined in the Stransham-Ford case. Robin Stransham-Ford, a well-known South African lawyer, was diagnosed with terminal stage 4 cancer and after several applications and court cases was granted permission to end his life on the grounds that he was of sound mind and not under any influence or coercion when he made his court application (McQuoid-Mason, 2015: 35). Based on the results of the Stransham-Ford case and the “right to life” described in the South African constitution, I will argue that that same Right to Life can and should extend to the Right to Death; and that there exists a right to end that life, should an individual or patient feel that their life is not of a sufficient quality. It is ironic then that the constitution gives an individual the Right to Life but does not consider the circumstances that constitute a life worth living.

In this chapter, I discuss the importance of legalising euthanasia on the grounds of preserving dignity and quality of life. I support this argument by exploring the current legal stance of euthanasia in South Africa, and with reference to the several Right to Death societies as well as the several Right to Death cases that have been prominent in South

Africa. These public societies and cases have challenged the justice system and its stance on euthanasia in present day South Africa. Finally, I will argue that the above-mentioned leads to a conclusion that the Right to Life in the South African Constitution should also be interpreted as the Right to Death[4].

3.2. Case studies in euthanasia

Below, I discuss the legal aspects related to euthanasia through the lens of several case studies, to support my argument that euthanasia should be legalised in South Africa as enshrined in the Constitution.

3.2.1. Dr Kervorkian – A problematic case study

One of the most notable figures in the physician-assisted suicide and euthanasia space is Dr Jack Kervorkian. Dr Kervorkian, who is a retired pathologist and infamous for assisting a fifty-four-year-old Alzheimer's patient to end her life in June 1990 (Gorsuch, 2006: 1). Dr Kervorkian assisted the patient (Miss Atkins) to end her life in the back of his Volkswagen van (a space which is already very chilling and discomforting).[5] Importantly, it was established that Dr Kervorkian had not taken the medical history of the patient prior to his assistance in her suicide, and he had also not conducted a medical or mental examination of the patient. In addition, he had not consulted the patient's primary care physician to gather any information on her condition (Gorsuch, 2006: 1).

I would argue that this act, conducted in this manner, was reckless on the part of Dr Kervorkian. By not conducting medical examinations or consulting the patient's physician,

[4] By exploring the idea of the "right to life" I am not merely suggesting a focus on quality of life per se. Rather, the idea that the constitution grants the South African citizen the "right to life" should be extended to the freedom to make a decision regarding when or how that life should end (choosing the nature of one's death is a "right to death").

[5] I argue that if euthanasia is to bring about a painless death, free of suffering, that the act should also include consideration of the environment in which the act is conducted.

had no certainty that ending the patient's life was the final solution to her problem, since there could have still been life-extending practices that could have contributed positively to her continued existence prior to taking such a final decision. Moreover, it was problematic that he had not taken a mental examination which could prove that the patient was of sound mind to make such an irreversible decision (for indeed, the patient could have made the decision in an impulsive state of mind). Such aspects support the view that the euthanasia debate should closely consider the importance of the extent to which the patient meets the criteria for eligibility to receive euthanasia (Roscoe, *et al.*, 2000).

Dr Kevorkian acted carelessly in this particular case, and potentially in other cases as well (such as the case of performing euthanasia on television) (Gorsuch, 2006: 6). It is imperative to note the sensitivity of the topic under discussion (that of euthanasia), and to ensure that euthanasia is not used as a form of exploitative gain for physicians or proponents of euthanasia who are attempting to advance their careers or their own causes. These problematic cases therefore demand that the philosopher and ethicist should pause and reflect on the issue carefully.

Dr Kervorkian was convicted of second-degree murder for his television spectacle (Gorsuch, 2006:6), which sparked a massive debate around the topic of euthanasia. Information also surfaced that Dr Kervorkian had claimed to have assisted an estimated 130 patients in their suicides (Gorsuch, 2006: 5). His aim was to establish not only a right to receive assistance in suicide, but to afford individuals a right to be killed by another person, as long as consent is provided and the person who assists is motivated by compassion or mercy. This description inherently alludes to both voluntary and involuntary acts of euthanasia (Gorsuch, 2006: 5). I argue that it would be an injustice towards individuals if an unqualified individual (for example a friend or family member) conducts the act of euthanasia: the act must be conducted in the correct and appropriate manner and environment by a trained physician with the appropriate knowledge and skill set. Allowing unskilled persons (regardless of their motives) to assist in killing an individual, is reckless and could potentially lead to situations where the act of euthanasia does not turn out as planned. On the other hand, if things do not go as planned in a

hospital or hospital-like environment, with a physician on hand to assist, the physician can always resort to other measures to remedy the situation.

In a mostly conservative society, such as South Africa, it is important to consider the potential reception of a situation such as the foregoing among its citizens, particularly in light of the significant emphasis placed on palliative care and life-prolonging practices in the South African context. Philosophical studies, such as the present investigation, may be a crucial first step towards uncovering insights with regard to euthanasia in our context, thereby furthering our contextualised understanding.

3.2.2. Sean Davison – Opening the door in South Africa

In this section I wish to highlight a figure similar to Dr Kervorkian, namely Sean Davison, who propelled the euthanasia and end-of-life debate in South Africa (Ncayiyana, 2012). I will discuss the differences and similarities of both cases and reveal the significant role that Sean Davison has played in the euthanasia debate in South Africa, particularly in terms of the constitutional Right to Life and Death (as will be explored in more detail in Section 3.3).

Sean Davison is a prominent figure who advocated for euthanasia and assisted dying, arguing for the right to die with dignity. Dignity South Africa emerged as a direct result of the arrest and subsequent legal proceedings involving Professor Sean Davison in New Zealand during September 2010. Dignity SA is the most prominent Right to Death society in South Africa. It is an end-of-life group whose vision is to see a “world where every individual is afforded the basic human right to self-autonomy in end-of-life-decisions” (Dignity SA, 2019). Dignity SA’s mission is to “advocate for a change in South African laws that would enable mentally competent adults the option of a dignified death, should they so choose” (Dignity SA, 2019). Dignity SA conducts their work through court cases, assisting individuals in court cases, rallying, or marching and drawing up petitions for the public to participate in. The most prominent case on which Dignity SA is currently working,

is that of Diethelm Harck, a man who suffers from multiple myeloma and wants to have his life terminated when the time comes that his health completely fails (Dignity SA, 2021).

The Kervorkian and Davison cases are similar, in that both individuals acted in assistance with another individual's suicide. In doing so, both the assisting individuals were motivated by compassion, and the actions of both led to them being charged with murder. Although they both received suspended sentences, their actions sparked a national debate in their respective countries regarding end-of-life issues. What makes these cases relevant to this study is that in each case, the individual took a stand to assist someone whose life was in a deteriorating state. Despite public scrutiny, Kervorkian and Davison both continued to fight for people's right to die in the name of individuals exercising their freedom of choice.

In the next sections I will introduce cases that were significant in both South Africa and America for the purpose of comparison, and also to investigate what one country can learn from the other in terms of legislation and in terms of the individual's exercising of their rights.

3.2.3. Prominent Right to Death/Pas/Euthanasia cases in South Africa: Stransham-Ford, Diethelm Harck, and Susan Walter

Even though euthanasia is illegal in South Africa, there have been several prominent cases of patients who have attempted to have their lives terminated. The most prominent case is Stransham-Ford v Minister of Justice and Correctional Services and Other. This was a case that involved a lawyer (Robin Stransham-Ford) who was terminally ill with stage 4 cancer and sought assisted suicide. However, he died before his court ruling. In this section, I will be referring to *Stransham-Ford* as the *applicant* based on his application to the Constitutional Court to have his life terminated.

Robin Stransham-Ford's lawyer that was representing him in his case (Stransham-Ford v Minister of Justice and Correctional Services and Others), made the Judge aware of the applicant's age, number of accomplishments and number of children in order to indicate that *Stransham-Ford* knew what he wanted in launching this application and understood why he was making the decision to terminate his life. Furthermore, the lawyer made mention of the fact that the applicant had received a psychological evaluation from a clinical psychologist on 10 April 2015, who agreed that the applicant was of rational and sound mind at the time of making his decision. The point of this was to further emphasise that *Stransham-Ford* was not making the decision based on impulse and lack of rationale (Jordaan, 2017). This involves a critical criterion for the consideration of euthanasia, mentioned in chapter 2, where I indicated that being of sound mind is of importance in evaluating the criteria that one must meet in order to request euthanasia. *Stransham-Ford* was a middle-aged man who was now in a position where his health was deteriorating, and his quality of life was being compromised. These are crucial points that I will further emphasise in this study.

When the Stransham-Ford application was made, specific questions were asked in order to qualify the argument. These questions were:

- Is it possible that an individual's health can deteriorate to the extent that an individual would want to end his/her own life?
- Is it morally justifiable to allow the sufferer to take their own life?
- Is it morally justifiable to allow another individual to assist a patient or sufferer to end their own life?
- Should this person specifically be a medical practitioner?
- What measures must be put in place to protect the individual and the medical practitioner?

Each of these are ethical questions that not only address the issue of ending one's own life, but also the involvement of others. Overall, these questions address the central 'quality-of-life' question in Stransham-Ford's case, which formed the basis of request since his quality of life began deteriorating from the middle of March 2015. He suffered

severe pain, nausea, vomiting, stomach cramps, constipation, disorientation, weight loss, loss of appetite, high blood pressure, increased weakness and frailty related to kidney metastasis. He also suffered other problems in addition to these, including a slight decline in mental health. However, though one could argue that his decline in mental health would have prompted him to feel an increased need to end his own life, the applicant was deemed mentally fit to make the decision to end his life, as mentioned above. His state of health compromised his quality of life significantly and as I will illustrate, according to the World Health Organisation, good health is one of the primary indicators for an individual to be considered to live a life of quality (WHO, n.d.).

The South African Constitution is the highest order of authority and all laws must conform to the constitution. This is one of the reasons why it is important to look to the constitution first when trying to find justifiable reasons for the possibility of legalising euthanasia. As indicated above, the main focus of this study in the constitution is “the right to life”. The constitution is in place to protect individual rights and those rights may not be violated unless there is a justifiable reason (Section 36 (1)). This is to say that since the constitution protects the right to life, that individual’s life cannot be put to an end with no reasonable meaning. The court also stated that it is not constitutional for the Health Professions Council to subject doctors to rules that do not allow them to help patients practise the constitutional rights, such as the right to dignity (Section 10) and freedom and security of the person (section 12), by forbidding physicians to assist patients in their end-of-life choices (McQuid-Mason, 2015: 35; Jordaan, 2017)

The rights in the South African Bill of Rights (including the Right to Life) are rights that are linked to an individual’s dignity. McQuid-Mason (2015) mentions that the right to life does not simply refer to one’s mere existence but that that right to life is also a reference to one’s dignity. I interpret this as that there is more to an individual than simply existing or simply just being: a person possesses a particular essence, which is what provides an individual their dignity. I will further elaborate on this in chapter 4 where I dive deeper into the philosophical aspects of my argument. I will do so by providing a brief account of Jean-Paul Sartre’s idea of Being and essence, before investigating this same idea through the framework of African thought. McQuid-Mason explains that the constitution

does not protect the right to an existence, but simply protects the right to life (Mcquid-Mason, 2015:36; Jordaan, 2017). This clearly draws a distinction between the two concepts, which in my opinion is where the ambiguity lies in this section of the constitution. There is also a clear overlap between the legal and philosophical spheres in the point. This distinction is what led the court to its decision in the Stransham-Ford case. The court focused on the constitutional rights to dignity (Section 10) and freedom and security of the person (Section 12), alongside the right to dignity and life (Section 1) and concluded that these rights intertwine. I used the SA Constitution as my primary base because I drew inspiration from my previous work that was focused on how A philosophical analysis of the values of the South African constitution reveal underlying contradictions in the relation between the right to exercise one's free-will and the question of euthanasia. I suggested that the illegality of euthanasia stands in contrast to the existential values of freedom of choice enshrined in the constitution. There is no objective answer to whether or not legalising euthanasia would compromise the constitution's values per se without the introduction of questions of ethics and the "right to life" into the current legal debate.

Another South African case is the Diethelm Harck case. Diethelm Harck and Dr Suzanne Walter are currently in court to be granted permission to end their lives with dignity. Similar to Stransham-Ford, the individuals are extremely ill and are experiencing a deterioration of their quality of life. Harck and Walter both suffer from Motor Neurone Disease (MND). Motor Neurone Disease occurs when specialist nerve cells in the brain and spinal cord, known as *motor neurons*, stop working properly. The case of Diethelm Hack and Suzanne Walter presented each of them as plaintiffs who were requesting end-of-life assistance legally. Suzanne Walter was classified in the court documents as "an adult female practicing medical doctor specialising in palliative medicine of sound mind". Similarly, Diethelm Harck was described as "an adult of sound mind" (Martin, 2021; Parle, 2022). This information, specifically describing them as individuals of sound mind, is of importance as it serves as one of the requirements for receiving permission to make an end-of-life decision legally, as identified in chapter 2.

The court documents describe that in February 2017, Suzanne Walter was diagnosed with Multiple Myeloma (MM), which is a type of bone marrow cancer. Bone marrow is

found in the centre of some of the bones in the body and is important to the body as it produces the body's blood cells. The disease is called *multiple myeloma* because the cancer affects several areas of the body, for example, the spine, skull, pelvis and ribs. MM presents its patients with many symptoms which affect everyday life for an MM patient. These symptoms are a persistent bone pain, usually in the back, ribs or hips; tiredness; weakness and shortness of breath (caused by anaemia); high levels of calcium in the blood (hypercalcaemia, which may cause symptoms including extreme thirst, stomach pain, needing to urinate frequently, constipation or confusion); weight loss, blurred vision; dizziness or headaches (hyperviscosity, caused by thickened blood), repeated infections; bruising and unusual bleeding (such as frequent nosebleeds, bleeding gums and heavy periods); weak bones that fracture easily (if this affects the spine, it might cause symptoms such as pins and needles, numbness and weakness in the legs and feet and problems controlling one's bladder and bowels (which requires emergency investigation); as well as kidney problems. Myeloma does not have a cure, but the symptoms can be treated in order to allow patients to at least live somewhat of a decent life. The treatments include anti-myeloma medicines that attempt to destroy myeloma cells or control the cancer when it comes back. There are also medicines and procedures that can prevent and treat the problems that are caused by myeloma, such as bone pain**.** However, most of these treatments are for the symptoms, which are the secondary results of multiple myeloma. The treatments can and do have side-effects, which make it difficult to live with the disease.

A strikingly similar case is that of Diethelm Harck, who was diagnosed with Motor Neurone Disease (MND) in June 2013 (Martin, 2021; Parle, 2022). MND is a condition that damages different parts of the nervous system and can cause muscle weakness brought about by the damaged parts of the nervous system. When MND occurs, motor neurons (specialised nerve cells in the brain and spinal cord) stop working properly. They undergo neurodegeneration. Motor neurons control muscle activity like gripping, walking, speaking, swallowing and breathing. All these functions, I argue, are necessary for living a quality life. As one's condition becomes worse, it becomes difficult for an individual to do some (or all) of these activities, thus making it difficult to live one's life in a productive sense. As MND progresses to its final phase, individuals suffering from it might experience increasing body paralysis, with the consequence that an individual will need

assistance with most daily activities. The individual will also experience a significant shortness of breath, which will eventually necessitate non-invasive breathing assistance. Additionally, individuals suffering from MND also stand to suffer from secondary symptoms which are caused by the stress of living with MND, with symptoms such as anxiety, depression and insomnia being prominent**.** Like MM, there is no cure for MND, but there are treatments available to assist in relieving the symptoms. However, if one's condition continues to deteriorate and the symptoms do not improve, one might have to opt for palliative care.

As noted above, both Walter and Harck are suffering from diseases which affect their day-to-day experiences as well as their financial survival in ensuring the management of the diseases, which explains why these individuals would opt for end-of-life assistance. In their case, it was explained that in terms of the common law, it is not unlawful (i.e. it is lawful) for Walter and Harck to commit suicide, nor is it unlawful for a physician to prescribe them with medicine which will assist in ending their lives. The conditions, however, are that both Walter and Harck must make the decision based on a free and voluntary request and the physician must know and have confirmed the terminal illness diagnoses of both patients. Additionally, the physician must not act in a negligent way when prescribing this requested medication, nor must the physician encourage or influence the individuals to make the decision to end their lives. Lastly, the plaintiffs (Walter and Hack) must administer this said medication as prescribed. These are crucial stipulations, because it can assist in avoiding abuse of patients by physicians. It can also assist in ensuring that the ill patients make the decision of sound mind and do not make the decisions for the wrong reasons. It is to ensure that the decision to end one's life is the final decision after one has attempted all the available options to assist with the symptoms of the illness. The court in the Walter and Harck case found that it is unlawful for a physician to end the lives of, or to administer any medical advice on ending the lives of Walter and Harck through administering anything lethal to them. The court explained its stance on Physician Assisted Euthanasia (PAE), stating "PAS and PAE are considered 'unprofessional conduct' " (Martin, 2021; Parle, 2022).

This disease has affected Harck's life, who used to be a physically active individual who participated in marathons, cycling, hiking and the like (Daily Maverick, 2021). However, during his trial in 2021, he was using a walking stick and was not functioning at his best physical level. Harck's deteriorating health was clearly the main reason for his request to have his life peacefully terminated. He expressed that "my biggest fear is that when my love of life reaches the stage of fearing life, I will not be able to die" (Daily Maverick, 2021). He witnessed many MND deaths which were not peaceful, and he realised that his life would become much more difficult; therefore he requested a peaceful and dignified death. Harck's main grievance is essentially not being able to have a choice (Daily Maverick, 2021).

The Health Professions Council of South Africa (HPCSA) and the Minister of Health, Justice and the National Director of Public Prosecutors are opposing Harck and Walter's applications, based on the claim that palliative care is available to all South Africans to alleviate suffering, and that the ban on euthanasia is there to protect the Right to Life, which is a pivotal right in the South African Constitution (Daily Maverick, 2021). A flaw I find in this argument of the HPCSA and the other mentioned institutions is that palliative care is a choice as well, since one has the choice to refuse palliative care. An alternative to palliative care, however, does not exist in South Africa. I propose that euthanasia should be that alternative, or at the least that physician-assisted suicide be allowed. Palliative care leans more towards extending practices on the spectrum of life-and-death practices.

Next, I will investigate prominent and pivotal international cases that relate to euthanasia.

3.2.4. Prominent Right To Death/Pas/Euthanasia cases internationally: Vacco vs Quill and Washington vs Glucksberg

Deciding to end one's own life is a major decision to make. It is a very intimate and personal choice and one which is central to personal dignity and autonomy (Gorsuch,

2006: 9). I wish to explore this claim through the examination of case studies involving individuals who seek to make this decision to end their lives based on personal dignity and autonomy in the international context. The cases on which I will focus in this section are Washington vs Glucksberg, and Vacco vs Quill.

In the introduction of the book *Law at the End of Life: The Supreme Court and Assisted Suicide (2000)*, Schneider states that the two cases, namely Washington vs Glucksberg and Vacco vs Quill, are centrally important to the modern history of end-of-life issues because they have provided the legal cornerstone for other court battles that followed in their wake. Many end-of-life cases have looked to these cases as reference on how to navigate judgements (Gorsuch, 2006:25; Scheiner, 2000).

Washington vs Glucksberg was a 1997 court case that ended up in the US Supreme Court. The decision of the case was that “assisted suicide in the US was not protected by the due process clause” (Gorsuch, 2006: 11; Scheiner, 2000). A physician, Dr Harold Glucksberg, four other physicians, three terminally ill patients and a Non-Profit Organisation called ‘Compassion in Dying’ challenged Washington’s ban against assisted suicide in the Natural Death Act of 1979. Their argument was that assisted suicide was a “liberty interest protected by the Due Process Clause of the Fourteenth Amendment of the United States Constitution, which included a fundamental right to assisted suicide”. He described this liberty interest as a right to die (Gorsuch, 2006:11, Scheiner, 2000). A statute had already existed in Washington which did not allow physicians to assist patients with suicide, and thus anyone who assisted in suicide could be subject to criminalisation.

The case started in the district court, which affirmed Gluckberg’s claim that the liberty interest was unconstitutional. The 9th circuit appealed this, but Glucksberg still won the case (which affirmed his claim). However, once the case reached the US Supreme Court, the court stated that Washington’s assisted suicide ban was not unique and other states held a similar position and there was already a long tradition of banning suicide. The outcome of the case was that the right to assisted suicide was not deeply rooted in the

country's history and traditions (Gorsuch, 2006:11). In other words, there was no historical evidence of assisted suicide being legal in the US, therefore, Glucksberg's requests and claims held no weight constitutionally – there was no precedent. The court wanted to know whether the right to die was a sufficiently particular right, meaning that the right was of a broad nature. The court instead chose to view this claim as a request to assisted suicide.

The court leaned on the Nancy Cruzan case, which recognised that a person in a persistent vegetative state had a right to be taken off life support. The court stated that the fundamental right recognised in the Cruzan case was the right to refuse life-saving medical treatment, and not a general right to die (Gorsuch, 2006:11; Scheiner, 2000). This was less broad in the opinion of the court, and narrowed down the request to one that could be met. The right to die left too much room for anything to happen. The court overturned the Ninth Circuit decision and declined to recognise a constitutional right to die. The decision of the court was deliberate in drawing a clear distinction between refusing life-saving treatment, which is constitutionally protected; against receiving life-ending treatment, which is not constitutionally protected.[6]

Another important case took place on 20 June 1994, when a New York litigation was led by Dr Timothy Quill, the author of the *New England Journal*, who wrote an article defending his decision to prescribe sedative medication to a terminally ill patient (Gorsuch, 2006: 9). Dr Quill and a group of other individuals, which included fellow-physicians, decided to challenge the New York law prohibiting the intentional assistance or promotion of suicide (Gorsuch, 2006: 11). Vacco vs Quill was also a case that made it to the Supreme Court. The court ruled that the New York ban on physician-assisted suicide was constitutional and prevented doctors from assisting patients to end their lives, whether the patients were terminally ill or incapacitated. The court's decision held that

[6] I agree that it was an unnecessary distinction to draw, but I would argue that it is ambiguous in itself because refusing life-saving treatment leads to one's death, albeit at a slower and more natural pace. This is then also a decision to end one's life.

there was no constitutional guarantee of a “right to die”. In other words, the right to die was not recognised as a human right in the state’s law (Scheiner, 2000).

Similar to the outcome of Washington v Glucksberg, the judge in Quill’s case examined the case via the historical lens of pre-existing laws. Similarly, there existed no laws that supported the right to die as an actual human right (Gorsuch, 2006: 12). Dr Quill and his fellow physician-plaintiffs argued that, even though there were no pre-existing laws, the Fourteenth Amendment renders statutes against assisted suicide unlawful. They pointed out that the New York statutory law allowed patients the right to refuse medical care or life-saving treatment, which would result in premature death. It would only make sense to allow assisted suicide, because withholding life-saving treatment at the request of the patient is in itself assisted suicide. The judge, however, disagreed, stating that the New York State merely needed to present a rational and clear distinction in its law between refusing treatment and seeking assisted suicide, so as not to blur the lines (Gorsuch, 2006: 12).

The Glucksberg and Quill cases are similar in that the laws in both states allowed both Glucksberg and Quill to lean on the fourteenth amendment for their respective cases (Gorsuch, 2006:12). One issue that has been highlighted by the analysis of the two cases, is the concept of the double effect. The double effect may be explained as follows: “pain medication is typically used to relieve a patient’s pain and reduce suffering; however, when administered in sufficient doses, it can end the patient’s life. Under this scenario, relieving pain is the primary purpose and ending life is a secondary one; together, the two are often known as ‘double effect’ ” (Gorsuch, 2006: 25). Pain medication is therefore a pharmakon.

3.2.5. A comparison of two worlds

What the presented American and South African cases have shown, is that even with palliative care or refusal of life-saving treatment, the final results will still be death. The

difference is that there is suffering involved in waiting out one's death as opposed to ending that life. Living through constant and unbearable physical pain and mental anguish is, I would argue, as good as being dead.

The conditions that Harck, Walter and Stransham-Ford experience/d are exactly what Quill and Glucksberg argue against putting people through. As physicians, they regularly encounter patients like these and they understand the effects of treatments on terminally ill patients and how unbearable such treatments can be. Additionally, they understand that life-saving treatment is not necessarily always fully life-saving, since individuals might not recover fully.

Both countries' laws lean heavily on the final option for terminally ill patients being palliative care. However, palliative care may simply be a step closer to death, and I would argue that it is in fact a preparation for death.

3.3. Euthanasia legality and the Constitution of South Africa

Euthanasia is currently illegal in South Africa and, if committed, is considered as murder or a punishable crime (Koenane, 2017: 1). The Bill of Rights is a section in the Constitution of the Republic of South Africa, 1996, which holds great weight, as it emphasizes the human rights of South African citizens. The Bill of Rights enshrines the democratic values of human dignity, equality, and freedom. The Bill of Rights furthermore states that everyone is equal before the law, and everyone has the right to equal protection in the eyes of the law. The Bill of Rights essentially provides a safety net for South African citizens' rights, and the State must protect and fulfil the rights in the Bill of Rights. Two crucial rights that must be protected, are found in the Bill of Rights, namely the Right to Life and the right to an inherent dignity. These two aspects are of great importance to my developing argument in this study, as they lay the foundation for my standpoint that euthanasia should be legalised in South Africa. The aim of this portion of the study is to reveal this exact contradiction that is found in the constitution.

3.3.1. The Right to Life

The Bill of Rights in the South African Constitution is there to protect South African people's rights, and these rights include provisions that are related to the right to health. This right to health extends beyond the right to healthcare services, as it includes the various social determinants of health, i.e. "adequate water, social security, housing and education as well as fundamental rights such as dignity, equality and life" (London, 2011: 97).

Sections 10 and 11 of the South African Constitution (1996) state that everyone has the Right to Life and to dignity. The general interpretation of this Right to Life in the South African Constitution is that individuals are offered this Right to Life by virtue of birth, by the very fact that they are alive, to have basic needs and to have that life protected by the state. No one has the right to violate or endanger that life, and this extends to physicians who are also ethically bound by their Hippocratic Oath.

My interpretation of the Right to Life in the Constitution is that, as an individual of sound mind, I have the right and the responsibility to decide how I want to live my life, while respecting those around me and their right to life. The interpretation of the Right to Life as the Right to Death suggests that I have the right to decide when I no longer deem my life as one of quality, and hence to end it. The quality-of-life argument that I posit will also take account of specifically those physical boundaries that terminal illness can impose on one's general well-being and those social boundaries that arise around the individual, namely those of the family or community.

The Right to Life is the right to not only be alive but the right to live a life of dignity and quality. This is essentially the right to define what "life" constitutes. Making the decision to end one's own life is having freedom over one's own body (a concept which I will later explore in this study). This is emphasised in the section of the Bill of Rights, which states that individuals have the right to security and control over their body. This is one of the core justifications of my argument, namely that one should have autonomy or freedom to choose what to do with one's body or life if it is no longer of quality due to terminal or incurable illness. Having the Right to Life, along with control over that life, grants me the right to essentially end that life – I therefore translate the Right to Life as the Right to Death.

Euthanasia as a Right to Life implies that by choosing euthanasia, one chooses to exercise their Right to Life in a way that one sees fit. I argue that citizens of South Africa may choose the right to a life of quality, as based on what that individual deems to be quality.[7] Consequently, euthanasia as a Right to Life refers to one choosing euthanasia in order to release one of a life that one does not deem worthy of living; a life that is not of quality. The South African Constitution states that every individual has a Right to Life, which may not be harmed by any other individual. The constitution does not, however, mention anything about the quality of that life – this is one of the constitutional ambiguities that could be pointed out. Based on this, I argue that determining what quality of life means and constitutes is the primary consideration for the act of euthanasia. If I have an incurable disease, and I am struggling with daily activities while accumulating multiple medical bills, I am not necessarily living a life of quality. Therefore, I am allowed to make a decision to end that life, and a right to decide what quality of life I want. In order to make that choice however, I also exercise the right to have a freedom of choice. Freedom is inherently afforded to all human beings as their birthright per the Constitution, and entails a natural right over one's own life.

[7] Disclaimer: I suggest that his section of the study specifically applies to people who are terminally ill or in a vegetative state.

It may be claimed that this palliative care is intended to protect the right to life of South African citizens, but I will argue that protecting the Right to Life in this context does not consider the dignity of the individuals receiving that palliative care. The concept of dignity and what it truly entails to live a dignified life will therefore be discussed in the next chapter.

3.4. Chapter conclusion

Choosing when and how to die is a very personal matter, and in fact one of the most important decisions that one can ever make. As an individual, I argue that the government should not be able to intrude on that decision. In this chapter it was shown, however, that the laws in both South Africa and the United States stand in the way of those individual decisions, by not allowing the option for euthanasia or the option for end-of-life decisions to be explored. Individuals' personal choices regarding their quality of life are not taken into account, which results in an ambiguity with regard to individuals' Right to Life in the South African constitution.

I argue that the relevant laws can be changed. Just because a law has never existed or does not have constitutional backing in a country's history, it does not mean that the law cannot be re-evaluated and adjusted on a case-by-case basis. A major question in this chapter is whether the constitution allows people the right to die. The answer in both the American and South African contexts is a definite "no", and the public must therefore make the argument for the legalisation of this right. Evidently, monitoring abuse of power, abuse of terminally ill patients, and abuse of people in general is of great concern when considering the legalisation of any form of assisted suicide. This is something that should be guaranteed not to happen if assisted suicide is legalised. There should be strict rules in place and the necessary checks and balances must be performed. The most important of these, I argue, is the preservation of individuals' dignity and personhood. In addition to all the provided information above, two bodies of work that can further elaborate the current legal stance on euthanasia are D Thaldar's article 'Human dignity and the future of the voluntary active euthanasia debate in South Africa' and H Strauss' essay

‘Physician-Assisted Suicide: Examining the Feasibility and Justifiability of Regulating Voluntary Active Euthanasia in South African Law’. These bodies of work provide the reader with additional information pertaining to how the euthanasia debate has been approached legally in South Africa

Chapter 4 – "The Right to Life, The Right to Death": An African perspective

4.1. Chapter introduction

A crucial aspect to note when embarking on a discussion related to euthanasia and other conundrums found in medical ethics, is to understand the relationship between ethics and philosophy. The argument I am formulating is founded on medicine and legality, but supported by philosophical thought. AA van Niekerk (2011) explains that ethics is a practice or mode of thinking that has been around since the beginning of philosophy. It constitutes a very significant part of thinking amongst some of the best recognised ancient Greek philosophers, such as Plato, Socrates and Aristotle. However, in the 20th century this mechanistic idea of the body in medicine was re-evaluated, as it was *philosophically* necessitated by criticism of Descartes' notion that the body and soul were somehow separate (this idea formed the basis of medical science at the time, and still informs the actions of doctors to this day). The problems of Cartesian dualism in medical science underlines the importance of philosophy in providing a space in medical science for the criticism of restrictive medical formulations of topics like the body and treatments, suggesting a path forward for how those ideas can be reformulated to better accommodate patients.

This approach is also applicable to some of the most influential ways of thinking in medical science with regard to ethics. An important example here is the thought of Hippocrates, who is positioned as the historical founder of Western medicine and is the originator of the Hippocratic Oath (Moodley, 2011:7). This document directs much of the medical resistance towards euthanasia that have been under discussion in this study thus far – especially as related to the idea of first doing no harm. New ways of thinking in philosophy, such as thinking that originated from Africa and other sources in the Global South (in contrast to Western ways of thinking), can inform historical positions, such as the one taken in the Hippocratic Oath, in novel ways to birth new futures. This is reflective of the route that I have taken in this study, namely to reformulate the idea of euthanasia from a South African perspective in order to justify its possible legalisation – particularly through

rethinking personhood and the related themes of quality of life and dignity through a different lens in this chapter.

Chapter 2 and chapter 3 have already been suggestive of the impact of dignity and quality of life on decision-making relating to euthanasia. This has been illustrated through court cases and through case studies that have outlined people's deteriorating physical, emotional and mental circumstances that have led individuals or their family members to seek euthanasia. In earlier chapters I have used the South African Constitution to highlight the ambiguities that affect ethical medical practices in South Africa, specifically in relation to end-of-life issues. A crucial point in the Constitution that I highlighted in chapter 3 is the section on dignity – which was stated as a fundamental aspect that informs my view that a Right to Life also entails a right to a dignified death.

In chapter 2 I explored the relationship between Western academic approaches to euthanasia with African academic perspectives on this same topic. By drawing parallels between the two forms of thinking I have illustrated that Western academia (and its related rationality) dominates worldviews and thinking on euthanasia – though this claim is applicable to a myriad of other topics that find contrasting philosophical treatments between Africa and the West. In chapter 2 I explained that euthanasia is primarily focused on and structured by Western worldviews and thinking regarding individualism and autonomy, which is problematic since most of the academic literature on euthanasia is similarly developed from a Western perspective (and is therefore similarly individualistic in nature).

Contrastingly, the African discussion of euthanasia in literature is limited and is often informed by Western conceptualisations, which is one of the reasons I – as an African scholar – chose to contribute to this topic from an African perspective. This entails an evaluation of euthanasia from a collectivist standpoint in this chapter; hence my focus on euthanasia from the perspective of quality of life, not as conceptualised in the West, but

as informed by African conceptions of personhood. My exploration of euthanasia in light of an African conceptualisation of personhood, as informed by quality of life and dignity, is informed by the works of Kwasi Wiredu, as reflected in engagements therewith by Motsamai Molefe. My reasoning behind this focus on Wiredu by means of Molefe is that Molefe articulates Wiredu's works in a clear and concise manner. Furthermore, Molefe (2017) is one of the most prominent African scholars who focus on euthanasia and his work has made a substantial contribution to the euthanasia debate from a South African perspective. As has been made clear throughout this study, the study is at least somewhat comparative in nature – contrasting Western approaches to Euthanasia with African approaches. Therefore, in this chapter I will contrast the South African perspective on personhood (developed by Wiredu and Molefe) with that of Sartre, who has made a contribution to the personhood debate from the Western perspective by foregrounding individualism and autonomy, concepts which have been held as central to euthanasia from the Western perspective.

I will use these contrasting perspectives to ultimately draw my final conclusion to this study, namely that euthanasia as a right to life translates as quality of life and dignity, which is to be founded in one's personhood, and which may only be developed to its fullest from an African philosophical perspective. In the current chapter I will also discuss two case studies to support my central claim that there is a need for African thought in terms of euthanasia. The first of these studies is Nancy Cruzan's case, which illustrates how euthanasia can be a beneficial practice to not only the individual but also to their surrounding tribe. The second case, that of Vincent Humbert, presents the case of an individual making a decision to end their life and how that individual decision can also be a decision that is beneficial to the community at large.

By translating both these real-world examples through the lens of African thought, I will illustrate the insights that may be offered with regard to euthanasia in the South African context. Such an alternative perspective on the issue of euthanasia is founded, from the start, in the contrast between Western and African theories of personhood.

4.1. Personhood

Personhood is a contentious topic in the academic space, particularly at the intersection of Western and African thought, but it is also a concept that is central to conceptualisations of euthanasia. It is also a concept that is hard to pin down, but as a preliminary or working conceptualisation I will describe it as the characteristics that make an individual a human being – these being the physical, emotional, mental and moral characteristics. The theme of this study has been to re-think Western conceptualisations of euthanasia through the lenses of African modes of thinking. As mentioned above, I wish to do so by providing an analysis of personhood and its relation to dignity and quality of life. I will achieve this through exploring Sartre (who will provide a Western perspective of personhood), and Wiredu and Molefe (who are representative of the African perspective). To trace the differences between the Western and African traditions with regard to euthanasia, therefore, an illustration of personhood in both contexts is needed. Exploring personhood is an ambitious topic, and I attempt to implement it in the study with the least contradictions possible.

4.2.1. Personhood per Sartre

Jean-Paul Sartre is a major proponent of the Western conception of personhood.[8] Sartre, a seminal figure in existentialist philosophy and a prominent intellectual of the 20th century, occupies a distinct place in the annals of philosophical thought that has shaped contemporary conceptualisations of the subject. Born in 1905 in Paris, France, Sartre's philosophical work is characterised by an intricate exploration of human existence, ontology, and the nature of subjective consciousness. Jean-Paul Sartre's concept of "being-in-itself" and "being-for-itself" is fundamental to his existentialist philosophy

[8] The selection of Sartre here might be controversial. Other (arguably more significant) proponents of Western individualism, such as Smith, Bentham, de Tocqueville, Locke, and Hobbes may also be investigated in this regard. One reason for the selection of Sartre is his infiltration into popular conceptions regarding questions of free will, which feed directly into public views regarding the question of euthanasia.

(Sartre, 2022: 18-23). Being-in-itself refers to the existence of objects, entities, or things in the world that lack consciousness or self-awareness. These entities simply “are”, without any subjective awareness or intentionality – they are fixed, inert, and lack freedom. Being-for-itself, on the other hand, represents conscious human existence. It is the essence of human consciousness, self-awareness and subjectivity, and is characterised by freedom, choice, and intentionality. Human beings, according to Sartre, are beings for themselves because they are not just in the world like objects, but actively engage with the world through their consciousness. They have the capacity to reflect, make choices and define their own essence through their actions (Cerbone, 2014: 93, 94).

Sartre’s concept of personhood entails three important elements, namely (1) Sartre’s philosophy of existence, (2) Sartre’s idea of engagement, and (3) Sartre’s concept of humanism. Sartre’s concept of personhood heavily emphasises that every human being comprises possibility, which carries constant responsibility for our actions (Rajkovic, 2019: 191). His ideas on personhood stand out in the philosophical realm due to his description of essence and existence, through which personhood is conceptualised for him. His claim that existence precedes essence, is a unique contribution to the idea of personhood. This means that a person exists, and then needs to describe their own essence. As human beings our essence is prescribed to us through our ability to freely make choices and to do certain things. As Patrick Lee explains, our ability to think or have consciousness is opposed to animals or inanimate objects (Lee, 2001). As humans, we exist first, and then develop who we are as humans. Human beings get their essence from being able to exist as free-thinking beings, and as beings who are in a world. As humans, we spend our entire lives creating our essence, and we do so by means of choice (Cerbone, 2014: 87, 88).

Following on this, we can then therefore say that personhood is (for Sartre, and as indicative of the Western tradition) a purposeful realisation of possibilities conducted through concrete actions that are made by human beings (Rajkovic, 2019:193). Sartre puts personhood into context through the ideas of being-for-itself, which describes

possibility, freedom, choice, and intentionality. A human being's essence is an example of this, in that it is a possibility that has not yet been actualised; whereas that human's existence is an already-given. Sartre explains that "Man is condemned to be free" because once thrown into the world, he is responsible for everything he does. My interpretation of this is that as human beings we inherently possess the ability to make of ourselves what we wish. That ability is the possibility that Sartre speaks of as an utmost power, or capacity.

Although Sartre is not the proponent thinker in the subject of personhood, his line of thinking is found to be the best foundation when thinking about end of life decisionsOther contributory aspects to consider include the Four Principles, utilitarianism, Kantian deontology, and virtue.

4.2.2. Personhood per Wiredu and Molefe

The Western view of personhood, as personified in Sartre's philosophy, contrasts sharply with the African view that I will discuss in this section. Keep in mind that these conceptualisations of personhood shape and determine approaches to end-of-life choices. While African philosophy is a divergent and dynamic school of thought in philosophy, I will utilise the views of Wiredu and Molefe to circumscribe a broadly African concept of personhood that may shed light on alternative approaches to euthanasia. Such approaches are crucial for the rethinking of euthanasia in South Africa.

In Molefe's (2019: 194) view the ethics of personhood is constituted by three components, namely

> (1) the fact of being human … Human nature describes biological aspects of being a human being. This human nature means that we are all born with specific qualities that make us human beings. Essentially, we are all a blank canvas with no particular purpose. Human nature informs (2) a view of the moral status quo, the capacity

> for moral view. This essentially describes the distinctive features that humans possess that create moral perfection. Those features are the ones that differentiate us from other creatures. Lastly, this moral view (3) assists in developing a morally virtuous character. Becoming these morally virtuous characters is what leads to us being considered as "persons".

Molefe explores personhood through critically analysing Kwasi Wiredu's idea of personhood. He explains that Kwasi Wiredu identifies two distinct concepts of personhood: the ontological and normative. "The ontological notion refers to the fact of being human or the idea of human nature" (Molefe, 2019: 196). This notion is focused on the biological aspects that make up a human being, what makes up our human nature. In contrast, "the normative concept of personhood involves grading a human life in terms of excellence or virtue, relative to the quality of the moral agent's performance" (Molefe, 2019:196). Personhood, in this sense, refers to the moral status that individuals receive through their consistent moral effort to become better moral agents. According to Molefe, to have moral status means to be morally significant, which should result in an individual being owed moral respect. This moral significance arises on grounds directly related to the nature of the entity in question (Molefe, 2019:196).

4.4.3. Conceptualising personhood in the West and in Africa

Although the African and Western modes of thinking differ, both modes of thinking believe that the fact of being human is what is most important before the idea of a person can be conceptualised. Western thinking is extremely difficult to define and circumscribe. Simply defined, we can say that it is the thought and work of the Western world. On the contrary, African thought is thinking that focuses on pan-Africanism, community, and a heavy emphasis on morals and cultural mores. It stems from thinkers who are of African descent and aims to bring light to African lived experience. African philosophy can be formally defined as a critical thinking by Africans on their experiences of reality – in contrast to the hegemonic perspectives presented by the Western mind. The difference, I argue, is that

in the Western mode of thinking, the human being creates his or her essence outside of other influences, i.e. other people. The African perspective, however, prioritises relations with others to form one's moral status and to "assist" one in the process of becoming a person, whereas becoming a more individualistic formation of personhood is prominent in the West. These divergent conceptualisations shape the debate concerning euthanasia in dissimilar ways.

When one is ill and has to decide whether to end one's life, the Western view prioritises the physical and psychological well-being of the individual. This means that the decision regarding euthanasia is focused on the individual's best interest. An individual decision may be made in this regard because individuals ultimately are born on their own and create their own meaning for their life; and once that meaning is no longer there, they see no reason to live. The responsibility of the individual is to ensure that the decision that they make does not affect those around them, and also that the decision should not be a means to an end. The individual must act responsibly in ensuring that they have exhausted all their options once they finally settle on a decision. Therefore, the Western perspective of personhood relates to questions of quality of life and dignity through an individualistic lens.

In the African view, when one makes the decision to end one's life it is because one's physical and emotional well-being has deteriorated to a point where one's connection to one's environment and social relationships are affected. This perspective is deeply rooted in the communal values and interdependence that characterise many African societies. It underscores the belief that an individual's suffering is not solely a private matter but has broader implications for the community, as it disrupts the intricate web of relationships and responsibilities within which one is embedded. Consequently, the decision to end one's life is considered a communal concern.

Two important considerations in relation to euthanasia, which need to be developed to engage with a communal African account of euthanasia, are the questions of quality of

life and the question of dignity (as espoused from an African perspective). Crucially, African thought entails that these concepts need to be approached holistically and relationally, and that the terms cannot be disentangled.

4.3. Quality of life

Quality of life (QoL) is a wide concept with different definitions associated with it, being defined from philosophical, political and health perspectives. It is therefore difficult to pin one definition to the concept. Furthermore, as has been pointed out in the previous sections, there is a difference in the existential weightings given to the concept of quality of life in the Western and the African view. There are challenges with regard to the question of quality of life. The concept of quality of life is a subjective one and largely involves how individuals measure the "goodness" of multiple aspects of their lives (Theofilou, 2013:151). Furthermore, it is shaped by the broader cultural worldview of which one forms part. Dignity and quality of life are concepts that are bestowed upon a person from a broader context.

Quality of life, as defined by the World Health Organization, may be seen "an individual's perception of their position in life, in the context of the culture and value systems in which they live and in relation to their goals, exceptions, standards and concerns" (World Health Organisation: 11). For the sake of this study, which entails both philosophical and medical ideas, the Health Related Quality of Life (HRQol) index is a good starting point for analysing quality of life. HRQol is defined as the physical, functional, social, and emotional well-being of an individual (Fellowfield, 2009: 1). QoL indicators include, among others, physical and mental health, education, life satisfaction, cultural perspectives, values, personal expectations and goals employment, social relationships, housing and the environment. and security, and freedom (Barcaccia, 2013). When one cannot have the pleasure of these QoL indicators, one can be considered not to be living a life of quality. In the case of an individual who is considering euthanasia, the relevant aspects would be the individual's health, the individual's ability to go about their daily activities without

hindrance, and any physical boundaries that an individual might incur, i.e. doing daily activities such as taking a bath or feeding oneself.

Apart from these basic needs, however, other indicators may be important as well, and even more crucial, depending on who an individual is and what their subjective needs might be. The University of Toronto has a quality of life model that is based on philosophical concepts, namely being, belonging, and becoming (University of Toronto, 2014). The University of Toronto's quality of life research unit defines the quality of life as "a person who enjoys the important possibilities of his or her life". The University of Toronto's quality of life research unit posed the question of possibility, stating that "possibilities result from the opportunities and limitations each person has in his/her life and reflect the interaction of personal and environmental factors" (University of Toronto, 2014). Enjoyment has two components: the experience of satisfaction or the position of achievements of some characteristic (University of Toronto, 2014).

Thus, in everyone's life possibility plays a major role. That possibility is determined by how one is able to enjoy life. When one is ill, one may not have the privilege to enjoy those possibilities. One may, for example, not have the privilege to enjoy something like good health. Enjoying good health is relative, however, because one person might have the advantage of eating healthy, exercising and drinking clean, fresh water; whereas another person might be from a disadvantaged background and might not have access to the necessary things to experience a healthy life. An individual who is terminally ill or in a wheelchair for life, does not get to enjoy the pleasures that other able-bodied or much healthier people might enjoy, and consequently their possibility is stifled.

The University of Toronto's research model consists of three domains of life which are considered to be what make up one's quality of life, with three subdomains for each. The first domain, *being*, is described as who one is and how one is. The sub-domains for being are *physical being*, *psychological being*, and *spiritual being*. The second domain is *belonging* (which is particularly prominent in African thought) and is described as how

one is connected to one's environment. The sub-domains for belonging are *physical belonging*, *social belonging*, and *community belonging*. The third domain is *becoming*, which is described as whether a person can achieve their personal goals, hopes, and aspirations. The sub-domains of becoming are *practical becoming*, *leisure becoming*, and *growth becoming*. Research has found that an individual's quality of life in terms of being, belonging and becoming can be determined by two factors, namely the importance and the enjoyment of the subdomains to an individual. How important a person's physical health, personal values, community life, domestic life, etc. is to a person will determine how that person interprets their quality of life. The same goes for how much they get to enjoy these aspects. The importance and enjoyment of these subdomains are therefore considered to be relative to the individual (University of Toronto, 2014).

Based on the above, I argue that quality of life is a subjective concept and that how one finds meaning in life, differs from person to person; especially in relation to physical capabilities. One's quality of life is a personal matter which cannot be measured by other individuals. Additionally, and as emphasised by African thought, I believe that external factors are important in and contribute to determining one's quality of life – factors which include one's social context and one's community. How one moves around the world, and the agency to do so, are afforded by an individual's quality of life, which is in turn founded upon such consideration. The fact that someone is able to wake up daily, take a bath and go to work, and to repeat the routine daily, is determined by that person's physical capabilities and experience of his or her external world (which includes objects, individuals, and groups), which I believe is what truly makes up one's quality of life. In the next section I will develop the concept of dignity as it arises from this multitudinously informed conceptualisation of the idea of quality of life.

The word *dignity* is often used in discussions that focus on respect, love and well-being. Those who love me, will ensure that their actions do not compromise my dignity; and those who respect me, will do so because of the inherent dignity that I possess as a human being who must be respected. The ability to take care of myself in whatever capacity also contributes to my having a sense of dignity: it is a personal dignity that

arises from this self-care. Dignity plays an important role in how one navigates through life, and dignity impacts on the building of one's sense of worth. A sense of worth is crucial in the foundation of one's existence. Such considerations shape the way in which the individual will deal with end-of-life decisions, and will shape their evaluation of euthanasia.

4.3.1. Quality of life as dignity

In this section I will explore how the compromising of one's dignity can lead to an individual opting for euthanasia, and also what dying with dignity means from an African perspective. I will begin by analysing different types or forms of dignity and the role they potentially play in end-of-life decisions. I will then move on to explore the importance of one's dignity in end-of-life decisions through the concept of existence as well as personhood (again, from an African perspective).

As mentioned in the previous section, physical and mental health are the indicators of quality of life which are of main concern in end-of-life decisions. Quality of life is a subjective issue, which makes it difficult to measure or to establish at which point one's quality of life has debilitated. McDougall and Gorman (2008: 35) argue as follows:

> "The crux of the issue of quality of life is what the individual gains from life. Even though individuals at the same terminal point to the same debilitating condition, there can be two different answers. One might find the incapacitation of the illness too debilitating to allow for any meaning in life, while the other may view the period of incapacitation as a final chance to bid farewell to friends and family".

Quality of life is evaluated differently by different people. Stransham-Ford was not the first individual to encounter the struggles that come with being a cancer patient, but his threshold for the experiences may have not been the same as other individuals who have

been in a similar situation. Ultimately, quality of life is a personal concept, and whatever suffering someone encounters is known only by that person and it is not the place of others to speak on or to decide whether or not that individual is making an unreasonable decision by going the end-of-life route. At the same time, one's debilitating quality of life can affect the family and others around oneself (through the requirements of caretaking, finances and the third party's emotional well-being too). I would like to illustrate this through the example of Nancy Cruzan, who was mentioned in chapter 3.

Nancy Cruzan was involved in a car accident at the age of 25. She was left severely injured, with oxygen deprivation and permanent brain damage (McDougall & Gorman, 2008: 131). After spending four years in a coma, her family made the decision that Nancy would not have wanted to live such a life. Nancy was not on a ventilator or any form of life support machines, she was being fed through a feeding tube and was confined to a hospital bed. Her family believed that removing her feeding tube would not only bring an end to her life but also relieve her of her suffering. The administrators at her rehabilitation facility did not agree to this, which led to her parents taking this matter to court. The dilemma was that prior to her accident Nancy did not leave behind any written directives regarding any end-of-life decisions. Due to this, the court ruled that preserving the sanctity of life was more important than the family's concerns about Nancy Cruzan's quality of life (McDougall & Gorman, 2008:132).

The Cruzan family disagreed with the court's decision and appealed the decision. The case famously known as Cruz vs Director Missouri Department of Health went to the US Supreme Court, who ruled in favour of the Cruz family, citing "the right to die as a constitutionally protected liberty interest" (McDougall & Gorman, 2008:132). The reason for this final judgement was, as has been mentioned in chapter 3, is that Cruzan's case was considered a right to refusal of treatment, which is constitutionally protected and therefore not illegal. On 14 December 1990, Nancy's feeding tube was removed and she died on 26 December 1990, in fulfilment of her family's wishes of freeing her from her suffering. Cruzan's case represents the detrimental effects that a person in a terminally ill condition (or in this case in a coma) can have on their loved ones, as it affects the

quality of life of both the patient and individuals who are close to the situation (not only financially but emotionally and mentally as well).

Caretakers of individuals in such situations tend to suffer psychological effects. Hence, I argue that the decision to end an individual's life through means of euthanasia can be a communal decision; one that takes into consideration the wellbeing of the family and the ill individual while preserving everyone's dignity. Nancy Cruzan's situation is an example of the argument for withdrawing or withholding life supporting or life-extending treatment. This is an argument in favour of euthanasia and is viewed as "omission", while PAS and VAE are considered to be "acts" (Moodley, 2011: 279). I argue that it is contradictory that people have to go through long legal battles to request withdrawal or withholding of treatment when this act does occur from time to time, but is referred to as "omission" as though it is morally and legally less damaging to physicians who participate in this act.

In chapter 8 of *Medical Ethics, Law and Human Rights*, London explains that "it is important to re-humanise medicine" (London, 2011: 87). I interpret this as needing to step away from the scientific aspect of the discipline and think of medicine in a pragmatic and holistic way; and mainly how it affects individuals in everyday experiences and how decisions in the healthcare system impact those individuals that are meant to be taken care of by the healthcare system. The proposal is that human rights must be thoroughly considered in the medical system, and it is therefore necessary to consider ethics in the practice. As mentioned earlier, South Africa is a post-Apartheid country which prides itself on its human rights practices. Dignity, respect and a right to life are fundamental principles in the South African constitution and should therefore extend to the medical realm as well. The topic of dignity directly relates to African thought and will be outlined in the sections that follow. First, however, an overview of human rights will be given, because I believe that these rights inform our understanding of dignity, and quality of life in general and in the South African perspective. This will inform my argument for the right to life to also be interpreted as the right to death more clearly.

Human rights are said to be “entitlements that people can claim relating to their basic needs because they are human” – as such, human rights are inherently related to dignity (London, 2011: 88). When speaking of human rights, it is important to consider the respect for human dignity, which London (2011) explains was violated during the Apartheid-era in South Africa. Human beings and their basic human dignity were disregarded during the Apartheid-regime, as the state participated in the mass killings of people of colour (particularly during the infamous Sharpeville Massacre of 1960 and the Soweto Uprising of 1976). In my opinion these might have been some of the human rights violations which could have informed the South African Constitution post-Apartheid to emphasise that no human being (including the state and physicians) has the right to kill another human being. It is for this reason that the Constitution says that dignity is and must continue to be a central aspect of South African society. Such insights must also inform our approach to euthanasia.

4.4. What Is dignity

Lee (2001) stresses that there is no particular physical difference between intentionally killing someone and causing a death, because the action of killing a person and the results of the person being pronounced dead are the same. However, what differs is the intention. Both acts are murder, even if (like in the case of euthanasia) it is something that has been requested by a patient. In his view, both acts are morally wrong. He does, however, provide an example of a case where two acts can be carried out with the same outcome, but can produce a different outcome morally (Lee, 2001: 332):

> “The same physical behaviour – for example, injecting a patient with morphine – might in one case be carrying out a choice to relieve pain with the side effect of hastening death, and in another case carry out a choice to kill in order to relieve pain. Although the external results are the same, there is a tremendous moral difference between the two cases”.

Thus, even when an act can be considered to be morally wrong, full consideration must be given to the circumstances that can lead to situations such as the examples mentioned by Lee. Although the acts might be considered morally wrong, they are not of malicious intent, especially when consideration is given to how an individual's dignity is being compromised due to their declining quality of life. Such a decline in quality of life involves not just the individual, but their community as well.

In his work "Personhood, dignity, suicide, and euthanasia", Patrick Lee (2001) explains that dignity is defined as "the possession of qualities that allows one to excel in certain activities as well as elicit and merit respect from others". He identifies three types of dignity. The first type is that held by those individuals in higher social classes in countries in the Global North. Lee argues that these individuals have a certain dignity not possessed by those in lower classes (2001: 341). This form of dignity, I would argue, is not restricted to countries in the Global North, but also occurs in a country like South Africa, which has an incredible gap between the rich and poor in the country. While one may suggest that such a form of dignity is afforded to those of a higher socio-economic class, this form of dignity is merely at a surface level. The second type of dignity is the dignity of a person or personal dignity (Lee, 2001: 341). This is the inherent dignity that each individual possesses. By virtue of being human, an individual automatically acquires this dignity. Lastly, Lee explains that there is a certain type of dignity which is realised as a result of humans having particular capacities that distinguish them from animals. The dignity of a person, or personal dignity, and the dignity that distinguishes us from other animals are two of the forms of dignity that will be discussed in this chapter, as they are pertinent to the topic of euthanasia.

South Africa, as an economically deprived nation, can be an even more undignified experience for an individual considered to be of a poorer socio-economic background. Stransham-Ford, for example, having been an attorney, which is considered a high-earning career in South Africa, could have potentially been at more of an advantage in that he could afford proper medical care in a private hospital facility and most likely live-in assistance at his most frail and ill. A terminally ill individual who is on the poorer end of

the spectrum, however, might not be afforded such relative comfort. Such an individual might be subjected to poor public health care, with spaces shared with other individuals, little to no privacy, and – in worst cases – having to be at the care of their children or other family members. This is a degrading experience that can be considered burdensome, and it could leave one with many questions regarding the meaningfulness of life. I would consider it to be a fate that no one would appreciate, and one that renders an individual's existence completely void.

Lee explains that personal dignity must be distinguished from manifested dignity, which is the secondary form of dignity described above. He suggests that by virtue of being human, every individual has a basic, real dignity which is what should afford them the respect that every individual is owed. However, certain conditions come into play that can potentially disrupt or harm an individual's dignity, especially when they lose the ability to do things for themselves (as is explained in the third sense of dignity above). This can result in loss of privacy, or a preoccupation with pain (McDougall & Gorman, 2008: 342). Although Lee acknowledges that no one would be happy to be in such a condition, he believes that it does not mean that one should resort to ending their life. Rather, it is better to exhaust all options to alleviate the condition (Lee, 2001: 341).

> "First, the end doesn't justify the means. And, second, the very act of killing a person with the supposed justification that the one killed has lost his dignity, or is about to lose his dignity, denies the intrinsic personal dignity of the one killed. No one wants to die without dignity, but we do not really want to die now with dignity either. Death itself is never a dignity-it is, in a way, the supreme indignity. We may bear suffering and death well, and whether we do so depends, in part, on whether we continue to treat ourselves, as well as others, as persons with intrinsic dignity, that is, persons who have dignity simply because they are persons. Finally, another way of construing death as sometimes a good in itself good and life an evil has been proposed".

The foregoing may be compared with the case of Vincent Humbert. Humbert was an active 22-year-old man from France, who was injured in a car accident in 2000. The accident took away his ability to walk, his sight, speech, and sense of smell and taste. He had the ability to move his right thumb, which he used to indicate letters so that he could spell out his wish to die legally in a book entitled *Ie vous demand Ie droit de mouri*, which can be loosely translated as “asking for the right to die” (McDougall & Gorman, 2008:134). Humbert was frustrated by the fact that his request was not being granted. Eventually, his mother agreed to help him commit suicide**.** Following this, Humbert’s mother was arrested, but the charges were eventually dropped (McDougall&Gorman, 2008:134). This case is similar to that of Sean Davison and his mother, where the assistance was motivated both by compassion and the need to assist an individual in exercising their freedom to choose.

There are a few arguments in support of euthanasia, on which I rely for my euthanasia argument for dignity and quality of life. The argument for personal autonomy states that if an individual is competent (see eligibility criteria in chapter 2), they have a moral right to make their own choices about their life, as well as the right to act on those particular choices. Therefore, any willing doctor should assist that individual in fulfilling their right – in this case, the right to die (Moodley, 2011: 278).

The argument for the prevention of suffering states that due terminal illness or any other situation that can cause suffering in a person’s life, death should be an alternative to relieve that “burden” from that person’s life. This argument states that it would be an injustice to an individual to refuse them an opportunity at PAS or VAE, as those choices would be a gentler approach than suffering. This is the argument that brings out the “mercy” in mercy killing (Moodley, 2011:278). The above-mentioned point sheds light on the importance of considering the idea of a “person”, and how a person comes to have the freedom to choose. It is informed by dignity and quality of life, which influences how one comes to an end-of-life decision. This decision is based on personhood (as discussed at the start of this chapter).

4.5. Personhood, euthanasia, and Africa

The initial aim of the project was to return to an African way of thinking on seemingly Western concepts, and in this case specifically euthanasia. By looking at these philosophical questions and concepts through an African lens, it is possible to achieve the objective of diverging from a completely Western conception of ideas and thinking in terms of the academic subject matter of euthanasia. I have explored this idea by navigating the topic of personhood and describing how it can assist in mapping out one's sense of dignity and ultimately one's quality of life.

Legalising euthanasia from an African perspective would mean that the individual's decision has to be assessed from a collective standpoint, taking into consideration the family and community, in accordance with Ubuntu values.[9] The word *Ubuntu* originates from the Zulu and Sotho languages, describing a philosophy that humans are persons by virtue of other humans. It entails "the art of virtue of being human" (Griffin, 1995:1). Here the concept of Ubuntu is an important justifying aspect, since Ubuntu relates to and emphasises the interconnectedness of individuals within a community. Thus, by allowing for this crucial principle in African communitarian thought, it may be argued that killing oneself amounts to killing the community, or at least part of the community.

We may consider South Africa an Ubuntu society, in the light of the post-Apartheid practices of unifying the nation, and rebuilding a society free of bias and founded on the principles of working together to build a rainbow nation (Baines, 1998: 1). An Ubuntu society entails a collectivistic or communitarian[10] society that is based on the moral theory of Ubuntu (or personhood). Viewing euthanasia through this community perspective – through an Ubuntu perspective – suggests that legalising euthanasia in South Africa could

[9] The term *Ubuntu* is interchangeably used with the term *African Humanism* in most Ubuntu scholarship (Praeg, 2014: 12).

[10] It must be noted that there are Western communitarians such as Durheim, Day, Taylor, MacIntyre, and Benhabiby.

be viewed as individualistic and inconsiderate of the effects on the community or family: hence, that euthanasia is a selfish and self-centred act that goes contrary to the ideals of Ubuntu. This is not the end of the discussion, however. I have indicated how the traditional debate justifies euthanasia on the basis of individualism, and how the legal frameworks support such interpretations, while still rendering euthanasia illegal. The African perspective, however, is often neglected in such discussions.

Instead, I argue that viewing euthanasia as a Right to Life extends to the community in unique and dynamic ways. The decision to end one's pain and suffering through death essentially frees the community, enhancing and benefitting that community. I argue that the decision to end one's own life is selfless and that it releases all parties – not only the individual but the community itself – from the financial, emotional, mental and physical impacts of living with or taking care of a chronically ill patient. Metz (2011), for example, points out that Ubuntu is criticised for its collectivist standpoint or group-thinking which causes one to make extreme sacrifices for the community, thereby compromising the rights of the individual.[11] Rather than being constrained by the collectivist standpoint, however, I assert that considering others in a decision of undergoing euthanasia (in an Ubuntu society) should be considered in the context of the holistic relation between the individual and the community. While it may be argued that such a social structure may rob one of making an individual choice (or even of one's individual freedom), it may also be posited that one may make the decision for the benefit of oneself and others in an entangled and relational manner – thus, without seeing the Ubuntu society as foreclosing one's freedom of choice. This maintains, and even enhances, the dignity and quality of life in South Africa.

Ubuntu is personhood that forms one's human identity, human virtue and nature. This is exactly the aspect which is emphasised by Kwasi Wiredu and Molefe's perspectives on personhood. Ubuntu accentuates the notion of an individual being an individual because of others and the importance of an individual's "belonging" being their moral virtue.

[11] This is prevalent in extreme collectivism. According to Metz, Ubuntu is a form of moderate collectivism (he uses the term *Afro-communitarianism*).

Furthermore, the *World Health Organisation quality of life manual* also identifies social relationships and the social environment as indicators of one's quality of life. Personal relationships and social support are listed under the social relationships section as being vital factors when an individual has to make a decision in cases such as the above. One may experience feelings of shame and guilt in having their family members take care of them; but it might also provide one more comfort to know that they have that social support in "fighting" through their health predicament. I argue, however, that this can prevent an individual from making a decision for themselves. The decision becomes one that is focused on how others feel, as opposed to how one feels as an individual. This African perspective of personhood is more patient-centred, and it is also prominent in Kwasi Wiredu's concept of personhood. According to Molefe (2019: 196), the patient-centred notion of personhood is one that

> assigns value to the individual relative to whether she possesses the relevant metaphysical capacities or not. The patient-centred notion is tantamount to the technical idea of moral status in moral philosophy that identifies entities (moral patients) that are a part of the moral community as far as they possess the relevant metaphysical capacities.

This translates into every person having all the abilities to become what they wish. From a euthanasia perspective, I interpret this as, firstly, having the necessary medical care provided when one falls ill – this medical care serves the purpose of providing one with a quest to die in a dignified manner. Secondly, it means that one has the information at hand to become aware of one's options as a terminally ill person. Lastly, and probably most importantly, one is provided with the freedom to choose in relation to oneself and one's community.

In this chapter and study, I primarily mentioned Western examples because there are more Western literature available on the topic of euthanasia. My aim was to, however, reveal the complexities of how one's existence is compromised when they are not living a life considered to be dignified. In arguing for the right to life as the right to death, dignity provides an important perspective to consider the project through. Personhood should be

a central feature of such dignity, as I have argued. An important body of work which I wish to further explore by Motsamai Molefe in future explorations of this subject matter is his book *An African Ethics of Personhood and Bioethics: A Reflection on Abortion and Euthanasia*. This, I believe, could assist in enhancing the presented argument of this thesis and providing a more expanded interpretation of Molefe's views on personhood, thus strengthening my claims on personhood and its role in the euthanasia debate.

4.6. Chapter conclusion

This chapter has presented an examination of the African and Western accounts of personhood and offers insights into the multifaceted ethical considerations surrounding end-of-life decisions. These differing perceptions of personhood not only shape individual worldviews but also have profound implications for the understanding of quality of life and human dignity on a societal level. By comparing these perspectives, one can appreciate the nuanced and culturally contingent nature of ethical debates surrounding euthanasia and the valuable contribution that an African perspective can make, ultimately highlighting the need for a context-sensitive approach to address the complex ethical dimensions of this contentious issue. Such considerations are particularly important in the wake of the COVID-19 pandemic and its impact on South Africa.

The South African community has been greatly affected in the past by the global COVID-19 pandemic, which saw societies shift from being mostly interconnected to becoming completely isolated in a short space of time, due to lockdowns and national shutdowns intended to ensure the containment of the COVID-19 virus. In a communal society, such as the Ubuntu-based society of South Africa, individualism had been elevated in the social space due to long-term isolation and quarantine periods. People isolated themselves for long periods of time, and decisions were made for the greater good of a country ravaged by the pandemic. Concurrently, the preservation of individual life became more important than other considerations, such as the economy, since both the government and individuals felt the need to protect themselves and their families from the virus.

Additionally, the COVID-19 pandemic has had a major impact on the conceptualisation of life in South Africa, specifically with regard to thinking about mortality and the medical race to preserve life. People all over the world have been confronted with the possibility of death, whether it be through being diagnosed with COVID-19 or experiencing the COVID-19 related deaths of family, friends and colleagues. These circumstances should, in my view, serve as a basis to educate the South African society on the options that could be offered to them if they are faced with such dire circumstances again – whether globally, nationally, or in terms of their own life. The option to undergo euthanasia should be a talking point not only in academic spaces but also in social spaces. These ideas should become socially normalised, as has been the case with other subject matters that are widely discussed, such as feminism, LGBTQIA+ issues, and race and gender politics.

Lastly, the aim of viewing euthanasia from a community perspective is to show how euthanasia can be beneficial to the community at large and reveal that the practice is not a selfish and individualistic act, but in fact, in the grand scheme of things, it can benefit everyone. I am aware though that this can bring about a slippery slope, as it might cause harm to innocent individuals in the long run should their family members deem them to be burdensome. This can occur in cases of disabled people, special needs children, and the elderly. This is why my study was specifically focused on voluntary active euthanasia. Hence, the word individual continues to show up even in the community perspective. The aim for that is to show that individual decisions to undergo euthanasia can have a positive impact on one's surrounding community despite the negative impact that might be implied in such instances.

Chapter 5 – Conclusion

Consider that I find out that I am ill and I decide to start a lifesaving treatment. However, after a year, there are no improvements and health continues to deteriorate. I have exercised my available medical options but now I feel emotionally, mentally and physically

exhausted. I cannot conduct most daily tasks on my own, I struggle with walking and eating, and my quality of life is being compromised (see the indicators of QoL in 4.2 above). I then decide to conduct research on what my potential options can be, and I come across euthanasia – the option to end my life in a painless and gentle manner. If I am living in a country where euthanasia is legal, I will make the decision to arrange for an evaluation to start the process. I am exercising my freedom of choice to rewrite my life story, but I have family members and a community at large who do not agree with my decision. This study explored how the Western perspective of personhood, which is more individualistic, and the African perspective of personhood, which is a more community-based perspective, respectively would inform my decision.

5.1. Study overview

At the start of chapter 2 I made a clear distinction between euthanasia and physician-assisted suicide. In spite of the clear differences between the two concepts, they are often used interchangeably, which brings about ambiguity in this discussion. The aim of chapter 2 was to provide an outline of the foundational argument of this paper, which is that Western perspectives are dominant in the academic space, as opposed to African perspectives. In this paper, which focused specifically on euthanasia, I indicated that the debate is often sketched as a predominantly Western topic. I elaborated on this through providing the examples that most academic writings, think-pieces, debates, and legal cases on euthanasia and end-of-life have mostly been of Western origin. I explored the history of euthanasia to provide a clear guide on the evolution of this concept. I began by providing a definition of euthanasia and its Greek origins. The historical literature on euthanasia shows that suicide is an act that has always been deemed socially unacceptable, so much so that the bodies of the dead were even desecrated after they had made an end to their own lives.

Euthanasia needs active involvement of a physician or another individual, which means that it has the potential to greatly implicate more than one individual legally, as I illustrated

in chapter 3. I focused on an active voluntary type of euthanasia because I wanted to highlight the agency of the individual in deciding to end their life. Although examples of non-voluntary euthanasia (such as the Cruzan case) are provided later in the chapter, the main focus of the study remained on the agency of the individual.

In chapter 3, with regard to the individual's agency, I focused on quality of life through the lens of the legal sphere in South Africa and its current stance on end-of-life decisions. Euthanasia is illegal in South Africa, but there is a potential loophole in the Constitution of South Africa through which legalization may be reconsidered. I consider the concept of the "Right to Life", as stipulated in the Constitution, an ambiguity. I argue that this Right to Life can also be interpreted as a Right to Death. I developed this argument by analysing the several cases that have been brought before South African courts, advocating for the right of individuals to fulfil their end-of-life decisions legally. The Stransham-Ford case, for example, allowed for an exception to be made for the patient to end his life with assistance, although he succumbed to his battle with cancer prior to the court verdict. This case was a landmark finding, because Stransham-Ford was not only an ideal candidate (terminally ill and of sound mind), but he was also a perfect example of how the decline of one's health can impact the quality of one's life. This ultimately has consequences for the idea of the Right to Life, because we can ask, "What kind of life is worth living?" Other examples in the national and international context also illustrated this point, and the need to explore this concept in-depth from an African perspective was stated again.

Chapter 3 furthermore provided an analysis of the development of the debate on end-of-life issues in South Africa through exploring end-of-life societies in South Africa. Although there are not many of these, it reveals a gap in the South African space in terms of advocating for end-of-life decisions and education on end-of-life decisions. This is particularly relevant in disadvantaged areas, where people are not provided the best health care and the financial implications of a sickly person are detrimental for family members. I believe that if euthanasia is legalised, it will benefit the individual as well as

the community at large, particularly in a society like South Africa. Even if euthanasia is not legalised, increased discussion on the topic is necessary to inform individuals.

In chapter 4, I discussed the African and Western accounts of personhood to illustrate how these different conceptions influence quality of life and dignity, which lie at the heart of the question of euthanasia. The Western perspective of personhood, as epitomized in Sartre's philosophy, stands in contrast to the African viewpoint discussed in this section. The conceptualizations of personhood are integral in shaping and influencing approaches to end-of-life choices – as was illustrated through the perspectives of Wiredu and Molefe to delineate a broadly African concept of personhood, offering insights into euthanasia in this context.

Molefe (2019: 194) contends that the ethics of personhood comprises three components: the inherent human nature, the capacity for moral judgment, and the development of a morally virtuous character. Human nature, encompassing biological aspects, lays the foundation for moral distinctions that, in turn, contribute to the cultivation of virtuous character, culminating in the attribution of personhood. Molefe further examines Kwasi Wiredu's dual notions of personhood—ontological and normative. The ontological concept pertains to human nature, emphasizing biological aspects, while the normative concept involves evaluating human life in terms of excellence or virtue. Personhood, within the normative framework, denotes the moral status achieved through sustained moral efforts, resulting in an individual deserving of moral respect. This nuanced understanding of personhood in African philosophy provides a foundation for reevaluating perspectives on euthanasia in the South African context.

Legalizing euthanasia from an African perspective, particularly within the framework of Ubuntu values, involves a collective evaluation of an individual's decision, taking into account the family and community. Ubuntu signifies a philosophy that defines humans as persons through their connections with others, emphasizing the "art of virtue of being human." This concept is pivotal in justifying the interconnectedness within a community.

In the context of South Africa as an Ubuntu society, characterized by post-Apartheid efforts to unite the nation and build a bias-free society, legalizing euthanasia could be seen as conflicting with Ubuntu principles. From this perspective, euthanasia might be perceived as a self-centered act that neglects the impact on the community or family, contradicting the ideals of Ubuntu. However, I argue that considering euthanasia as a Right to Life extends to the community in unique ways, contending that the decision to end one's suffering benefits not only the individual but also releases the community from the financial, emotional, and physical burdens associated with caring for a chronically ill patient. Acknowledging the criticism of Ubuntu's collectivist standpoint, I propose that within an Ubuntu society, the decision to undergo euthanasia should be viewed in the context of the holistic relationship between the individual and the community. Rather than restricting individual choice, this perspective allows for decisions that benefit both the self and others, maintaining and enhancing dignity and quality of life in South Africa.

5.2. Contribution of this study

This study serves to make a general contribution to the euthanasia debate which continues to develop in Western countries according to specific presuppositions and biases. I argue that the development of different perspectives for approaching the subject matter is crucial. As mentioned earlier, the euthanasia debate is primarily discussed from a Western perspective and the purpose of this study is to contribute an African perspective, and a South African, Ubuntu-based perspective in particular.

The Global South requires a context-specific development of the euthanasia debate, and there is a need for development that is not merely socio-economic, but also academic in nature. Hence, there is a need to educate members of society regarding such subject matters and to attempt to merge ideas from different disciplines, such as philosophy, medicine, law, and politics, as was done in this study.

Additionally, this study aims at exploring euthanasia in a society that is considered to embody Ubuntu principles, and at revealing that the areas of knowledge of Ubuntu and euthanasia are not mutually exclusive, but in fact closely intertwined.

Lastly, this study serves to evaluate the impact of the COVID-19 pandemic on end-of-life decisions and on the concept of life in general. The COVID-19 pandemic brought questions such as euthanasia to the forefront, and showed that euthanasia should be reconsidered in light of factualities in our contemporary communities.

5.3. Study conclusion

South Africa can be termed a dynamic society. It is a society that is characterised by diversity and is often loosely termed “the rainbow nation”. The Rainbow Nation is closely associated with post-apartheid South Africa and was popularized by Archbishop Desmond Tutu; it also carries with it an existential weight that is not ignorant of the complex historical background of the country that has left South Africa with many problems, such as socio-economic issues, poor public health, large disparities in the education system, and all-round failing government institutions. In this study I have examined how modern-day South African society may approach the question of euthanasia anew, by interpreting the concept of the Right to Life as inclusive of a Right to Death that must be informed by an African perspective (in contrast to a Western perspective).

I have presented a contextualisation of euthanasia, illustrating its origins, history, and current contemporary place in society. In doing so, I was able to suggest that euthanasia is (and continues to remain) a predominantly Western topic of debate, since the majority of the academic writing, discourse and cases are Western in nature and in geographical setting. I also relied on a Western source – Gorsuch’s *The future of Assisted suicide and euthanasia* (2006) – to provide the context and foundation of my research on euthanasia.

Furthermore, the countries that have legalised euthanasia, or alternatively physician-assisted suicide, are mostly Western countries – most notably the Netherlands.

In this study I sought to contrast such a Western approach with an African perspective that involved decolonising Western thought. The works of Molefe, to which I referred in this dissertation, has provided a fruitful ground for discussing issues or concepts that relate to euthanasia, such as personhood, dignity and African philosophy. Additionally, I developed my central argument for an African account of euthanasia by exploring the current legal stance in South Africa on euthanasia. I did so by examining South African court cases (for example Sean Davison and Stransham-Ford) that drew attention to end-of-life discussions in South Africa. I contrasted these local cases to American cases in order to further display the difference in thinking on the Western end with approaches to end-of-life issues by means of African thought. I concluded that in spite of the differences, the South African cases can draw insight from Western cases on how to evaluate legislation in this regard.

In terms of the law, there are potential avenues for the legalization of euthanasia in South African law if one considers the outcome of the Stransham-Ford and Sean Davison cases and their impact on the end-of-life discourse in South Africa. I explored this by examining euthanasia as a Right to Life, thus by critically analysing the South African Constitution's Right to Life claim. I emphasize here that this entails merely a *claim* because I argue there is an ambiguity in the constitution in that it does not specify what the life that one has the right to live truly consists of. I proposed that this Right to Life should be expanded to also entail a Right to Death by keeping in mind the conceptual lenses of quality of life, personhood and dignity. I initially based my view on Western cases, namely Cruzan and Humbert. These cases suggested that if euthanasia should ever be legalised in South Africa, specific processes must be put in place to avoid a Slippery Slope situation. Healthcare providers and law enforcers must protect individuals by keeping records, following procedures, providing verbal testimonies and doing anything necessary which will improve quality and access to healthcare services in possible end-of-life situations.

More crucially, however, I also used these cases to illustrate the importance of personhood and dignity in the discourse on the Right to Life. Utilizing the measure of quality of life, I illustrated how an African perspective on these concepts could justify one's end-of-life decisions in terms of euthanasia. Personhood and dignity are central to one's quality of life. However, while Western thinking reveals a mainly individualist way of approaching the question of euthanasia, there is a generative potential in African philosophical thinking as regards this topic. The major contribution of the African perspective is its contextual sensitivity (in terms of the community and family, for example) which I posit may inform those Western debates that are at an apparent stalemate marked by a persistent dichotomy of perspectives espousing either advocacy or opposition. I therefore suggest that substantive progress in terms of the legalization of euthanasia is hindered if one disregards perspectives from the Global South, such as African philosophy, in the global debate on euthanasia.

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