The recognition of euthanasia and physician-assisted suicide in South African law

M.M Tlhapi

 orcid.org/0000-0002-5967-670

Mini-dissertation submitted in partial fulfillment of the requirements for the degree *Master of Laws* in Public Law and Legal Philosophy at North-West University.

Supervisor: Dr JC Kanamugire

Graduation: May 2023

Student number: 27390330

SOLEMN DECLARATION

I hereby declare that the mini-dissertation titled**: The recognition of euthanasia and physician-assisted suicide in South African law,** submitted in fulfilment of the requirements for the Master of Laws (LLM) is the product of my research and opinions except for references to the sources acknowledged herein. I have not submitted it to this or any other university for higher degrees qualification.

M.M TLHAPI — 15/09//2022

Initials & Surname — **Date**

Acknowledgments

First and foremost, I thank the Almighty Lord for carrying me throughout this research process. I would not have made it without His mercy and grace. I pray that your unwavering love continues to reign in my life.

Secondly, I convey my deepest gratitude to my father, Andrew Tlhapi, and my best friend, Thato Bamphitile, for convincing me to pursue my Master's. I would not have gone back to school had it not been for your encouragement. Not only did my father convince me to study further, but he also ensured that my initial fees were paid. I will forever be grateful to you. To my loving mother, Lydia Tlhapi, thank you for your unending belief in me, for having so much faith in me even at times when I did not believe in myself. To my girlfriend, Tumisang Modise, you are the one person who saw this process from its infant stages to what it is now. Thank you for keeping me sane and always picking up the pieces. I never ever want to do this life thing without you, I love you with all my heart.

I would also like to thank my supervisor. Your support and patience are second to none. There were times I would miss our deadlines because I am forever at work, but you did not give up on me. I pulled through because of your guidance in every step. I could not have asked for a better supervisor. Thank you again.

DEDICATION

This mini-dissertation is dedicated to my loving family, friends, the institution, and everyone who supported me throughout the process.

ABSTRACT

This study assesses the current legal position of euthanasia and physician-assisted suicide in South Africa and the possibility of legalizing the two practices. Currently, the legal position of euthanasia and physician-assisted suicide renders both these practices as illegal and thus constitute an offence. The offence, based on the facts of the case, may vary from murder to attempted murder. The problem that arises from these two practices being illegal is the intractable pain and suffering that terminally ill patients are subjected to as a result of their respective illnesses. The terminally ill patients are without an option to have a say as to when that suffering may be stopped and by what means. Moreover, it is common knowledge that some of these illnesses are extreme to an extent that the person suffering from them is unable to perform even the most basic of duties. These duties include, but not limited to, being unable to bathe themselves, feed themselves or even use facilities in the bathroom. The inability to perform these activities and having to seek the assistance of others strips the patients off their human dignity. The recognition and legalisation of euthanasia and physician-assisted suicide in South Africa could provide these patients with their preferred passing with their dignity still intact. Furthermore, the right to human dignity is not the only right affected by terminal illnesses and the illegality of euthanasia and physician-assisted suicide. The *Constitution* of South Africa confers to all persons the right to life, the right to bodily integrity and the right to personal autonomy, which are also directly affected adversely by terminal illnesses and the illegality of euthanasia and physician-assisted suicide. The recognition thereof, could be introduced through new legislation to regulate both practices. The existing fundamental rights, including the right to life, right to dignity, right to bodily integrity and personal autonomy could be utilized to facilitate and justify euthanasia and physician-assisted suicide. This study concludes by claiming that at the end-of-life, a terminally ill, cognitively unimpaired person should be allowed to choose death by euthanasia or be assisted by a physician to terminate their life.

Keywords: euthanasia, physician-assisted suicide, terminally ill, patients, medical practitioner

TABLE OF CONTENTS

List of abbreviations

CAJM	Central African Journal of Medicine
CILJSA	Comparative and International Law Journal of Southern Africa
DEA	Drug Enforcement Agency
DJLJ	De JURISCOPE LAW JOURNAL
OHRH	Oxford Hub of Human Rights
PAS	Physician-assisted suicide
PER/PELJ	Potchefstroom Electronic Law Journal
SALJ	South African Law Journal
SAHRC	South African Human Rights Commission
SAJBL	South African Journal of Bioethics and Law
SAJHR	South African Journal of Human Rights

Chapter 1: Introduction

Illnesses form an inescapable part of the cycle of life and as such, it constitutes an unfortunate fate that could befall anyone. Similarly, there is nothing that is certain in life, except for death and taxes.[1] These facts of life have not changed, however, the consistent advancement in the fields of medicine and law have given humans the ability to choose when their lives may end and by what means.[2] However, this option is only provided for terminally-ill patients in numerous jurisdictions but South Africa does not form part of these jurisdictions.[3] It is this hiatus that prompted this study. Patients with chronic diseases may now obtain treatment that enables them to survive longer than what was possible a few decades ago.[4] Through the advancements in the medical field, patients have been able to be informed about what illnesses and infirmities they could be subject to long before the onset of symptoms.[5] Despite these developments, society's definition of survival remains purely as having the body's mechanical process functioning and fails to include the patient's quality of life and suffering into the discussion.[6] This study contends that if people who endure constant suffering as a result of illness could have a chance for the relief of their pain, and they deem euthanasia as the only alternative, then they should be allowed to utilize this reprieve irrespective of opinions of the communities in which they live.[7] The ways in which the medical field and the law have advanced in South Africa suggest that there is definitely a place for euthanasia and physician-assisted suicide to be legalised and practised.[8]

Euthanasia and physician-assisted suicide are discussed in detail with the goal of providing an answer to whether these two procedures should be recognised in South African law.[9] In essence, this is a call for the legal development and reform in law and

[1] Nienaber and Bailey 2016 *SAJBL 71.*
[2] Nienaber and Bailey 2016 *SAJBL 67.*
[3] Paleker *Euthanasia in South Africa: A normative analysis and application of dignity 20.*
[4] Paleker *Euthanasia in South Africa: A normative analysis and application of dignity 22.*
[5] Jacobs 2018 *SAJBL 66.*
[6] Benatar *Cape Times* 10.
[7] Jacobs 2018 *SAJBL 66.*
[8] Paleker *Euthanasia in South Africa: A normative analysis and application of dignity 32.*
[9] Jacobs 2018 *SAJBL 66.*

modern-day medicine to recognize and permit euthanasia and physician-assisted suicide in South Africa.[10]

1.1 Background to the study

In South Africa, the problem of euthanasia and physician-assisted suicide has taken centre stage from time to time. However, the question of whether these two practices should be made legal was not seriously considered until they were at the heart of a much publicised case, that of Cape Town advocate Robin Stransham-Ford in which the latter had approached the Pretoria High Court to allow him to commit assisted suicide.[11] The said case was preceded by the recommendation submitted by the Law Commission in 1999 to legalise passive euthanasia or assisted suicide.[12] The Parliament did not take a decision with regards to the legality of active euthanasia or assisted suicide, where a person actively does something, such as administering a lethal dose of a drug, to hasten death.[13] It is submitted that some illnesses, depending on the kind and their severity thereof, often subject patients to extreme suffering, pain and side effects.[14] These may include losing consciousness, losing body mass, being unable to perform hygienic duties such as bathing oneself. In that regard, people suffering from debilitating ailments often elect to save themselves from the indignity that comes with that suffering and wish for their lives to be terminated utilising medical means.[15] By virtue of the intrinsically subjective nature of such requests from a patient, the significant element to be taken into account in the ethics of requests to die would be how the patient views their quality of life and suffering, not the observations of third parties.[16]

For some individuals, the possibility of living in a minimally conscious or unconscious state for the rest of their biological life is a fate worse than death.[17] There are instances where dying a dignified and painless death is preferred as compared to living a life

[10] Jacobs 2018 *SAJBL 66.*
[11] Van Der Walt 2015 *SALJ 23.*
[12] Humphries 1976 *CAJM 56.*
[13] Van Der Walt 2015 *SALJ 12.*
[14] Nienaber and Bailey 2016 *SAJBL 54.*
[15] Van Der Walt 2015 *SALJ* 34.
[16] Nienaber and Bailey 2016 *SAJBL 65.*
[17] Humphries 1976 *CAJM 35.*

one considers to be meaningless without any hope or prospect of getting better.[18] Furthermore, dignity in dying may be realised when one's last chosen moment involves interacting with loved ones in a lucid, coherent state and not when one is experiencing extreme pain.[19] These are similar instances in which euthanasia could be applied for under the *Termination of Life on Request and Assisted Suicide Act* in the Netherlands.[20] In accordance with the Dutch Due Care Criteria, The *Termination of Life Act* endorses the right to dignity. This particular *Act* provides terminally-ill patients subject to unbearable suffering without the possibility of improvement with the opportunity to elect a dignified death.[21] There are numerous foreign jurisdictions that followed suit after Netherlands legalised euthanasia. This speaks to the viability of euthanasia and physician-assisted suicide.[22]

Euthanasia, physician-assisted suicide and their application within the law still need to be researched further for the constant development of the law and advancement of the medical field in this regard.[23] Furthermore, there is a need for further research regarding the establishment of adequate mechanisms to accommodate an ever growing society and its ever changing needs.[24] In essence, this analysis into euthanasia and physician-assisted suicide strives to propose ways in which they could be legalised and applied in South African law. This comes as a result of terminally ill patients who have to endure intractable suffering and pain due to their various terminal diseases and illnesses.[25] To this end, the researcher submits that a broad interpretation of fundamental rights in the Constitution needs to be applied to accommodate the recognition of euthanasia and physician-assisted suicide.

1.2 *Statement of the problem*

The practices of physician-assisted suicide and euthanasia remain controversial topics, not only nationwide but throughout the world as well.[26] The countries that are

[18] Humphries 1976 *CAJM 23.*
[19] Humphries 1976 *CAJM 22.*
[20] Nienaber and Bailey 2016 *SAJBL 32.*
[21] Jacobs 2018 *SAJBL 66.*
[22] Sagel-Grande 1998 *SALJ* 56.
[23] Sagel-Grande 1998 *SALJ* 56.
[24] Humphries 1976 *CAJM 44.*
[25] Sagel-Grande 1998 *SALJ* 56.
[26] Jacobs 2018 *SAJBL 66.*

deemed relatively free and democratic still refuse their citizens this one fundamental freedom, the freedom to secure medical assistance from those who are open to assisting them die in a dignified manner. This freedom could be realised when they deem their lives unbearable and no longer worth living intractable suffering emanating from an illness.[27] It is necessary to first define euthanasia and physician-assisted suicide. Euthanasia refers to the intentional termination of the life of another person at their explicit request.[28] Physician-assisted suicide refers to instances when a physician or a doctor supplies information and/ or the means of committing suicide (e.g. a prescription for a lethal dose of sleeping pills, or a supply of carbon dioxide gas) to a person, in order for the sufferer to terminate their own life.[29] This means that the process involves the self-administration of a lethal dose to terminate the life of one in extreme pain. South Africa is one of the countries where this freedom is denied, and as a result, this imposes a burden on both the terminally ill patients who are consequently forced to continue living whilst enduring intractable suffering and those who defy the law to provide the desired medical assistance.[30] However, usually the former prevails.

In the well-documented case of the right-to-die activist, Sean Davison, in which he pleaded not guilty in April 2019 to charges of murder for assisting three terminally ill persons who wanted to end their lives.[31] In these cases, Sean Davison assisted one Anrich Burger, by means of a lethal amount of drugs in November 2013; Justin Varian by means of placing a plastic bag over his head and administering helium in July 2015; and lastly Richard Holland in November 2015 by means of administering a lethal dose of drugs.[32] Although the matters are still pending in the Western Cape High Court, these cases show a demand for medical assistance to die by terminally-ill patients. These cases merit revisiting in a bid to locate prospects of enacting legislation to regulate euthanasia and physician-assisted suicide. Moreover, in 2015 the judiciary was faced with a matter of the so-called “right to die”, when Robin Stransham-Ford made an application to the North Gauteng High Court for an order to have his life

[27] Jacobs 2018 *SAJBL 67.*
[28] Benatar *Cape Times* 10.
[29] Jacobs 2018 *SAJBL 68.*
[30] Benatar *Cape Times* 11.
[31] Shoba 2019 https://www.dailymaverick.co.za/article/2019-04-30.
[32] Shoba 2019 https://www.dailymaverick.co.za/article/2019-04-30.

ended by means of euthanasia as he was suffering from Stage 4 cancer.[33] The High Court made an order declaring "that the applicant is a mentally competent adult who has freely and voluntarily, and without undue influence, made a request to the court to authorize that he be assisted in an act of suicide." [34] The court further declared that "the applicant was entitled to assistance by a qualified medical doctor, who was willing to do so, to end his life, either by administration of a lethal agent or by providing the Applicant with the necessary lethal agent to administer himself but stated that no medical doctor was obliged to accede to the request of the Applicant."[35] In relation to the liability of the doctor who agrees to assist, the order states that "they would not be acting unlawfully and shall not be subject to prosecution by the fourth respondent or subject to disciplinary proceedings by the third respondent for assisting the Applicant."[36] The court highlighted the fact that "the order shall not be read as endorsing the proposals of the draft Bill on End of Life as contained in the Law Commission Report of November 1998 (Project 86) as laying down the necessary or only conditions for the entitlement to the assistance of a qualified medical doctor to commit suicide."[37]

The common law crimes of culpable homicide and murder in relation to assisted suicide by physicians, insofar as they provide for an absolute prohibition, unfairly put a limitation on the Applicant's fundamental rights to inherent dignity, freedom to bodily and psychological integrity. To that end, they are in conflict with the aforementioned relevant provisions of the Bill of Rights.[38] Apart from the above, the Court declared that "the crimes of culpable homicide and murder in relation to assisted suicide by medical practitioners are not affected".[39] However, the Supreme Court of Appeal set aside the order on procedural grounds. It is safe to submit that the High Court's judgment paved the way towards renewed attention concerning the prospects of legalising

---

[33] Knoetze *The right to conscientious objection against administering euthanasia in the context of the right to freedom of religion* 1.
[34] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP), para 15.
[35] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP), para 11.
[36] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP), para 13.
[37] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GPP) para 26.
[38] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP) para 21.
[39] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP) 33.

euthanasia.[40] In addition, the way the right to human dignity, right to life and bodily integrity have been interpreted throws a spanner in the works considering how rigid and conservative the interpretations are. There are esteemed legal scholars who argue that the underlying spirit, purport, and values of relevant sections of the Constitution would support and facilitate the launching of assisted dying in South Africa,[41] provided the rights are interpreted broadly.

The conundrum of euthanasia is not new in South African law. In 1975, there was a case of *S v Hartmann* in which euthanasia was the subject matter.[42] Dr Hartmann was a doctor who was charged with the murder of his father. The deceased, who was aged 87, was suffering from carcinoma of the prostate for the longest time.[43] After a while, secondary cancer developed in his bones, more specifically the ribs.[44] He was then taken to Ceres Hospital and admitted as a private client of the accused after having induced him to come to Cape Town by air.[45] It was clear at that point that no cure could save him from the illness. The deceased was said to be very incontinent, had lost a lot of weight and was on pain-killing drugs. A few days later, the deceased was in a critical state of sickness and expert medical evidence regarded him as being close to death.[46] The accused gave instructions to a nurse to inject the deceased with ½ gram of morphine, which she hesitantly did.[47] An hour later the accused administered a further ½ gram of morphine into the drip of the deceased.[48] Within seconds of administering the morphine the deceased died.[49] The Western Cape High Court held that "the accused did not possess a desire to terminate his father's life: his motive was regarded as compassionate, to relieve his father of the persistent pain emanating from his condition."[50] He was, however, aware that his conduct would inevitably end his father's life.[51] The court thus held that "the accused clearly entertained that intention which is an

[40] Knoetze *The right to conscientious objection against administering euthanasia in the context of the right to freedom of religion* 1.
[41] Van Der Walt 2015 *SALJ 801-814*
[42] *S v Hartmann* 1975 (3) SA 532 (C) para 4.
[43] *S v Hartmann* 1975 (3) SA 532 (C) para 4.
[44] *S v Hartmann* 1975 (3) SA 532 (C) para 4.
[45] *S v Hartmann* 1975 (3) SA 532 (C) para 5.
[46] *S v Hartmann* 1975 (3) SA 532 (C) para 5.
[47] *S v Hartmann* 1975 (3) SA 532 (C) para 6.
[48] *S v Hartmann* 1975 (3) SA 532 (C) para 6.
[49] *S v Hartmann* 1975 (3) SA 532 (C) para 6.
[50] *S v Hartmann* 1975 (3) SA 532 (C) para 7.
[51] Sneiderman and McQuoid-Mason 2000 *CILJSA 203.*

essential ingredient of murder."[52] The court further held that "as to the evidence that the deceased had consented to the administration of such a drug, that would not amount to a defence to the charge."[53] It further stated that "the accused's conduct of mercy-killing rendered him guilty of murder as charged."[54] The court also stated in its judgment that "taking into consideration the mitigating factors, this was a case, if ever there was one, for giving full measure to the element of mercy and that the accused should be sentenced to one year in prison."[55]

In *S v De Bellocq,* an ex-medical student mother of a child who was terminally ill suffering from toxoplasmosis resorted to drowning the sick child in the bath because the child stood no chance of living long as he could not drink and had to be fed through a nasogastric tube.[56] The Court found her guilty but took into consideration the strong mitigating factors which had burdened her with immense pressure to terminate her child's life.[57] The accused was released and required to enter into a recognisance to return for sentence six months post the discharge if she was called upon, but she was never summoned to do so.[58]

A striking similarity in the judgments is evident: the sentences imposed on both these cases demonstrated ambivalence. In the *De Bellocq* case, no sentence was imposed *and* in the *Hartmann* case a suspended one-year sentence was imposed.[59] Considering these earliest cases of euthanasia and physician-assisted suicide in South Africa, the courts have portrayed or seem to understand the use of these practices and the motive behind them.[60] Even though it is illegal, the sentence imposed was lenient or no sentence at all. Both appear to accept that mercy killing may be required.[61] This research focuses on past and recent case law and other developments relating to euthanasia and physician-assisted suicide in South Africa. It explores the relevant sections in the Constitution, various case law, legislation and other literature relevant material to the subject matter.

---

[52] Sneiderman and McQuoid-Mason 2000 *CILJSA 203.*
[53] Sneiderman and McQuoid-Mason 2000 *CILJSA 204.*
[54] *S v Hartmann* 1975 (3) SA 532 (C) para 64.
[55] *S v Hartmann* 1975 (3) SA 532 (C) para 64.
[56] *S v De Bellocq* 1975 (3) SA 538 (T) para 10.
[57] *S v De Bellocq* 1975 (3) SA 538 (T) para 12.
[58] *S v De Bellocq* 1975 (3) SA 538 (T) para 45.
[59] Abrahams and Gross 2018 http://www.abgross.co.za
[60] Abrahams and Gross 2018 http://www.abgross.co.za
[61] Humphries 1976 *CAJM 32.*

1.3 *Motivation*

The study was primarily prompted by the pain and hardships that severely sick individuals undergo during their intractable suffering emanating from their respective sicknesses. Several terrible fates could fall upon people. Amid these are incurable diseases that are characterised by constant deterioration (e.g progressive paralysis) till the patient's passing. These conditions subject victims to numerous indignities, including but not limited to the inability to feed, bathe, and dress themselves, or to perform bathroom activities without help.[62] This deterioration is often coupled with pain and suffering, which could be only alleviated by means of reducing the patients to a condition of either minimal consciousness or unconsciousness.[63] Some individuals desperately wish to escape these fates. Suicide is not punishable by law, but it can be either unsuccessful or messy. Those that wish to take their own lives may not want to expose others to the trauma of discovering their lifeless bodies and risk scarring them for life. Moreover, they might fear that other suicide methods could fail, leaving them in a still worse situation.[64] In light of this, there are instances whereby people who need to take their lives either need or prefer the assistance of others, especially health care practitioners. There are medical practitioners who would be open to providing this assistance in some instances, but they are legally prohibited from providing such aid.[65] This places a substantial burden on those who would rather die and constitutes a serious limitation on their freedom to make health decisions. In addition, these individuals who are in vegetative states impose a severe burden on their relatives and other family members. With the above-mentioned submissions, there are various jurisdictions around the world that allow for euthanasia and physician-assisted suicide. They have legalised the practices that are explored in this study in support of the researcher's stance.[66]

---

[62] Humphries 1976 *CAJM 99.*

[63] Casell and Rich Intractable End-of-Life Suffering and the Ethics of Palliative Sedation, *Pain Medicine*, p 435-438.

[64] Benatar *Cape Times* 11

[65] Benatar *Cape Times* 11

[66] The said jurisdictions are The State of Oregon in the United States of America, The Netherlands and Canada.

This research study benefits different categories of individuals. It is primarily aimed at benefitting terminally ill persons to enable them to have their personal autonomy respected and promoted. It strives to ensure that their right to human dignity as per section 10 is affirmed and upheld. Moreover, it extends the manner in which the right to life is interpreted. Moreover, it allows for terminally ill patients to elect euthanasia or physician-assisted suicide if the quality of life is low and undesirable. The "right to bodily integrity" of terminally-ill patients could also be protected in terms of section 12(2)(b) considering the magnitude of the suffering and pain the patients go through to eventually request euthanasia or physician-assisted suicide. It also benefits the family members who are burdened with enduring the emotional and physical strain of having to take care of a severely terminally ill relative. Furthermore, it also benefits persons who embark on research similar to this research study in the future. Lastly, the research intends to inspire medical professionals in helping terminally ill patients to end their lives. It is thus submitted that the time for a legislative change is imminent to address this controversial and sensitive topic.

1.4 *Research question*

This research seeks to address the following question:

Should South Africa recognize euthanasia and physician-assisted suicide in its laws?

1.5 **Aims and objectives of the study**

1.5.1 Aims of the study

This research seeks to:

(a) Shed light on the current legal position of euthanasia and physician-assisted suicide in South African law.
(b) Provide recommendations that may be utilised if parliament enacts legislation or policy regulating euthanasia and physician-assisted suicide.

1.5.2 Objectives of the study

To achieve these aims, the following objectives are set:

(a) Provide platform and arguments for the recognition of euthanasia and physician-assisted suicide in South Africa.
(b) Identify and analyse the benefits of legalisation of euthanasia and physician-assisted suicide in South Africa.

1.6 Research Methodology

There are two research methods often used: quantitative research method which refers to the process of collecting and analysing numerical data, and qualitative research method involving collecting non-numerical data to comprehend concepts, opinions, or experiences.[67] The qualitative method may be utilised to gather in-depth insights into a problem or provide new ideas for research. This study utilises a qualitative research method based on literature review. It relies on a desktop study based on the following research methods:

(a) Primary and secondary sources

This research uses relevant data found in primary and secondary sources. The primary sources utilised are the Constitution of South Africa, relevant case law and legislation. The secondary sources consist of books, journal articles, book chapters and other internet sources relating to euthanasia and physician-assisted suicide. For purposes of this mini-dissertation, the North-West University Potchefstroom Electronic Law Journal Referencing style is utilised.

Furthermore, a comparative analysis is employed as there are other jurisdictions that have legalised the two procedures and developed laws and policies regulating it.[68] Since the primary aim of this research is to propose that euthanasia and physician-assisted suicide be legalised in South Africa, these jurisdictions and their laws serve as guidelines and reference for South Africa. The comparative analysis considers The Netherlands, Canada, and The United States of America, particularly The State of Oregon relative to legislation related to euthanasia and physician-assisted suicide. The Netherlands is selected as they have the *"Termination of Life on Request and*

[67] Watson 2015 *Quantitative research, Nursing Standard* 44.
[68] Numerous jurisdictions have made efforts and taken steps to pursue the legalisation of these medical practices that other states frown upon. In that regard, the jurisdictions that have taken steps are The Netherlands, The United States of America (particularly the state of Oregon), Switzerland and Canada.

Assisted Suicide (Review Procedures) Act 2001" as legislation regulating euthanasia in its jurisdiction. In the United States of America, the aforementioned jurisdictions have enacted legislation to legalise and regulate these practices and the manner they have been regulated in these States is varied as others have enacted legislation and others have only dealt with them through case law.[69] These jurisdictions were selected because they have the best practices for euthanasia and physician-assisted suicide. Not many jurisdictions have legalised these practices as numerous legal systems still regard them as culpable homicide or murder and thus, a crime punishable by law.[70] This analysis is dedicated to these jurisdictions that have pursued efforts to legalise or are presently in the process of legalising assisted death and euthanasia. A comparative analysis of different jurisdictions is imperative in order to establish the methods of regulation that are applied to euthanasia and assisted dying. The justifications and reasons put forth for legalising euthanasia and physician-assisted suicide in the jurisdictions could substantially contribute to answering the question of whether South Africa should legalise euthanasia and physician-assisted dying to assist terminally ill patients or not.

1.7 Framework of the dissertation

The mini dissertation has five chapters.

Chapter 1 introduces the research study. It comprises the statement of the problem, motivation, research question, aims and objectives of the study, framework of the study, relevance for the research unit, and statement regarding ethics.

Chapter 2 provides the historical development and nature of euthanasia and physician-assisted suicide in South Africa.

Chapter 3 covers the relationship between euthanasia, physician-assisted suicide, and the right to dignity, right to life, autonomy, and right to bodily integrity.

Chapter 4 examines the regulations regarding euthanasia and physician-assisted suicide in foreign jurisdictions, specifically the Netherlands and the United States of America (Oregon State) and Canada.

---

[69] Lavi *The modern art of dying: A history of euthanasia in the United States* 2009.
[70] Sagel-Grande 1998 *SALJ* 56.

Chapter 5 provides the conclusion and recommendations.

1.8 ***Relevance to the Research Unit theme***

This research focuses on providing a platform and arguments for the recognition and legalisation of euthanasia and physician-assisted suicide in South African law. This could assist terminally ill patients to end their suffering. Accordingly, this research study falls under Vulnerable Societies in the Faculty of Law Research Unit *Law, Justice and Sustainability*, which addresses developmental and legal challenges in South Africa.

1.9 *Summary*

Chapter 1 provides the introduction to the research study. It discusses the genesis of the research problem and the motivation to explore it further. Moreover, it also articulates the research question that the study examines, the research in its finality or conclusion will answer the said research question. This is done by utilising various research methods that are outlined above. Chapter 1 also borrows from other scholars on opinion related to euthanasia and assisted suicide by consulting journals and other literature material relevant to the study. It is imperative to familiarise oneself with what other legal scholars have said about the current topic and verifying their stance. The research study also outlines goals by means of aims and objectives that are achieved at the end of this study.

The following chapter discusses in detail the genesis of euthanasia and physician-assisted suicide in South Africa. The history of both these procedures and how the law addressed them in the past is also assessed by discussing old case law that deals with the conundrum.

Chapter two: The historical development of euthanasia and physician-assisted suicide in South Africa

2.1 *Introduction*

Like any other aspect of the law, there was a starting point and development over time for euthanasia and physician-assisted suicide in South African law.[71] Although its development was gradual and its discussion insufficient, there exists case law and reports that prompted the arguments on whether these two medical practices should be legalized or not. On that premise, the development and the history of the two elected forms of medical procedures (euthanasia and physician-assisted suicide) are explored focusing on how these two were developed in South Africa. Case law is utilised to asses this development in courts over the years.

2.2 *The legal development of euthanasia and physician-assisted suicide in South Africa*

Arguments on euthanasia and physician-assisted suicide have been a concern in sociological, moral, philosophical, cultural and legal discourse for centuries.[72] The issue of these procedures inspires a plethora of varying strong views, of which the legalisation is one.[73] In South Africa, the topic of euthanasia and physician-assisted suicide has come up from time to time, but the question of whether they should be legalised and recognised was not seriously considered until the South African Law Reform Commission received a request in 1991 to consider legislation regarding a Living Will.[74] The South African Reform Commission is a statutory advisory body. Its appointment is made by the President, their objective is the improvement and renewal of South African law.[75] The Commission agreed to hear this request but extended its duty to incorporate the entire spectrum of end-of-life healthcare decision-making issues, including voluntary active euthanasia and physician-assisted suicide.[76] Seven years later, in 1998, the very same South African Law Commission drafted a paper

[71] Larsen 2015 *SAMJ 513.*
[72] Ncayiyana 2012 *SAMJ* 1.
[73] Ncayiyana 2012 *SAMJ* 2.
[74] Mojalefa Koenane *Euthanasia in South Africa: Philosophical and theological considerations* 2.
[75] Mojalefa Koenane *Euthanasia in South Africa: Philosophical and theological considerations* 3.
[76] Konstant 2015 *OHRH* 2.

that they called Project 86 which dealt with euthanasia, physician-assisted suicide and the artificial preservation of life, and published a report in support of the stance in November of the same year.[77] A draft legislation which would govern these medical procedures was also presented to Parliament for consideration and possible approval.[78] One of the options contained in the Draft Bill was that a medical practitioner would be afforded the opportunity to carry out a patient's request to die without any legal implications.[79] Several recommendations were made by the Commission, firstly that the said patients had to be terminally ill, and be experiencing extreme suffering and pain but also be mentally competent.[80] Moreover, a second independent doctor would have to confirm the diagnosis and the findings would have to be written down for record purposes.[81] The said Discussion Paper also set out and provided comments on the legal position of end-of-life health-care decision-making in other countries.[82] This paper further incorporated a volume containing several books previously published separately that deal with end-of life Draft Bill with clauses on palliative care, refusal, withholding and withdrawal of life support, advance directives, physician-assisted suicide and voluntary active euthanasia, and the powers of courts and of the medical practitioners.[83] The Draft Bill defined terminal illness as "all illness, injury or other physical or mental conditions which (a) will inevitably result in the death of the patient concerned within a relatively short time and which is causing the patient extreme suffering; or (b) is causing the patient to be in a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient. With such submissions, basically the request by the patient must be based on an informed and well considered decision and the patient had to make this request frequently."[84] However, the efforts by the Law Commission were in vain as the recommendations were never tabled in Parliament. Consequently, no possible legalisation was ever discussed. No form of legal development took place until more than 10 years later.[85]

---

[77] Larsen 2015 *SAMJ 513.*
[78] South African Law Commission *Euthanasia and the artificial preservation of life* 3.
[79] South African Law Commission *Euthanasia and the artificial preservation of life* 10.
[80] South African Law Commission *Euthanasia and the artificial preservation of life* 10.
[81] South African Law Commission *Euthanasia and the artificial preservation of life* 17.
[82] Landman *A proposal for legalizing assisted suicide: What are the issues* 203.
[83] Knoetze The right to conscientious objection against administering euthanasia in the context of the right to freedom of religion 4.
[84] South African Law Commission *Euthanasia and the artificial preservation of life* 15.
[85] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP), 33.

2.3 *The historical development of euthanasia and physician-assisted suicide in South Africa through case law*

In the pre-democratic era, there were numerous case law principles which were established through court decisions that prompted debates surrounding euthanasia, assisted dying and their recognition.[86] In spite of numerous cases dealing with euthanasia and physician-assisted dying being appearing in South African courts, the precedent is that they remain illegal and could actually amount to murder. [87] Among the cases discussed in this study is the *Stransham-Ford*[88] case which revived the topic of euthanasia and physician-assisted suicide in recent times, and the *S v Hartmann*[89] case which saw the first case of euthanasia involving alleged consent by a patient. Some of the other cases that deal with euthanasia and physician-assisted suicide are discussed below.

2.3.1 *R v Peverett* 1940 AD 213

In 1940 there was a case of *R v Peverett,* which is the first recorded case dealing with the euthanasia and physician-assisted suicide.[90] In this case, the accused, Mr Peverett, made a suicide pact with his partner, Mrs Saunders.[91] He attempted to poison himself and his girlfriend by sitting inside his motor vehicle with the windows completely shut and connecting the exhaust pipe of the motor vehicle into the interior.[92] The intended end result was a fatal carbon monoxide poisoning, but instead they both survived.[93] The court in its decision stated that "Mr Peverett clearly desired for both of them to die and possessed the required intention to cause the death of Mrs Saunders, thus satisfying the legal requirements of murder."[94] But since she did not die, it could only be an attempted murder.[95] But for an expected result, the accused had done everything in his power to have the desired result occur.[96] It was confirmed by the

[86] Jordaan 2017 *SAMJ* 383.
[87] Abrahams 2018 https://www.abgross.co.za/euthanasia-legal-ambivalence/
[88] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 4 SA 50 (GPHC) para 34.
[89] *S v Hartmann* 1975 3 SA 532 (C) para 33.
[90] Robertson 2020 https://www.derebus.org.za/still-waiting-for-an-answer-physician-assisted-suicide-in-south-africa/.
[91] *R v Peverett* 1940 AD 213 para 7.
[92] *R v Peverett* 1940 AD 213 para 7.
[93] *R v Peverett* 1940 AD 213 para 9.
[94] *R v Peverett* 1940 AD 213 para 9.
[95] *R v Peverett* 1940 AD 213 para 10.
[96] *R v Peverett* 1940 AD 213 para 11.

court that "neither suicide, nor the attempted suicide, is a crime in South Africa."[97] Moreover, the judge concluded that "consent is not a valid defence on a charge of murder and the fact that the victim is free to prevent their death does not free the accused from criminal liability."[98] The accused was convicted and sentenced for attempted murder.[99]

2.3.1.1 *Analysis*

The first case within the Republic of South Africa to address one individual assisting another to commit suicide was this case of *Peverett*. As it stands, a person is guilty of aiding and abetting suicide if they knowingly provide a drug to a patient for self-administration, and thus can be found guilty of murder.[100] As much as suicide or an attempt to commit suicide is not a criminal offence in South Africa, an individual cannot in law consent to their life being taken by another party to a suicide pact.[101] If the person kills another in the execution of such pact, such killing is unlawful.[102]

2.3.2 *S v De Bellocq 1975 3 SA 538 (T)*

Decades later, 35 years to be precise, followed the case of *S v De Bellocq* in 1975. In this case, Mrs De Bellocq had just recently got married and was expecting her first child.[103] The accused went into premature labour and after a short time, the infant was found to suffer from toxoplasmosis. The baby could only be fed through a naso-gastric tube as the disease had left it severely disabled.[104] After some time in the hospital, she was discharged together with the child. She was also diagnosed with post-natal depression and she elected to, on the spur of the moment, drown the baby while bathing it.[105] In its decision, the court rejected the argument that this was culpable homicide and the accused person was thus found guilty of murder.[106] However, the court took into consideration the exceptional circumstances and decided to show mercy and sentenced the accused in terms of Section 349 of the *Criminal Procedure*

[97] *R v Peverett* 1940 AD 213 para 13.
[98] *R v Peverett* 1940 AD 213 para 56.
[99] *R v Peverett* 1940 AD 213 para 57.
[100] Pillay 2000 https://journals.co.za/doi/pdf/10.10520/AJA02500329_2862.
[101] Pillay 2000 https://journals.co.za/doi/pdf/10.10520/AJA02500329_2862.
[102] This speaks to the element of intention, showing premeditation even though there was a pact.
[103] *S v De Bellocq* 1975 (3) SA 538 (T) para 4.
[104] *S v De Bellocq* 1975 (3) SA 538 (T) para 5.
[105] *S v De Bellocq* 1975 (3) SA 538 (T) para 6.
[106] *S v De Bellocq* 1975 (3) SA 538 (T) para 45.

Act that was active at that time.[107] The said accused person was released on her own recognizance and the court imposed a condition of coming back for sentencing if, and when, called upon to do so. She never was summoned for this sentencing.[108]

2.3.2.1 ***Analysis***

It is in this case of *S v De Bellocq* where we see a court of law finding someone guilty of murder but subjecting them to a punishment and sentence that were not much more than symbolic in nature due to the exceptional circumstances and the element of mercy.[109] Now taking this judgment of the case into consideration, it is evident that a clear stance needs to be established with relation to euthanasia and physician-assisted suicide.[110]

2.3.3 *S v Hartmann* 1975 3 SA 532 (C)

In the very same year of 1975, there was a case of *S v Hartmann.* Dr Hartmann was a physician in Ceres whose father, the deceased, suffered from cancer.[111] The father suffered from carcinoma of the prostate for years and after a while the cancer also grew in his bones, specifically the ribs.[112] He consistently complained of being in extreme pain.[113] The accused asked the nurses to administer several doses of morphine to his father and shortly after he injected the patient with a large dose of Pentothal himself, which had the intended effect of death.[114] During those incidents, the deceased was placed on palliative treatment as there were no prospects of recovery and he was presumably very close to death in any case.[115]

The accused argued that "the deceased had given him consent to terminate his life, as he had inquired from him whether he would like to sleep and the deceased vaguely nodded his head."[116] This statement was challenged as it is not possible to know whether the deceased was able to make sense out of what was asked and even if his nodding

---

[107] Van Der Merwe *An analysis of Assisted dying and the practical implementation thereof in South African law* 44.
[108] *S v De Bellocq* 1975 (3) SA 538 (T) para 47.
[109] Van Der Merwe *An analysis of Assisted dying and the practical implementation thereof in South African law* 57.
[110] *S v Hartmann* 1975 (3) SA 532 (C) para 3.
[111] *S v Hartmann* 1975 (3) SA 532 (C) para 4.
[112] *S v Hartmann* 1975 (3) SA 532 (C) para 4.
[113] *S v Hartmann* 1975 (3) SA 532 (C) para 5.
[114] *S v Hartmann* 1975 (3) SA 532 (C) para 5.
[115] *S v Hartmann* 1975 (3) SA 532 (C) para 5.
[116] *S v Hartmann* 1975 (3) SA 532 (C) para 25.

established and constituted consent.[117] The court found that "at the time the accused administered the lethal dose of drugs he was cognisant of the repercussions and therefore, had intention to kill – an essential requirement for the crime of murder."[118] Although the accused was moved by his desire to relieve intractable pain, the court found him guilty of murder, despite his noble intentions nor the consent he claimed to have received from the deceased.[119] The motive that was claimed by the accused, no matter how merciful and noble, is not relevant for purposes of conviction.[120] It would, however, have an effect on the sentence after a successful conviction, as was the result in this case.[121] The court utilised "the mitigating circumstances of this case to impose a sentence as unique as the facts that gave rise to it."[122] The accused was in custody until the next court sitting. He was only left with one year from his prison sentence, which was eventually suspended.[123]

2.3.3.1 *Analysis*

This is the first recorded case which saw a medical practitioner actively euthanizing a terminally ill patient.[124] The judgment represented a stern disapproval for Dr Hartmann's conduct. However, the sentence, similarly to that of *S v De Bellocq* was limited to a symbolic gesture. Moreover, such circumstances appeal to humanity in such a way that medical practitioners are humans before they are doctors, thus, such cases do not come as a shock when doctors have given in to their basic human trait, that is compassion.[125] To cater for this basic human trait, a policy or legislation addressing this procedure must be enacted.[126]

2.3.4 *Clarke v Hurst NO and others* 1992 4 SA 630 (D)

Two years prior to the attainment of democracy and before the landscape of law in South Africa could shift, there was a case of *Clarke v Hurst* in 1992. In this case the applicant's husband, a medical practitioner, was in a constant vegetative state with no

[117] *S v Hartmann* 1975 (3) SA 532 (C) para 26.
[118] *S v Hartmann* 1975 (3) SA 532 (C) para 50.
[119] *S v Hartmann* 1975 (3) SA 532 (C) para 58.
[120] *S v Hartmann* 1975 (3) SA 532 (C) para 61.
[121] *S v Hartmann* 1975 (3) SA 532 (C) para 62.
[122] *S v Hartmann* 1975 (3) SA 532 (C) para 65.
[123] *S v Hartmann* 1975 (3) SA 532 (C) para 70.
[124] Paleker *Euthanasia in South Africa: A Normative analysis and application of dignity* 44.
[125] Paleker *Euthanasia in South Africa: A Normative analysis and application of dignity* 44.
[126] Paleker *Euthanasia in South Africa: A Normative analysis and application of dignity* 46.

hope of regaining consciousness.[127] The patient had drafted an advance directive which expressed his wish of not being kept alive by artificial methods should he ever be subject to a state of extreme mental or physical disability, such as he was currently experiencing.[128] The wife applied to the court to be appointed as the *curatix personae* in order to obtain legal power to enable her to order that the nasogastric tube be removed.[129] This would put an end to the artificial feeding of the husband which will bring about his death.[130] The court believed that the patient had lost all brain function permanently.[131] This, accompanied with the Living Will, led the court to believe that the legal convictions of the community would allow for the application to be granted.[132] The nasogastric tube was removed and the patient died.[133] The court further found that "in terms of criminal law, the act of removing the nasogastric tube might be the factual cause of death, but not the legal cause of death based on policy considerations."[134] As such, both the applicant and physician in this scenario are absolved from criminal liability as there is no causal link between their act and the unlawful result.[135] The court also stated that "it is acceptable for a doctor to give a patient pain relieving medicine, while knowing full well that the medicine could also shorten the patient's life."[136] This is known as the double effect.[137]

2.3.5 *Castell v De Greeff* 1994 4 SA 408 (C)

Speaking of the double effect, in the case of *Castell v De Greeff* in 1993*,* the principle of informed consent was presented and validated by the Appeal Court.[138] This doctrine placed emphasis on "a patient's right to bodily integrity and autonomy so that they may refuse medical treatment even if that would be detrimental to their health. In these circumstances, the unlawfulness of a physician's medical treatment would be

[127] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 5
[128] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 11.
[129] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 12.
[130] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 19.
[131] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 65.
[132] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 65.
[133] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 43.
[134] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 44.
[135] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 45.
[136] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 66.
[137] *Clarke v Hurst No and Others* 1992 (4) SA 630 (D) para 67.
[138] *Castell v De Greeff* 1994 (4) SA 408 (C) para 23.

excluded, if the patient was sufficiently warned of the material and dire risks involved."[139]

2.3.5.1 *Analysis*

It is submitted that this particular case and its judgment are influential in that it provides a significant enlightenment to medical health professionals and litigation that might arise to the effect that the life of a human being amounts to more than just biological functions but must also include both cortical and cerebral functioning.[140] Furthermore, it serves to highlight the existence of Living Wills in South African law. The utility of Living Wills would address the gap in the issue of physician assistance and euthanasia addressing what the terminally ill patient wishes, even in their incapability of actively saying what their wishes are, medically.

2.3.6 *S v Nkwanyana* 2003 1 SACR 67 (W)

In the post-apartheid era, there was a case of *S v Nkwanyana* in 2003 in which the deceased person was diagnosed with a severe psychiatric disorder and wished to die.[141] She had attempted, but was unable to commit suicide on numerous occasions.[142] She had requested the accused, with whom she had become friends, to assist her in dying.[143] In the beginning the accused had refused, but after persistent requests by the deceased, he finally gave in to the request.[144] In order to do so, he had illegally bought a firearm.[145] After again attempting without any success to discourage her, he shot and killed the deceased.[146] It was the first time the accused had committed an offence and he proceeded to plead guilty.[147] The evidence showed that the deceased was domineering the accused.[148] It was further clear that he did not pose any danger to society.[149] The court held that "the deceased had wanted to be killed and she had planned her own killing."[150] These were compelling and exceptional

[139] *Castell v De Greeff* 1994 (4) SA 408 (C) para 24.
[140] *S v Makwanyane* 1995 (3) SA 391 (CC) para 332.
[141] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 67.
[142] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 67.
[143] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 67.
[144] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 67.
[145] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 67.
[146] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 67.
[147] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 68.
[148] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 71.
[149] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 71.
[150] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 72.

circumstances that justified the imposition of a sentence less than that provided for under the provisions of the *Criminal Law Amendment Act*.[151] The court held that "the accused is guilty of murder but a suspended sentence of five years will be imposed."[152]

2.3.6.1 ***Analysis***

This case disrupts the typical cases addressing physician-assisted suicide and euthanasia: here, the person wishing to die suffered from mental disorder.[153] This speaks to the mental competence of the person, and whether they can make a sound and competent request. However, it is submitted that it would be unreasonable and discriminatory to utilise the blanket approach when faced with such a case as there are other persons suffering from mental disorders but are able to make competent and sound decisions.[154] What should be considered is the severity of their disorder and their ability or inability to make such complex decisions.[155]

2.3.7 *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 4 SA 50 (GPHC)

Most recently, there was the popular case of *Stransham-Ford v Minister of Justice and Correctional Services* in 2015. In this case, the applicant was terminally ill as a result of a severe form of cancer.[156] He experienced constant pain, nausea and was close to the end of his life and was not able to perform most of his daily basic tasks, such as personal hygiene and going to the bathroom.[157] He made an application to court for leave to seek assistance from a physician to help him with quickening his death, as he was no longer able to endure the suffering for much longer since palliative care did not give him the relief he wanted.[158]

---

[151] *Criminal Law Amendment Act* 105 of 1997.
[152] *S v Nkwanyana* 2003 (1) SACR 67 (W) para 73.
[153] This is the first recorded case of euthanasia involving a person with a mental disorder.
[154] In instances where persons with mental disabilities are involved, a blanket approach is normally utilised, which is discriminatory and perpetuates inequality.
[155] The extent and severity of the mental disorder should be considered before their request could be considered as this speaks to whether they are able to make competent decisions.
[156] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GPHC) para 3.
[157] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GPHC) para 3.
[158] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GPHC) para 6.

The court granted the application, stating that the physician who would carry out the assistance would be immune from criminal, disciplinary and civil liability should he provide or administer a lethal dosage which would cause the death of the patient.[159] A procedural and practical problem emerged with the court's ratio as a result of the applicant passing away prior to the judgment being delivered and as such, the cause for the application had ceased to exist.[160] This was further discussed in the Supreme Court's decision.

The Supreme Court of Appeal based its ruling on three pillars: the first one is that the cause of action had ceased to exist, therefore it was inappropriate of the High Court to grant that particular order.[161] Secondly and mostly due to the urgency of the circumstances at the time, sufficient investigation was not conducted into the subject matter, local or foreign, rendering the court's argument weak for the lack of necessary authority.[162] Third and lastly, the court disregarded the Uniform Court Rules as it did not comply with them and all interested parties were not provided equal opportunity and platform to raise their concerns.[163] This restricted the facts upon which the court based their order.[164] The court further stated once again with emphasis that "consent to be killed does not qualify as a valid defence under any circumstances and the accused should in these cases still be convicted of murder."[165] Moreover, in paragraph 41, the court submitted that "the High Court should not have made such an order which would profoundly alter the law's interpretation of murder."[166]

2.3.7.1 *Analysis*

This case resuscitated the controversial issues of physician-assisted suicide and euthanasia in South Africa. Even though the High Court judgment was successfully

[159] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GPHC) para 26.
[160] *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) para 3.
[161] *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) para 12.
[162] *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) para 13
[163] *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) para 23.
[164] *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) para 24.
[165] *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) para 25.
[166] *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* 2017 (3) SA 152 (SCA) para 26.

appealed, sound and valid reasons were advanced by the High Court to allow for Mr Stransham-Ford to be euthanized. The right to life, which is at the centre of these two practices, speaks to a particular quality of life, not just mere existence.[167] Moreover, the right to life, personal autonomy and human dignity are what makes a person human, and as such, should be given preference in analysing whether physician-assisted suicide and euthanasia should be legalised.[168]

2.4 Conclusion

It is evident from the cited cases and discussions that the law is still on the fence about euthanasia and physician-assisted suicide. In essence, the application of the law addressing this practice is inconsistent. Thus, unless a statutory body creates a legislation so it can intervene and regulate this practice, the matter remains fluid and unresolved. Moreover, considering how much of a remarkable legal precedent the decision of Fabricius J is in the *Stransham-Ford* case, one would even say it was long overdue. Considering this landmark ruling, there is now, more than ever before, a need for legislation to be enacted which regulates euthanasia and physician-assisted suicide.[169] Moreover, the Hippocratic Oath, which binds all medical health professionals, and requires that they do not administer or prescribe a lethal dose of medication to any patient even if asked, needs to be reconsidered and amended.[170] The South African Law Reform Commission's proposed Draft Bill certainly furnishes the legislature with a firm foundation on which legislation that regulates end-of-life decisions could be implemented.

As much as the courts are able to adapt and change, they seem reluctant to adopt a contemporary approach when it comes to euthanasia and physician-assisted suicide. According to these discussions, it seems that only passive euthanasia may be legally justified. But even though physician-assisted suicide and euthanasia are unlawful, there exists means and avenues for physicians and patients to avoid any form of criminal liability that might possibly arise. These avenues may include obtaining a second opinion from another medical practitioner and the utilisation of psychologists

[167] In this context, the right to life speaks to a quality of life, not a life below standard. Mere existence and living cannot be the standard set for citizens.
[168] These three rights are at the centre this study. Legalizing these two practices would broaden their meaning.
[169] Van Der Walt and Du Plessis 2015 *NMMU* 814.
[170] Van Der Walt and Du Plessis 2015 *NMMU* 810.

to ensure that terminally ill patients making the request are in the right state of mind. However, they could create a breeding ground for inconsistency and dishonesty in a system that should be safe, transparent and open. The courts and lawmakers must be open-minded and adopt a contemporary approach when considering assisted dying. This could be accelerated through impartial research, conducted without preconceived notions or hidden agendas.[171] This would also ensure that arguments are based on solid legal principles and not subjective feelings. To facilitate the legalization of euthanasia and physician-assisted suicide, it is submitted that the fundamental rights enshrined in the Constitution of South Africa could be utilised in this regard. The Constitution, its human rights relevant to these procedures, and their interpretation thereof should be explored.

[171] Van Der Merwe *An analysis of assisted dying and the practical implementation thereof in South African criminal law* 67.

Chapter 3: Euthanasia and fundamental rights

3.1 Introduction

Euthanasia and physician-assisted suicide speak and relate to several fundamental rights enshrined in the Constitution of South Africa.[172] There are plausible constitutional arguments that may be submitted for a constitutionally protected liberty interest in determining the manner and time of one's death.[173] This debate seeks to reconfigure the balance between the constitutional guarantees of the rights to dignity, the right to life, physical integrity and to autonomy. The Constitution of South Africa has provided the framework for numerous legal rulings that have promoted the rights of citizens of South Africa to access health care.[174] In this chapter, the said Constitution is analysed and its rights relating to the patient thereof, are discussed.

3.2 Analysis of "the right to life" in relation to euthanasia

Section 11 of the Constitution states as follows "Everyone has the right to life."

As submitted by Daniel J Ncayiyana, the cases for legalised euthanasia and physician-assisted suicide are compelling.[175] As articulated by Posel in a different context, "the right to life is not merely a right to biological life but a claim and entitlement to a particular qualify of life."[176] It may be argued that life, as meant by section 11, expects a particular standard of quality living.[177] This quality of a subject's life depends on their health, among other factors. From this perspective, it stands to reason that circumstances that are unbearable would vary from one individual to the next.[178] Thus, it is submitted that "an individual's life might no longer be worth living once that quality drops below a subjective level and they might consider seeking the options embedded in these two medical practices."[179] Therefore, the court in the *Stransham-Ford* case applied the values of the Constitution after assessing the patient's quality of life, and concluded that "the right to life cannot mean that an individual is obliged to live, no matter what the quality of his life is."[180]

---

[172] Sipunzi *Physician-Assisted Suicide in South Africa – A Constitutional* Perspective 2.
[173] Lawrence and Gostin 1997 *JAMA* 1523.
[174] Verwey and Carstens 2014 *SAJHR* 92.
[175] Ncayiyana 2012 *SAMJ* 334.
[176] Ncayiyana 2012 *SAMJ* 334.
[177] Jacobs and Hendricks 2018 *SAMJ* 484.
[178] Jacobs and Hendricks 2018 *SAMJ* 484.
[179] Sipunzi *Physician-Assisted Suicide in South Africa – A Constitutional* Perspective 45.
[180] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 4 SA 50 (GP), para 14.

Moreover, the right to life cannot be said to be synonymous with an obligation to live.[181] This approach is similar to the approach taken by the court in *Clarke v Hurst NO*, which found that "continued artificial feeding would not serve the purpose of supporting human life as it is commonly known and afforded the patient's wife the opportunity to order its withdrawal without being exposed to legal consequences."[182] It is argued that "the right to life is not synonymous with an obligation to live."[183]

It is submitted that the issues with the right to life and these two procedures emanate from the manner in which the right is interpreted by the courts, legal scholars, and lay persons respectively, causing much controversy around the right itself. It is further argued that the right to life is narrow and rigid in its interpretation, thus lacking the ability to extend its scope to provide for various matters relating to the right to life.[184] It is therefore submitted that the right to life should be interpreted broadly to make way for the development of a policy or legislation that allows for euthanasia and physician-assisted suicide. Furthermore, this proposed broad interpretation could serve as a pathway and freedom to make decisions in relation to one's life. Developing legislation or policy that concerns itself with euthanasia and physician-assisted suicide could assist and facilitate the broadening of the interpretation of the right to life as to include the freedom to make decisions with respect to a person's own life. This trajectory affords a much-needed freedom to terminally ill patients. If the quality of life is of a low standard and unbearable, it is the most humane thing to afford the patient with the choice of euthanasia or assisted suicide.[185] Only the patient who is suffering knows the extent of such suffering, and the way the emotional and physical pain of the illness and prolonged death affects their quality of life.[186]

In this regard, the right to life should be absolved from a conservative interpretation. Rather, a non-rigid and flexible interpretation should be afforded to the right so that individuals in this context may make choices in relation to their lives, including electing to terminate their lives through euthanasia or be assisted to commit suicide by medical practitioners. Even though as it stands the right to life does not as a corollary,

[181] Nienaber and Bailey 2016 *SAJBL 77.*
[182] *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) para 44.
[183] Nienaber and Bailey 2016 *SAJBL 44.*
[184] Nienaber and Bailey 2016 *SAJBL* 74.
[185] Nienaber and Bailey 2016 *SAJBL* 75.
[186] Lyon 2015 *BMEC 3.*

incorporate the right to choose to die, it still does not require a state to make sure that a person's life is protected when this is against the explicit wishes of that particular individual.[187] In the case of a request for euthanasia or physician-assisted suicide, "the state's obligation to protect life must be balanced against the personal right to autonomy which is within the right to privacy."[188]

3.3 Section 10: "The right to dignity"

"Everyone has inherent dignity and the right to have their dignity respected and protected."[189]

The Constitution of South Africa places significant emphasis on human dignity as both a value and a right. If all things are considered, human dignity is arguably the most essential right and also the most important value enshrined in the Bill of Rights.[190] It is further submitted that human dignity is at the centre of the protection of all other rights and every other right has an aspect consisting of human dignity. Taking into account these submissions, human dignity may be described as "a pre-eminent value in the Constitution, even more so than the right to life."[191]

Now, aligning this right and the two medical procedures, it is submitted that there exists a close relationship between health care and human dignity, as health is significant to human dignity and life itself.[192] Moreover, decisions in relation to one's body and the effect those decisions have on one's relationship with their own body is profoundly personal.[193] As such, the decisions affect one's dignity.[194] In this premise, the prohibitions of euthanasia and physician-assisted suicide significantly and directly violate human dignity. People are often worried that their dying process might become a burden to their family and loved ones. The deterioration of bodily functions may make it hard for some people to maintain their dignity in the eyes of loved ones or even nursing staff who may treat them as senile or infantile.[195] The horrific nature that terminally ill patients may be subjected to may include the inability to feed and bathe

[187] Ramcharan *The right to life in international law* 32.
[188] Schafer 2013 *IJLP 522.*
[189] Section 10 of the *Constitution of South Africa*, 1996.
[190] Olinger, Britz and Olivier Western privacy and/or Ubuntu? 31-43.
[191] Olinger, Britz and Olivier Western privacy and/or Ubuntu? 31-43.
[192] Liebenberg 2005 *SAJHR* 31.
[193] Nienaber and Balley 2016 *SABL* 74.
[194] Nienaber and Balley 2016 *SABL* 74.
[195] Slabbert and Westhuizen 2007 https://journals.co.za/doi/pdf/10.10520/EJC97948.

themselves, go to the bathroom and even do the most basic of day-to-day chores. According to the Constitution, terminally ill patients who are subject to intractable suffering are entitled to have their "physical and psychological integrity and right to die in dignity respected."[196] Irreversible vegetative state and incapacitation that is deemed to be permanent, and terminal illness with intractable pain all diminish human dignity. It is thus submitted that it is harder morally to justify letting a person die a slow and ugly death dehumanised than it is to justify helping to avoid it.[197] The restriction encoded into these practices unjustifiably limits the patient's constitutional rights to human dignity, bodily and psychological integrity.[198] In some cases decided before the new Constitution came into effect, the courts held that "the test for unlawfulness was the *boni mores*."[199] However, since then the Constitutional Court has held that "the courts should not be influenced by public opinion but by the values of the Constitution – the most important of which is the right to dignity."[200]

3.4 The right to personal autonomy

The term autonomy is derived from "*the Greek auto (self) and nomos (rule),"* which refers to an individual's ability to make independent choices and decisions in relation to their life.[201] Autonomous competent individuals possess a fundamental right to make a decision on what they regard to be good and necessary for themselves after having reviewed all available options, with specific reference to health care and, by extension, life.[202] Individual autonomy relates to "individual freedom, especially the freedom of competent patients living an unbearable, restricted life due to them suffering from an incurable illness."[203] The principle of patient autonomy is a long standing principle in medical law. However, its application is seen in the patient's ability to refuse medication.[204] On this previous already established foundation, it is argued that owing to a developing world and developing medical field, it is a viable option to be extended to the procedures of euthanasia and physician-assisted suicide. This would enable a competent terminally

[196] Slabbert and Westhuizen 2007 https://journals.co.za/doi/pdf/10.10520/EJC97948.
[197] Ncayiyana 2012 *SAMJ* 334.
[198] Ncayiyana 2012 *SAMJ* 334.
[199] Du Plessis 2002 *SAJHR* 40.
[200] Du Plessis 2002 *SAJHR* 40.
[201] Kanu 2019 *JATRP 1.*
[202] Grisso and Appelbaum *Assessing Competence to Consent to Treatment: A Guide for Physicians and other Health Professionals 5.*
[203] Yuill *The unfreedom of assisted suicide: How the right to die undermines autonomy* 494.
[204] Pellegrino *Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship* 47.

ill patient to elect to be provided with a lethal dose of medication for self-administration or be assisted by a medical practitioner, resulting in the termination of their life. Good or bad, right or wrong – all of these have to be compared and weighed against the patient's autonomy and, eventually, their decision must be respected.[205] To arbitrarily refuse a patient's autonomy, without a valid reason, is a clear sign of a lack of respect for the patient's rights and their ability to choose.[206] Should a patient not be able to choose such as when a person is in a persistent vegetative state, then their wishes should be determined by means of a directive or living will drafted in advance, if possible.[207] If such directive is not available, then the lawmakers should determine by means of policy or legislation who would be allowed to make any final decisions, as per the study, that person being the patient.[208]

In the South African context, a patient's autonomy is acknowledged as an element of inalienable constitutional rights, as enshrined in the Constitution of South Africa and the *National Health Act*.[209] The advocates for patient autonomy have argued that "the right to elect when one dies is or should be included in the understanding of this legislation."[210] In the case of *Castell v De Greeff*,[211] another concept similar to patient autonomy was introduced and confirmed by the Supreme Court of Appeal. This concept is called the doctrine of informed consent.[212] This emphasizes "the patient's right to autonomy so that they may refuse medical treatment even if that refusal may prove detrimental to their health."[213] This is indirect evidence that patient autonomy exists, and patients can make decisions even if they are in severely sick states. In that respect, it is argued that a patient who suffers from terminal illness but still retains their sound mind should be permitted to waive one constitutional right to give effect to another, since a dying person is still alive and can still enforce the rights of a living person.[214] It is thus

[205] Quill 2008 https://doi.org/10.1007/978-1-4020-6496-8_5.
[206] Sheehan 2020 Can Broad Consent be Informed Consent? 226.
235, https://doi.org/10.1093/phe/phr020.
[207] Yuill *The unfreedom of assisted suicide: How the right to die undermines autonomy* 494.
[208] Yuill *The unfreedom of assisted suicide: How the right to die undermines autonomy* 495.
[209] Nevhutalu *Patient's rights in South Africa's public health system: Moral-critical perspectives* 221.
[210] Nevhutalu *Patient's rights in South Africa's public health system: Moral-critical perspectives* 222.
[211] *Castell v De Greef* 1994 (4) SA 408 (C) A para 44.
[212] *Castell v De Greef* 1994 (4) SA 408 (C) A para 45.
[213] *Castell v De Greef* 1994 (4) SA 408 (C) A para 49.
[214] Du Plessis 2002 *SAJHR* 39.

submitted that the physician's duty to respect the patient's autonomy outweighs their duty to preserve and protect their life.[215]

Moreover, internationally, patient autonomy and its importance thereof in relation to terminal illness and the wish for euthanasia and physician-assisted suicide are acknowledged and comprehensively detailed in the World Medical Association (hereinafter WMA) Declaration of Venice on Terminal illness that was made in 2006.[216] As much as the WMA views euthanasia as unethical, it does not prohibit the physician from respecting the wish of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.[217] Moreover, the WMA states that "when a terminally ill patient's medical diagnosis rules out the prospects of health being restored, and the death of the patient is inevitable, the physician and the said patient are likely to be confronted with a complicated set of decisions in relation to medical interventions."[218] Also, as much as there have been advancements in the field of medicine that have improved the abilities of medical practitioners to tackle many problems associated with end-of-life care, it is an aspect of medicine that has historically not received the attention it is worthy of.[219] The Association also acknowledges that "beliefs and attitudes towards death and dying differ vastly from culture to culture and from religion to religion, and also how palliative and life-sustaining measures require technologies and financial resources that are simply not available in many countries."[220] Taking these factors into account, South Africa is a developing country that lacks these resources. Despite the lack in resources, a patient's rights should not be marginalised, ignored nor denied as a result this lack.

3.5 "Right to freedom and security of the person"

Section 12(1)(e) states that "Everyone has the right to freedom and security of the person, which includes the right not to be treated or punished in a cruel, inhuman or degrading way."[221]

There are instances where medication and palliative care no longer serve their intended purposes as compared to the initial stages of their administration without negative side effects.[222] This may be ascribed to the increased tolerance to pain

[215] Du Plessis 2002 *SAJHR* 38.
[216] Jacobs and Hendricks 2018 *SAMJ* 489.
[217] Liebenberg 2005 *SAJHR 22.*
[218] Du Plessis 2002 *SAJHR* 40.
[219] Jacobs and Hendricks 2018 *SAMJ 32.*
[220] De Lima Et al 2019 *JPM 32.*
[221] Section 12 of the *Constitution of South Africa,* 1996.
[222] Lyon 2019 *UBJ 3.*

medication which results in the patient experiencing consistent pain.[223] As such, the patient is left in excruciating pain and not knowing when the eventual moment of death would come. The legal prohibition of these two medical procedures compels these terminally ill patients to live with extreme and chronic pain, against their express wishes.[224] Knowingly subjecting a person to this misery may be described as "cruel, inhuman or degrading" treatment as per section 12(1)(e).[225] On that premise, it may be argued that by doing nothing as a doctor, such a medical practitioner unintentionally but still knowingly and consciously subjects the patient to an ordeal which directly infringes upon the patient's "right to bodily integrity" and in turn the right to dignity as well. It is further submitted that "a state denying a person the option of being euthanized or assisted by a physician to commit suicide has the consequences of forcing the patient to endure cruel, inhuman or degrading treatment."[226] This argument was also utilised in the case of *Pretty v the United Kingdom*,[227] where the applicant suffered from Motor Neurone Disease.[228] The applicant was paralysed from the neck down and had virtually no decipherable speech and the only means to feed her was through a tube.[229] Her life expectancy was limited to a few months or even weeks.[230] However, even with such severe impairments, she had full mental capacity.[231] It was stated by the European Court on Human Rights that "The final stages of the disease are exceedingly distressing and undignified. As she is frightened and distressed at the suffering and indignity that she will endure if the disease runs its course, she very strongly wishes to be able to control how and when she dies and thereby be spared that suffering and indignity".[232]

Section 12(2) of the Constitution states that "Everyone has the right to bodily and psychological integrity, which includes the right to – (a) to make decisions concerning reproduction; (b) to security in and control over their body; and (c) not to be subjected to medical or scientific experiments without their informed consent."[233]

---

[223] Lyon 2019 *UBJ 5.*
[224] Pellegrino *Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship* 23.
[225] Section 12 of the *Constitution of South Africa,* 1996.
[226] De Lima Et al 2019 *JPM* 14.
[227] *Pretty v United Kingdom* 2346/02, para 45.
[228] *Pretty v United Kingdom* 2346/02, para 4.
[229] *Pretty v United Kingdom* 2346/02, para 4.
[230] *Pretty v United Kingdom* 2346/02, para 5.
[231] *Pretty v United Kingdom* 2346/02, para 6.
[232] *Pretty v United Kingdom* 2346/02, para 40.
[233] Section 12(2) of the *Constitution of South Africa*, 1996.

For the purposes of this study, section 12(2)(b) is the focus as it relates to the freedom and right of a person to practise unequivocal control over their body, which includes medical decisions such as the two medical procedures being discussed.

The right to physical integrity, as contained in the above stated section of the South African Constitution, is "the foundation on which jurisprudence concerning patient autonomy and the right to refuse treatment rest."[234] This right is supplemented in the *National Health Act*, more specifically in sections dealing with informed consent and refusal of treatment. It is submitted that the right to physical integrity essentially amounts to a right to be left alone.[235] This means that a person possesses the right to make decisions concerning their own body without any undue interference by others.[236] The way this section is phrased, with the inclusion of *security* and *control over* their body, bestows a cluster of rights on a patient in the healthcare context.[237]

3.6 Conclusion

It is evident that there are stories of extra-ordinary people who are inspirations to all as they can overcome and recover from serious illnesses, despite having all the odds stacked against them. However, this is not often the case with all terminally ill patients and the release by death could prove more attractive than being subject to a life where existence is painful.[238] "There is, of course, no duty to live, and a person can waive their right to life". This highlights the fact "that the right to life, like all other rights, does not place a positive obligation on the holder and as such, it can be waived and limited in terms of section 36 of the Constitution."[239] This limitation could come into play in the instance where euthanasia and physician-assisted suicide are legalised in South Africa. The right to life has a bearing on euthanasia and physician-assisted suicide as it allows a person to invoke such right when they want to be euthanized or assisted by a physician to commit suicide. This is dependent on the broad or restricted interpretation of the right to life. Moreover, in a sense, all the above-mentioned rights are intertwined in that human dignity entails that the same individual is entitled to autonomy. In turn,

[234] Nienaber and Bailey 2016 *SAJBL* 73.
[235] Bailey 2016 *SAJBL* 73.
[236] Bailey 2016 *SAJBL* 73.
[237] Chima *An investigation of informed consent in clinical practice in South Africa 1.*
[238] Van Der Merwe *An analysis of assisted dying and the practical implementation thereof in South African Criminal law 33.*
[239] Van Der Merwe *An analysis of assisted dying and the practical implementation thereof in South African Criminal law 28.*

autonomy, means that all individuals should be able to pursue their subjective idea of the good life. Whilst there may be a lot of ideas of what constitutes a good life, it can be stated with certainty that suffering is nobody's idea of the good life, hence suffering is antithetical to autonomy.[240] Accordingly, as a general rule as a rule, suffering violates human dignity.[241] Moreover, the pain and suffering a terminally ill patient is subject to because of the illness infringes upon their right to bodily integrity as contemplated in section 12(2). No one should withstand and endure such suffering when other alternatives exist. It is therefore submitted that terminally ill patients whose health has deteriorated and wish to utilise these two medical procedures are perfect exhibits of persons having to choose between a dignified death and a life that can barely be called living.[242]

There are other jurisdictions that have made strides in this space by electing to legalise euthanasia and physician-assisted suicide in their respective countries. In that regard, euthanasia and physician-assisted suicide are approached in various ways by different countries and jurisdictions. Consequently, it is essential to explore approaches of various foreign jurisdictions in relation to how these two procedures have been legalised and effected in making legal decisions.

[240] Krause *Going gently into that good night: The Constitutionality of consent in cases of euthanasia 45.*
[241] Krause *Going gently into that good night: The Constitutionality of consent in cases of euthanasia 42.*
[242] Krause *Going gently into that good night: The Constitutionality of consent in cases of euthanasia 43.*

Chapter 4: The regulation of euthanasia and physician-assisted suicide in The Netherlands, The United States of America (Oregon) and Canada

4.1 Introduction

The development of law differs from country to country, in that some countries can recognise, adopt, and enact laws quicker than other countries.[243] In a sense, the laws of these jurisdictions eventually serve as a blueprint or reference point for other countries that want to follow in the same footsteps. On this premise, there are some jurisdictions that have promulgated policies and legislation for the purpose of regulating euthanasia and physician-assisted suicide.[244] These include The Netherlands, Canada, and the State of Oregon in the United States of America. They contain statutes and policies that allow them to regulate and implement euthanasia and physician-assisted suicide. These jurisdictions are discussed for comparative purposes to ascertain the best practices. These jurisdictions are specifically chosen for their unique and varying positions regarding euthanasia and physician-assisted suicide, as well as their relevance to South African law. This is designed to explore other perspectives on the topics to ascertain the best practices for South Africa in legalising euthanasia and physician-assisted suicide. This chapter investigates and compares laws regulating euthanasia and physician-assisted suicide in the selected jurisdictions by analysing legislation and the development thereof, and various cases decided in the courts.

4.2 The regulation of euthanasia and physician-assisted suicide in The Netherlands

4.2.1 The history of euthanasia and physician-assisted suicide in The Netherlands

The Netherlands remains one of the jurisdictions with a longstanding history of euthanasia and physician-assisted suicide, since 1886.[245] The *Dutch Criminal Code* made strides to enact legislation that would regulate the practice of euthanasia when it was adopted in 1886.[246] In accordance with the *Code*, euthanasia deserves a

[243] Bailey and Nienaber 2021 *SAJBL 3*.
[244] Bailey and Nienaber 2021 *SAJBL 4.*
[245] Grande 2000 *SALJ 21*.
[246] Grande 2000 *SALJ 21*

separate penalty clause from murder and manslaughter.[247] This was a result of the notion that "murder and manslaughter are crimes against the right to life, whereas euthanasia does not violate this right of the deceased individual owing to the fact that the deceased would have consented to the act."[248] However, it was still criminalised because of the substantive rule, "thou shalt not kill" and violated the respect for life itself.[249] This Dutch approach was developed over a period of 30 years and founded on three pillars of Jurisprudence through Supreme Court decisions; namely, case law, legislation and prosecutorial policy.[250]

4.2.2 The legal history of euthanasia and physician-assisted suicide through legislation and case law in The Netherlands

The public discussion relating to euthanasia, physician-assisted suicide, and the conditions under which the termination of life by a medical practitioner could be justified and their decriminalisation thereof was preceded by several historical-juridical events. Prior to *The Termination of Life Act* 2002, assisted dying was regulated by article 293 of the *Criminal Code*, which stated that "a person who takes the life of another person at that other person's express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine of the fifth category."[251] However, the Dutch Courts accepted the defence of necessity.[252]

In 1952 the District Court in Utrecht condemned a medical doctor who had killed his suffering brother with tablets and an injection to a one-year prison sentence, ordering suspension of sentence on probation.[253]

Moreover, in 1974 another medical doctor killed her 78-year-old mother who was suffering severely from Cerebral Haemorrhage and was deaf, partly paralysed and had trouble speaking by administering a lethal dose of morphine in a nursing home.[254] The administration of the legal dose came after the mother had repeatedly expressed

---

[247] Grande 2000 *SALJ 22.*
[248] Bogaert and Ogunbanjo 2013 *SALJ 33.*
[249] Care Not Killing (2015) "Lord Falconer's Assisted Dying Bill" Care Not Killing 66-76.
[250] Van Der Merwe *An analysis of assisted dying and the practical implementation thereof in South African criminal law 98.*
[251] Article 293 of the *Criminal Code.*
[252] Article 293 of the *Criminal Code.*
[253] This case marks one of the very first cases of euthanasia in The Netherlands. The District Court found the doctor guilty of killing on request (article 293 of the Criminal Code). The citation for this case is unavailable.
[254] Jordaan 2011 *DJLJ* 34-48.

her wish to die. The court in Leeuwarden found her guilty because she did not aim to end the suffering but directly to kill her mother instead of increasing the dose of morphine with the secondary effect that the patient's life would have been shortened.[255] The medical practitioner was punished with a one-week prison sentence but the presiding judge again ordered suspension of the sentence on probation of one year.[256] In this case, the requirements for euthanasia were summed up for the first time, namely, that there is no prospect of relief for the patient who is subjectively suffering unbearable bodily or mental pain, a written request from the patient, being in a final stage of a terminal illness is required, and the euthanasia should be performed by a physician.[257] In 1984, a decade later in the case known as the *Alkmaar* case, an old woman aged 95 years old was severely ill without any hope of recovery.[258] The weekend prior to her death, she suffered a significant deterioration as she was unable to eat or drink, and had lost consciousness.[259] She had pleaded with the medical practitioner several times to put a stop to her suffering. After she had regained consciousness, she stated that she did not wish to go through the experience again and convinced her doctor to end her life.[260] Finally, the medical practitioner elected to grant the patient her wish as he believed that every single day would serve as a heavy burden to the patient.[261] The doctor was, however, found guilty but the conviction was overturned by the Court of The Hague that eventually acquitted the doctor taking into account whether the factor of necessity had existed and whether the patient would no longer be able to die with dignity in circumstances worthy of a human being.[262] In light of all of these cases, in 1985, the state Commission on Euthanasia proposed that "Article 293 of the Penal Code be amended in such a manner that the intentional causing of death of another person at their explicit and earnest request would not be an offence, provided this is carried out by a doctor in the context of careful medical practice in respect of a patient who is in an untenable state with no prospect of improvement."[263]

---

[255] The court in this case set a legal precedent for matters relating to euthanasia. This precedent was followed until the practice was decriminalized.
[256] Care Not Killing (2015) "Lord Falconer's Assisted Dying Bill" Care Not Killing.
[257] The Crown Prosecution Service (2014) "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" *The Crown Prosecution Service.*
[258] This case is often referred to as the 1984 Alkmaar case. No proper citation has been provided.
[259] This case is often referred to as the 1984 Alkmaar case. No proper citation has been provided.
[260] Care Not Killing (2015) "Lord Falconer's Assisted Dying Bill" Care Not Killing.
[261] The Crown Prosecution Service (2014) "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" *The Crown Prosecution Service.*
[262] Jordaan 2011 *DJLJ* 28-33.
[263] Griffiths, Bood and Helene Euthanasia and Law in The Netherlands 444.

Owing to the increased cases of euthanasia and assisted suicide in The Netherlands, the government commissioned a study into the practice of Dutch euthanasia in 1991 and released the results thereof on the 10th of September 1991. The two-volume chronicle referred to as the Remmelink Report documents how high the rate of involuntary euthanasia is in Holland and how to some extent, medical health professionals have taken over end-of-life decision making regarding euthanasia.[264] The data indicated that despite court-approved and long standing euthanasia guidelines developed for the purpose of protecting patients, abuse had become an accepted norm.[265]

4.2.3 The current legislation regulating euthanasia and physician-assisted dying in The Netherlands

As it stands, assisted dying is regulated by *The Termination of Life Act* which came into effect in 2002. This promulgation was the result of a long process of conflicting debates which began in the 70s-80s, with a nuanced understanding vision for medical practitioners, formed by case law, and based on numerous legislative proposals.[266] Without decriminalizing euthanasia itself, the current Dutch legislation permits it for some cases. Indeed, euthanasia, suggesting or inciting suicide and assisted suicide are still considered as crimes.[267] However, this current law has a release from liability clause for medical practitioners who adhere to the five criteria of due care. These criteria are as follows:[268]

a. *"The patient's request for euthanasia must be voluntary and well-considered, the consent of the terminally ill patient who is no longer able to express themselves may be taken into consideration if he has previously made a written declaration to that effect, and is at least 16 years old,*

b. *The patient's suffering must be considered unbearable without any prospect of improvement,*

[264] Kim 2019 *How Dutch Law Got a Little Too Comfortable with Euthanasia* 23.
[265] Kim 2019 *How Dutch Law Got a Little Too Comfortable with Euthanasia 34.*
[266] *The Termination of Life Act 2002.*
[267] Kim 2019 *How Dutch Law Got a Little Too Comfortable with Euthanasia 40.*
[268] *The Termination of Life Act 2002.*

c. *The patient must be fully informed and aware of his condition, prospects, and options,*

d. *Both the doctor and the patient must have reached the conclusion that there is no other reasonable alternative,*

e. *There must be consultation with at least one other independent doctor who needs to provide written confirmation of the above-mentioned conditions. If the request for euthanasia is made by a mentally ill patient, two independent physicians must have been consulted, including at least one psychiatrist."*[269]

The legislation also allows for minors to make requests and for the medical practitioners to accept such requests; however, there are conditions attached to this provision. The parents or legal guardians of the minor must actively participate in the decision-making when the minor is between the ages of 16 and 18 or provide parental consent when the minor is between the ages of 12 and 15.[270] All children under the age of 12 do not qualify to make the request, even with the involvement of guardians.

It is worth highlighting that the termination of the life of a terminally ill patient at their competent request is still considered illegal in Dutch law. This means that perceiving euthanasia or physician-assisted suicide as legal acts remains a misnomer.[271] The practice has been merely decriminalised by article 293(2) of the Criminal Code. Decriminalizing, as opposed to legalizing, means that the act or conduct is still considered a crime, but the person who assists in the suicide may not be subject to prosecution provided they adhere to all the necessary requirements stipulated in article 2 of the *Termination of Life on Request and Assisted Suicide (Review*

[269] *The Termination of Life Act 2002.*
[270] *The Termination of Life Act 2002.*
[271] Paleker *Euthanasia in South Africa: A normative analysis and application of dignity* 122.

Procedures) Act.[272] The "requirements of due care, referred to in article 293 second paragraph Penal Code, means that the physician:"[273]

a. *"Holds the conviction that the request by the patient was voluntary and well-considered,*

b. *holds the conviction that the patient's suffering was lasting and unbearable,*

c. *has informed the patient about the situation he was in and about his prospects,*

d. *and the patient holds the conviction that there was no other reasonable solution for the situation he was in,*

e. *he has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a - d, and*

f. *has terminated a life or assisted in a suicide with due care*."

4.2.4 Analysis

The Netherlands represents a jurisdiction that is non-rigid and contemporary in the sense that it has the ability to address controversial legal problems such as the practices of euthanasia and assisted-dying. Its legal system is flexible and can stretch itself to accommodate the evolution of the world. This is seen in the development of legislation and policies over time regulating these two practices.[274] The enactment of legislation in The Netherlands has resulted in a relatively transparent practice with regards these two controversial practices within the medical field. It is evident in the statistics that medical practitioners are now able to report the deaths resulting from euthanasia or assisted-suicide without fear of prosecution.[275] Moreover, taking into

[272] *The Termination of life on request and Assisted suicide (Review Procedures) Act* 2002.
[273] Article 2 of *The Termination of Life Act* 2002.
[274] The Netherlands remains, to this date, one of the first foreign jurisdictions to permit euthanasia. Its legal system is progressive, allows for development.
[275] Life Site (2012) "Euthanasia is out of control in the Netherlands – New Dutch Statistics" available online at www.lifesitenews.com/blogs/euthanasia-is-out-of-control-in-the-netherlands-new-dutch-statistics.

account the above submissions, it is evident that the use of euthanasia and physician-assisted suicide has been steady and that abuse has not been high, nor is there apparent disproportionate use in vulnerable populations.[276] It is also clear that doctors do not substitute hastening death for good palliative care, they rather concentrate on alleviating symptoms.[277] In fact, the rate of alleviation of symptoms is increasing more than any increase in euthanasia or physician-assisted suicide. Moreover, doctors grant fewer than half of euthanasia requests from patients.[278] Furthermore, even though statistics show that there has been an annual increase in the use of euthanasia since the legislation was passed, the increase itself has been slowing down and it is suspected that a decrease in its use is inescapable.[279] Another interesting factor worth noting is the fact that 99.93% of all euthanasia cases comply with statutory legal requirements.[280] It is submitted that this is owed to the fact that the requirements put in place are strict as much as they are clear. There is no grey area. This appears to be a pattern in most of the jurisdictions that have implemented laws to regulate euthanasia, The State of Oregon being one of the front runners in this regard.

4.3 The regulation of euthanasia and physician-assisted suicide in the State of Oregon (United States of America)

4.3.1 The history of euthanasia and physician-assisted suicide in the State of Oregon

The idea that death should be merciful is not a new concept. Around 1800, pioneers of euthanasia pulled on the legs of those who had been hanged to hasten their deaths.[281] This is the debate around euthanasia, physician-assisted suicide and their legal applicability and viability in the State of Oregon. The Oregonians first took the

[276] Dying for Choice (2016) "Netherlands – 2015 euthanasia report card" available online at www.dyingforchoice.com/resources/fact-files/netherlands-2015-euthanasia-report-card.
[277] Dying for Choice (2016) "Netherlands – 2015 euthanasia report card" available online at www.dyingforchoice.com/resources/fact-files/netherlands-2015-euthanasia-report-card.
[278] Life Site (2012) "Euthanasia is out of control in the Netherlands – New Dutch Statistics" available online at www.lifesitenews.com/blogs/euthanasia-is-out-of-control-in-the-netherlands-new-dutch-statistics.
[279] Oosthuizen 2003 http//pubmed.nlm.nih.gov.
[280] Oosthuizen 2003 http//pubmed.nlm.nih.gov.

[281] Death with Dignity (2017) "How to Access and Use Death with Dignity Laws" *Death with Dignity* available online at www.deathwithdignity.org/learn/access/#Going_Through_the_Process_of_Obtaining_Medications.

step to pass the *Death with Dignity Act* by means of votes in a November 1994 referendum by a margin of 51% to 49%.[282] However, on December 27, 1994, a preliminary injunction was issued against the measure and this delayed the immediate implementation of the Act.[283] This was followed by a permanent injunction on the 3rd of August 1995.[284] Furthermore, in 1997 the Ninth Circuit Court of Appeals elected to lift the injunction that physician-assisted suicide should become a viable legal option for terminally ill patients in Oregon. However, in the very same year, the United States Supreme Court elected to decline to hear the case.[285] To further emphasise its democratic nature as a nation, the State of Oregon once more put to the case to a vote in 1997 to determine the future and applicability of this *Act*, which was voted in by 60% votes.[286] The enactment of this Act was not implemented with ease as there were efforts from other authorities to derail the movement. In 1998 the Drug Enforcement Agency (hereinafter the DEA) determined that narcotics and other dangerous substances controlled by Federal law could not be utilised to assist suicide.[287] However, on the 5th of June of the same year, the United States Attorney General overruled the DEA determination and left it to the state to decide whether controlled substances could be prescribed to assist suicide.[288] On November 6, 2001, the United States Attorney General issued a letter reinstating the initial DEA determination, citing the United States Supreme Court's decision in *United States v Oakland Cannabis Buyers' Cooperative*[289] in which the Court held that "cooperatives that distributed marijuana for medical purposes violated the *Controlled Substances Act*[290] because marijuana had no proven medical value, a necessity for distributing controlled substances."[291] In a bid to halt the US Attorney General's letter, the Oregon's attorney successfully sought a restraining order on the United States Attorney General's letter

[282] Cavalo J (2017) "Examining the impact of 'Death with Dignity' Legislation: A Conversation with Charles D. Blanke, MD, FACP, FASCO" *The ASCO Post* available at www.ascopost.com/issues/march-25-2017/examining-the-impact-of-death-with-dignity-legislation.
[283] Cavalo J (2017) "Examining the impact of 'Death with Dignity' Legislation: A Conversation with Charles D. Blanke, MD, FACP, FASCO" *The ASCO Post* available at www.ascopost.com/issues/march-25-2017/examining-the-impact-of-death-with-dignity-legislation.
[284] Jordaan 2011 *DJLJ* 34-48.
[285] Bailey and Nienaber 2021 *SAJBL* 20-29.
[286] *Death with Dignity Act 1997.*
[287] *Controlled Substance Act 1971.*
[288] *Controlled Substance Act 1971.*
[289] *United States v Oakland Cannabis Buyers' Cooperative* 532 US 483 2001.
[290] *Controlled Substance Act 1971.*
[291] *United States v Oakland Cannabis Buyers' Cooperative* 532 US 483 2001 para 23.

which was temporarily granted by the court until November 20, 2001.[292] On the 20th of November, 2001, the temporary order was extended for four months by the court.[293]

4.3.2 The legal history of euthanasia and physician-assisted suicide through legislation and case law in the State of Oregon

Prior to 1997, the State of Oregon had no existing legislation or policy tasked with the purpose of regulating euthanasia or physician-assisted suicide in its jurisdiction.[294] However, due to the alarming growth of calls to legalise euthanasia, the state elected to draft a *Death with Dignity Bill* that would regulate physician-assisted suicide in the absence or exclusion of euthanasia.[295] The Bill was thus voted into effect by citizens of Oregon, leading to the current *Death with Dignity Act,* which is the first and current legislation tasked with the regulation of physician-assisted suicide in the State of Oregon.[296] This legislation generated conflicting views and perspectives as this medical practice would require physicians or medical practitioners to prescribe lethal drugs and medication for terminating the life of a terminally ill patient.

In 2001, in the case of *United States v. Oakland Cannabis Buyers' Cooperative*[297], the contention before the court was whether the respondent Oakland Cannabis Buyers' Cooperative had acted within the law when it manufactured and distributed marijuana to qualified patients for medical purposes.[298] The United States submitted that "the cooperative's activities violated the *Controlled Substances Act*[299] which prohibited the distribution, manufacturing and possession of marijuana with the intent to distribute or manufacture a controlled substance."[300] The Supreme Court held that "cooperatives that distributed marijuana for medical purposes violated the *Controlled Substances Act* because marijuana had no proven medical value, a necessity for distributing controlled substances."[301] On this premise, an issue arose of "whether assisted suicide was a legitimate medical

[292] *United States v Oakland Cannabis Buyers' Cooperative* 532 US 483 2001 para 23.
[293] *United States v Oakland Cannabis Buyers' Cooperative 532* US 483 2001 para 15.
[294] Dignity in Dying (2014) "Lord Falconer's Assisted Dying Bill (2014)" *Campaign for Dignity in Dying* available at www.dignityindying.org.uk/assisted-dying/the-law/lord-falconers-assisted-dying-bill-2014.
[295] Dignity in Dying (2014) "Lord Falconer's Assisted Dying Bill (2014)" *Campaign for Dignity in Dying* available at www.dignityindying.org.uk/assisted-dying/the-law/lord-falconers-assisted-dying-bill-2014.
[296] *Death with Dignity Act.*
[297] *United States v Oakland Cannabis Buyers' Cooperative* 532 US 483 2001 para 33.
[298] *United States v. Oakland Cannabis Buyers' Cooperative 532* US 483 2001 para 88.
[299] *Controlled Substances Act 1971.*
[300] *Controlled Substances Act 1971.*
[301] *United States v. Oakland Cannabis Buyers' Cooperative* 532 US 483 2001 para 86.

purpose within the meaning of the 1970 *Federal Controlled Substances Act*."[302] Under the *Act*, physicians could "prescribe federally regulated drugs for legitimate purposes only."[303] However, in a November 2001 letter to the Drug Enforcement Administration, the United States Attorney General John Ashcroft, citing the case of *United States v. Oakland Cannabis Buyers' Cooperative*,[304] submitted that "assisted suicide was inconsistent with the public interest and not a legitimate medical purpose."[305] The Oregon's Attorney General was successful in obtaining a temporary restraining order on Ashcroft's directive. In the following year, the Attorney General was taken to court by the State of Oregon in the case of *Oregon v. Ashcroft.*[306] The issue before the court was "whether the Attorney General had permissibly construed the *Controlled Substances Act* 21 and its implementing regulations to prohibit the distribution of federally controlled substances for the purpose of facilitating an individual's suicide, regardless of a state law purporting to authorize such distribution."[307] Judge Jones held that in the Attorney General's directive, he explicitly "sought to stifle an ongoing earnest and profound debate in the various states concerning physician-assisted suicide."[308] The judge ruled in "favour of the State of Oregon and entered a permanent injunction enjoining the defendants from enforcing, applying, or otherwise giving any legal effect to the Ashcroft directive."[309] Years later with a new Attorney General, the decision of the court was taken for an appeal at the Supreme Court in the case of *Gonzales v. Oregon.*[310] However, the US Supreme Court held that "the United States Attorney General could enforce the *federal Controlled Substances Act* against physicians who prescribed drugs, in compliance with Oregon state law, to terminally ill patients seeking to end their lives, commonly referred to as assisted suicide."[311]

4.3.3 The current legislation regulating euthanasia and physician-assisted suicide in The State of Oregon

The *Death with Dignity Act* 1997 provides terminally ill patients with the opportunity to obtain and utilise prescriptions of lethal medication from their physicians for self-

[302] *Controlled Substances Act 1971.*
[303] *Controlled Substances Act 1971.*
[304] *United States v. Oakland Cannabis Buyers' Cooperative* 532 US 483 2001.
[305] *United States v. Oakland Cannabis Buyers' Cooperative* 532 US 483 2001.
[306] *Oregon v. Ashcroft* 368 F.3d 1118 (9th Cir. 2004) para 45.
[307] *Oregon v. Ashcroft* 368 2004 F.3d 1118 (9th Cir. 2004) para 46.
[308] *Oregon v. Ashcroft* 368 F.3d 1118 (9th Cir. 2004) para 56.
[309] *Oregon v. Ashcroft* 368 F.3d 1118 (9th Cir. 2004) para 50.
[310] *Gonzales v. Oregon 546 US 243* para 66.
[311] *Gonzales v. Oregon 546 US 243* para 65.

administration.[312] Under this legislation, terminating one's life in compliance with the law does not constitute suicide. The law in this context refers to "physician-assisted suicide" because it permits individuals "to end their lives through self-administration of lethal medication prescribed by a physician for that purpose."[313]

The *Death with Dignity Act* legalizes physician-assisted suicide, but specifically prohibits euthanasia, where a physician or medical practitioner directly administers medication to end another person's life.[314] In order to be qualified to request a prescription of lethal medication, the *Death with Dignity Act* requires that a patient voluntarily express their wish to die and must be:

1. "an adult (age 18 or older),
2. an Oregon resident,
3. Capacity (able to make and communicate health-care decisions), and
4. Diagnosed with a terminal illness (incurable and irreversible) that would lead to death within six months."[315]

Terminally ill patients who meet the requirements in terms of the *Act* are eligible to request a prescription for lethal medication from an Oregon physician who has a license. To receive a prescription for lethal medicine, the following steps must be adhered to:[316]

1. "The patient must make two oral requests to his physician, separated by at least 15 days,
2. The patient must provide a written, witnessed request to his physician (two witnesses),
3. The prescribing physician and a consulting physician must confirm the diagnosis and prognosis,
4. The prescribing physician and a consulting physician must determine whether the patient is capable,

[312] *Death with Dignity Act* 1997.
[313] *Death with Dignity Act* 1997.
[314] *Death with Dignity Act* 1997.
[315] Paleker *Euthanasia in South Africa: A normative analysis and application of dignity* 122.
[316] *Death with Dignity Act* 1997.

5. If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, he must refer the patient for a psychological examination,
6. The prescribing physician must inform the patient of feasible alternatives to assisted suicide, including comfort care, hospice care, and pain control,
7. The prescribing physician must request, but may not require, the patient to notify his next of kin of the prescription request."[317]

For the purposes of complying with the law, physicians are obliged to report to the Oregon Health Services all prescriptions of lethal medications.[318] Reporting is not required if patients initiate the request but never receive a prescription.[319] Moreover, pharmacist must be informed by physicians about the ultimate use and purpose of the prescribed medication. Physicians and patients who comply with the act's requirements are immune to criminal prosecution. Furthermore, electing to terminate one's life by means of legal physician-assisted suicide cannot affect the status of such patient's life or health insurance policies.[320] Health care systems and physicians are under no sort of obligation to take part in the *Death with Dignity Act*.[321]

4.3.4 Analysis

It is evident that even though the State of Oregon is a developed jurisdiction, the implementation of the law that regulates physician-assisted suicide has had its own share of problems and non-believers. The *Death with Dignity Act* was enacted with all the significant democratic characteristics. In the first place, the fact that the citizens of Oregon were afforded the opportunity to vote for the Act to come into effect or not suggests democratic protocols.[322] Such landmark decisions that may have a substantial impact in history require pro-active lawmakers, such as the ones in Oregon. The *Death with Dignity Act* comprises clear and unambiguous provisions that enable the applicability of the Act to be met with less complications and conflict.[323] It

[317] Ganzini 2016 *DJLJ* 34-48.
[318] Ganzini 2016 *DJLJ* 25-30.
[319] Ganzini 2016 *DJLJ* 34-48.
[320] Further reading is encouraged at Death with Dignity (2017) "For Researchers" *Death with Dignity* available at www.deathwithdignity.org/learn/researchers.
[321] *Death with Dignity Act* 1997.
[322] Paleker *Euthanasia in South Africa: A normative analysis and application of dignity* 122
[323] Bogaert and Ogunbanjo 2013 SALJ 23-30.

is further submitted that the state of Oregon was cognisant of the possibility of a slippery slope. This is evident in how the provisions of the Act are termed and restricted for the purpose of avoiding the abuse thereof. Moreover, in order to practise control over this medical procedure and to avoid its abuse, the State of Oregon elected to decriminalize physician-assisted suicide and not euthanasia, thus confining the procedure to only allowing terminally-ill patients to "end their lives through voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose."[324] As the world and society is bound to evolve, it is only right that the law that governs them be developed and stretched in order to accommodate the needs of a constantly evolving society, and in that premise, some changes have taken place since the *Act* was enacted in 1997.[325] One of these requirements provide a safeguard for patients, stating that "physicians must work with the pharmacist for the purpose of tailoring a prescription for the individual patient."[326]

Secondly, the Act imposes an obligation on the physician to report to the Oregon Health Division all lethal prescriptions that have been prescribed; however, they do not have to report all of the requests they receive.[327] The Act also advances an essential element of accountability in instances of abuse in which the physician is prosecuted if they do not comply with the safeguards put in place to ensure proper safety and implementation of this Act.[328] Furthermore, the Act is drafted and implemented in such a manner that the role players such as the physician, pharmacists, and health care systems do not have to take part in physician-assisted suicide and may choose on an individual basis if they would participate, no absolute obligation rests upon them to participate.[329] As physician-assisted suicide has major personal implications, the *Act* provides for these implications to a certain extent. This is evident in the Act where it states that the choice of legal physician-assisted suicide is prohibited from influencing the status of a patient's life or health insurance policy.[330] Moreover, physician-assisted suicide does not constitute suicide according to the law, and for the purpose of health and life insurance.[331] It is thus submitted that no law is

[324] Bogaert and Ogunbanjo 2013 SALJ 23-30.
[325] Jordaan 2011 *DJLJ* 28-33.
[326] Jordaan 2011 *DJLJ* 28-33.
[327] Carstens & Pearmain *Foundational Principles of South African Medical Law* 200.
[328] Jordaan 2011 *DJLJ* 28-33.
[329] Jordaan 2011 *DJLJ* 28-33.
[330] Jordaan 2011 *DJLJ* 28-33
[331] Smies 2001 *The legalization of Euthanasia in The Netherlands* 4.

perfect and Oregon's *Death with Dignity Act* is no different. In their bid to track and provide feedback from the implementation of euthanasia, reports are published annually for the public by the Department of Human Services. In 2019, the Oregon Public Health Division stated that "the number of prescriptions written under the Oregon *Death with Dignity Act* have increased from 1998-2019 steadily but have not been found to be abused."[332] It is worth noting that the development of legislation in the State of Oregon carries significant similarity to that of Canada which occurred over a long period, but their first attempt was almost perfect.

4.4 The regulation of euthanasia and physician-assisted suicide in Canada

4.4.1 *The history of euthanasia and physician-assisted suicide in Canada*

Even though suicide was decriminalized in 1972 in Canada, assisted suicide remained illegal.[333] Any person found guilty of counselling a terminally ill patient or any other person to terminate their own life or aiding someone to take their own life was guilty of culpable homicide and was liable to imprisonment of up to 14 years.[334]

4.4.2 The legal history of euthanasia and physician-assisted suicide through legislation and case law in Canada

The *Criminal Code* was introduced in 1892 in Canada. Suicide and attempted suicide were deemed and classified as criminal offences under section 241(b) of the Code.[335] In 1972, suicide was decriminalized and assisted suicide remained illegal and as such, a criminal offence.[336] On the foundation of this substantial law, any person who was found guilty of aiding someone to take their own life or counselling someone to terminate their own life was guilty of culpable homicide and liable to a sentence of up to 14 years.[337] Several conflicting views were submitted in provincial and federal legislatures relating to the right of individuals to physician or other forms of assisted suicide, particularly in instances where the person is significantly disabled to perform

[332] Jordaan 2011 *DJLJ* 28-33.
[333] Carstens & Pearmain *Foundational Principles of South African Medical Law* 200.
[334] Jordaan 2011 *DJLJ* 34-48.
[335] Article 241(b) of the *Criminal Code.*
[336] Article 241(b) of the *Criminal Code.*
[337] Carstens & Pearmain *Foundational Principles of South African Medical Law* 200.

the procedure without any aid. In the case of *Sue Rodriguez v British Colombia*[338], Mrs Rodriguez was diagnosed with amyotrophic lateral sclerosis, the sickness is often referred to as Lou Gehrig's disease.[339] This one is "a quickly progressing neurological disease that attacks the nerve cells controlling voluntary muscle movement."[340] Confronted by a rapid decline into paralysis, she sought the legal right to have a qualified physician's assistance in terminating her life at a time she elected for herself.[341] However, assisted suicide was still considered illegal in Canada and punishable by up to 14 years' imprisonment. As a citizen of Victoria in British Columbia, Rodriguez made "an application to the Supreme Court of British Columbia in December 1992 to have section 241(b) of the *Criminal Code,* which prohibited assisted suicide, declared constitutionally invalid on the basis that it violated sections 7, 12 and 15 of the Charter."[342] Following the loss of her case on the 29th of December 1992, as well as a subsequent appeal on the 8th of March 1993, she applied to the Supreme Court of Canada.[343] On the 30th of September 1993, a majority of the Supreme Court judges held that "section 241(b) was constitutionally valid and did not violate the Canadian Charter of Rights and Freedoms in any manner."[344] They further held that "the most significant issue was whether section 241(b) of the *Criminal Code* violated section 7 of the Charter", which states that, "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[345] The majority of judges acknowledged that "Ms Rodriguez's right to security of the person was denied by the section in question as it deprived her of personal autonomy in decisions relating to her body and that it caused her both physical pain and psychological distress."[346] Nonetheless, the court still upheld that "the prohibition against assisted suicide endorsed principles of fundamental justice and, thus, did not in any manner violate section 7 of the Charter."[347] Their decision was based on the notion of "the sanctity of life and the state's interest in protecting human life." They further argued that "assisted suicide was widely considered to be morally and legally wrong and that removing this prohibition could potentially

[338] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 46.
[339] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 45.
[340] Carstens & Pearmain *Foundational Principles of South African Medical Law* 200.
[341] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 46.
[342] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 32.
[343] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 33.
[344] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 33.
[345] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 34.
[346] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 35.
[347] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 35.

lead to abuses, more especially among the vulnerable."[348] The minority judges argued that "the prohibition of assisted suicide was arbitrary."[349] The court further stated "In effect, a person who is physically able can commit suicide which is not regarded as a criminal act, while a disabled person commits a crime when she asks to be assisted to carry out the same act." In their opinion, "this difference was contrary to the principles of fundamental justice."[350]

In June 2014, just over two decades after the Rodriguez decision, Quebec put into effect legislation that legalized physician-assisted suicide for consenting adult terminally ill patients who suffer from a "serious and incurable illness", are in "an advanced state of irreversible decline in capability" and are "experiencing constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable".[351]

4.4.3 The current legislation regulating Euthanasia and physician-assisted suicide in Canada

On the 17th of June 2016, a "new federal legislation was passed establishing the eligibility criteria and procedural safeguards for medically assisted suicide."[352] In accordance with the *Medical Assistance in Dying Act,* Article 241.2 (1) states that "any person may receive medical assistance in dying only if they meet all the following criteria:"[353]

> *(a) "they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada,*
>
> *(b) they are at least 18 years of age and capable of making decisions with respect to their health,*
>
> *(c) they have a grievous and irremediable medical condition,*
>
> *(d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and*

[348] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 36.
[349] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 36
[350] *Sue Rodriguez v British Colombia* 1993 3 SCR 519 para 37.
[351] Lyon 2015 *UBJ 4.*
[352] Lyon 2015 *UBJ 6.*
[353] Article 241.2 *Medical Assistance in Dying Act.*

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

In more recent developments, in 2021, MAID legislation removed the requirement that "a patient's natural death must be reasonably foreseeable."[354] It further introduced a two-track approach to ensure procedural safeguards, depending on whether a person's natural death was foreseeable.[355] A new legislation called Bill C-14 was passed into law in 2016 to supplement the *Medical Assistance in Dying Act.* The Bill made numerous amendments to the Criminal Code, more specifically section 241.1. The essence of section 241(1) was kept the same with minimal changes to the wording. However, it still remained that any other form of assisted suicide other than the one mentioned in section 241.2, is still a crime.[356]

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

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

suicide; or

(b)Aids a person to die by suicide" [357]

The above-mentioned section still criminalizes the conduct of assisting a person to commit suicide. However, if read together with the sections discussed below, it could grant medical practitioners exemption. They would not be committing a punishable offence in terms of this provision.

4.4.3.1 Provisions absolving health practitioners from criminal liability

227(1) "No medical practitioner or nurse practitioner commits culpable homicide if they provide a person with medical assistance in dying in accordance with section 241.2.[358]

[354] *Medical Assistance in Dying Act.*
[355] Bill C-14.
[356] Article 241.2 of the *Medical Assistance in Dying Act.*
[357] Article 241(1) of the *Medical Assistance in Dying Act.*
[358] Article 227(1) of the *Medical Assistance in Dying Act.*

241(2) No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying in accordance with section 241.2.'[359]

These sections provide a safety blanket for medical practitioners that could be involved in the entire process of medically assisting a patient to die and absolves them from unfair liability. It should be borne in mind that the process of assistance in dying does not only impose a moral or religious burden on the practitioners but a criminal liability as well. As such, safety measures are put in place in terms of sections 227(1) and 241(2) to legally protect the practitioners. Moreover, in terms of these sections, a medical practitioner cannot be said to have negligently killed a person if they provided assistance in dying in terms of the *Medical Assistance in Dying Act* and complied with the requirements outlined in the Act. As such, medical practitioners are protected from undue liability.

4.4.4 Analysis

For a progressive nation such as Canada, the development of law concerning euthanasia and physician-assisted suicide was gradual. But in their primary attempt to legalise assisted dying and implement law that would regulate the practice, they passed into law a legislation that was progressive, clear, and not riddled with ambiguities. The *Medical Assistance in Dying Act* and the *Bill C-14* represent a remarkable shift in the deep ethos of medicine, in which medical practitioners are burdened with the responsibility as they must decide which suicides should be prevented and which ones should be abetted. The specific requirements outlined in terms of *Article 241* of the *Act* have somewhat made this duty less hard as they are clear-cut and make the applicability of the legislation easier.[360] To practically show the viability and successful implementation of the Act in the jurisdiction of Canada, more than 19 000 individuals that were terminally-ill and were nearing the end of life had been voluntarily euthanized by November 2020, even though it only became legal in June 2016.[361] It may be submitted with certainty that this number has increased

[359] Article 241.2 of the *Medical Assistance in Dying Act.*
[360] Smies 2001 *The legalization of Euthanasia in The Netherlands* 55.
[361] Smies 2001 *The legalization of Euthanasia in The Netherlands* 65.

dramatically as the figures for the past two years have not been recorded and made public. As it stands, there have been no court decisions on the constitutionality, viability and applicability of Bill C-14, even though it has been passed as law, it remains to be told by time whether this Bill is a success or a pipedream riddled with legal issues. It is submitted, however, that this Bill might need to be developed to some extent to enable physicians to terminate the life of persons with chronic illnesses at their voluntary and competent request and even provide means that will require the system to ensure that it happens. This should be allowed even in cases where these physicians are convinced, based on their expert knowledge, that the medical field has other alternative options that may be explored by the patient.[362]

4.5 Conclusion

Criminal offences in Netherlands have been regulated by the *Dutch Criminal Code* for decades. As such, it was entrusted with the duty to address the position of suicide and physician-assisted suicide in the jurisdiction. Physician-assisted suicide was always deemed illegal by the code; however, the Dutch courts would always be faced with a problem in sentencing when such cases arise. The courts in The Netherlands would always carry an element of mercy in their judgments in such cases. This is evident in some of the cases where a defence of necessity was accepted by the court even though this conduct was still unlawful. The court in Leeuwarden was also confronted with a case of assisted dying, and they found the accused person guilty of culpable homicide but gave her a suspended sentence of a year.[363] It is evident that, to some extent, the courts were open to assisted suicide and were cognizant of instances where it would be necessary for medical practitioners to assist a patient to die, hence the light sentences handed down in each instance. To further show its willingness, the court also summed up requirements that would be best suited if assisted-dying was to be permitted in this case.[364] The *Termination of Life Act* followed this judgment by the

[362] Smies 2001 *The legalization of Euthanasia in The Netherlands* 66.
[363] This case marks one of the very first cases of euthanasia in The Netherlands. The District Court found the doctor guilty of killing on request (article 293 of the Criminal Code). The citation for this case is unavailable.
[364] This case marks one of the very first cases of euthanasia in The Netherlands. The District Court found the doctor guilty of killing on request (article 293 of the Criminal Code). The citation for this case is unavailable.

court. The Act's purported duty was to regulate assisted dying and provide strict requirements thereto.

Moreover, the State of Oregon and its development of the law in this regard carried an explicit character of democracy as the enactment of law that would regulate these practices was placed in the hands of citizens of Oregon by means of votes. The *Death with Dignity Act* was voted in by 51% to 49%. However, the manner in which the *Act* was and is still drafted allows for physician-assisted suicide, where the doctor provides a prescription of a lethal dosage to the patient for self-administration.[365] It strictly prohibits euthanasia where the doctor is required to take up a much more active role of administering the lethal drugs himself.[366] Furthermore, the *Act* also outlines strict requirements that are almost bullet proof and these must be adhered to at all material times.

The last jurisdiction that was dealt with was Canada, which had a relatively gradual development of the law in this regard.[367] Up until 1972, suicide and physician-assisted-suicide were deemed illegal and thus constituted a criminal offence punishable by law.[368] Any person that would assist, aid or counsel a person to kill themselves would be guilty of culpable homicide according to the Criminal Code that was in law at that time.[369] The gradual development of the law in this regard is also seen in the Rodriguez case where the court interpreted the law so narrowly that it could not accommodate a terminally ill patient to seek assisted-suicide. Decades later, the *Medical Assistance in Dying Act* was enacted to regulate assisted suicide in Canada. This Act was a great effort for a start and to this day, it is still being developed.[370] This is seen by the recent Bill C-14 that was drafted to further develop the law in this respect.[371]

It is therefore argued that it is possible for assisted dying to be permitted with the absence of abuse or the little thereof. The Netherlands, the State of Oregon and Canada are perfect examples of this submission. However, South Africa cannot afford to emulate any of these jurisdictions' laws, no matter how full proof they might seem.

---

[365] Lyon 2015 *UBJ 8.*
[366] Lyon 2015 *UBJ 4.*
[367] Smies 2001 *The legalization of Euthanasia in The Netherlands 33.*
[368] Smies 2001 *The legalization of Euthanasia in The Netherlands 65.*
[369] Smies 2001 *The legalization of Euthanasia in The Netherlands 65.*
[370] *Medical Assistance in Dying Act.*
[371] Bill C-14.

This is due to factors such as culture, traditions, religion, and demographics. The statutes that have been successfully implemented in their jurisdiction may be utilised as guidelines to create and develop tailor-made legislation in South Africa.[372] This should provide for South Africa's culturally unique circumstances. It is advisable to first observe and analyse these laws and their effects, while working on developing our own version. Moreover, South Africa ought not to imitate these jurisdictions' laws as their legal systems are fundamentally different from South Africa's.[373] All these countries that legally permit assisted suicide are worthy of research as their legislation has been in existence for a lengthy period.[374] This could provide valuable empirical data, enabling South Africa to make accurate predictions when making its legislation, regardless of the differences in demographics.

It is evident that South Africa has a pool of resources and references to learn from. The law of these jurisdictions and the implementation thereof may only serve as a reference and blueprint for South Africa as it embarks on creating its own tailor-made version. The manner in which these jurisdictions have approached euthanasia and physician-assisted suicide are fertile ground in the compilation and framing of proper recommendations for South Africa. They are cases that provide a well informed and cogent conclusion to the research study.

[372] Smies 2001 *The legalization of Euthanasia in The Netherlands 60.*
[373] Paleker *Euthanasia in South Africa: A Normative analysis and application of dignity 75.*
[374] Smies 2001 *The legalization of Euthanasia in The Netherlands 23.*

Chapter 5: Conclusion and recommendations

5.1 Conclusion

It is therefore concluded that South Africa has a place and the means to recognise euthanasia and physician-assisted suicide in its laws. It is evident that South Africa has a long-standing history of euthanasia and physician-assisted suicide.[375] The legality thereof, however, has always been an issue that legal scholars and lawmakers have contested from different positioning for decades. There is a clear position established in relation to the legality of euthanasia and physician-assisted suicide, which is that they are both regarded as illegal, thus constituting criminal offences. In this regard, this study set out to investigate and advance reasons why and how these practices may be legally permitted in South Africa.

The South African Law Commission adopted an active role in initiating a debate relating to euthanasia and physician-assisted suicide. The Commission drafted a Bill that could be a leeway for the legalization of the medical practices of euthanasia and physician-assisted-suicide.[376] The Bill was called Project 98, and it outlined circumstances under which these practices may take place, and the requirements that must be adhered to. However, this was never tabled in Parliament and the Commission hit a dead end. There have been numerous case law surrounding the subject matter, but one case stood out: the case of *Stransham-Ford*.[377] The High Court granted the order in the applicant's favour that he could seek assistance from a physician to terminate his life as he was terminally ill, and that the particular physician would be absolved from any criminal liability. This was a shift in South African law as it broke away from the precedent that had been set by judgments in case law that had previously dealt with the subject matter.[378] This study established the fact that there have been challenges in the history of euthanasia and physician-assisted suicide in South African laws that need to be addressed.

The concept of euthanasia and physician-assisted suicide relates to a plethora of fundamental rights enshrined in the Constitution of South Africa. Section 9 of the

---

[375] Lyon 2015 *UBJ 4.*
[376] Paleker *Euthanasia in South Africa: A Normative analysis and application of dignity* 33.
[377] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 4 SA 50 (GPHC) para 33.
[378] The precedent was set by the decisions in the cases of *R v Peverett*, *S v De Bellocq* and *S v Hartmann.*

Constitution states that "everyone has the right to life".[379] This right to life is interpreted in a rigid and restricted manner and it is not afforded the contemporary interpretation it so deserves. As the world evolves and societies develop, the law should also be developed to accommodate the needs of an evolving society. As such, the interpretation of the right to life should be in such a way that allows a person possessing this inherent right to make any decision relating to their life, including choosing to terminate their life through euthanasia or assisted suicide. The interpretation of this right must not be confined and restricted to only the right to live, but the right to terminate one's life as well, utilising proper legal channels such as euthanasia and physician-assisted suicide. The right to life must be interpreted to allow some individuals or patients to decide on when and how to die. Moreover, the practices also relate to the right to dignity, as provided for in section 10 of the Constitution. It is emphasised that dying should not be a process or moment that strips individuals of their dignity. It is common knowledge that some illnesses take away the patient's ability to bathe, go to the bathroom and do the most basic of personal upkeep chores. Electing when and how to die when one is extremely sick retains one's dignity. Moreover, being terminally ill is accompanied by multiple discomforts such as intractable pain and suffering. In summary, expecting such a person to endure these extreme discomforts violates their right to bodily and psychological integrity in terms of section 12(2) of the Constitution. Denying a terminally ill patient the opportunity to avoid such dehumanizing suffering is an injustice to humanity. In essence, such refusal becomes a direct violation of their right to bodily and psychological integrity. The ability to make any decision about one's life and health, as previously submitted, speaks to a person's right to personal autonomy as well. Refusing a person the right to decide when and how their life ends is a direct contravention and violation of a person's right to autonomy. A person possesses the ability to act on their own values and interests. This right fits perfectly into the practice of euthanasia and physician-assisted suicide as a person should have the right to decide when and the way they die. Furthermore, these rights and the contemporary interpretation they could be afforded would provide a logical and legally based facilitation of euthanasia and assisted suicide in South Africa.

[379] Section 9 of the *Constitution of the Republic of South Africa*, 1996.

It is acknowledged that a country's legal system cannot function in isolation. Reference always must be made to other jurisdictions' laws for the purpose of developing South African domestic laws. In this respect, reference was made to The Netherlands, The State of Oregon and Canada. These jurisdictions were specifically selected for their unique and varying positions regarding euthanasia and physician-assisted suicide, as well as their relevance to South African law.[380] These jurisdictions have put forth requirements that must be adhered to before a patient could qualify for assisted suicide. The striking similarity in these requirements is how clear and strict they are; making them avoid the slippery slope or the abuse thereof. South Africa could adopt and apply the same methods of drafting legal requirements and implementing its legislation.

It is therefore concluded that indeed there is a place for euthanasia and physician-assisted suicide in modern day medicine in South African law. The South African Constitution contains rights that could carry and facilitate both these practices. South Africa should recognise and permit euthanasia and physician-assisted suicide in law, and possibly utilise the recommendations that are outlined below.

5.2 Recommendations

5.2.1 Developing a legislation to regulate euthanasia

South African parliament should enact a legislation to regulate euthanasia and physician-assisted suicide. The implementation thereof should not be in vacuum, suggesting that strict requirements must be outlined. The proposed requirements for euthanasia are:

(a) The patient must be 18,
(b) The suffering patient must be a South African citizen or permanent resident,
(c) The patient's request for euthanasia must be voluntary,
(d) The patient must have capacity to make such a request. In cases of incapacity, an advanced will or directive will should suffice.
(e) The patient's suffering must be considered unbearable without any prospect of improvement,

[380] Lyon 2015 *UBJ 33*.

(f) The doctor and the patient must have reached a conclusion that no other reasonable alternative exists,
(g) There must be detailed and proven consultation and written confirmation from an independent doctor who should confirm the desire to terminate life by the patient. This should be designed to ensure impartiality and avoid abuse.

Since euthanasia and physician-assisted suicide are different concepts for the purposes of this study, euthanasia would see the terminally ill patient administering the lethal dose to themselves. The requirements for receiving the prescription (lethal dose) for euthanasia must be as follows:

(a) The consulting physician and the prescribing physician must confirm and reach a consensus about the diagnosis and prognosis,
(b) The consulting physician and the prescribing physician must determine whether the patient can self-administer the lethal dose,
(c) If either of the medical practitioners believes the patient's judgment is impaired, services of a psychologist must be sought,
(d) The prescribing physician must request, but may not require, the patient to notify his next of kin of the prescription request.

5.2.2 Enacting legislation to regulate physician-assisted suicide.

Even though the proposed single legislation would regulate both euthanasia and physician-assisted suicide, they should be provided for in separate provisions. The requirements for physician-assisted suicide must be as follows:

(a) The patient must be 18 and older,
(b) The suffering patient must be a South African citizen or permanent resident,
(c) The patient's request for physician-assisted suicide must be voluntary,
(d) The patient must have capacity to make such a request. In cases of incapacity, an advanced will or directive should suffice,
(e) The patient's suffering must be considered unbearable without any prospect of improvement,[381]

[381] Sipunzi *Physician-Assisted Suicide in South Africa – A Constitutional* Perspective 33.

(f) The doctor and the patient must have reached a conclusion that no other reasonable alternative exists,[382]
(g) There must be significant and traceable consultation and written confirmation from an independent doctor who must confirm the above-mentioned conditions. This is to ensure impartiality and avoid abuse,
(h) The doctor who will administer the lethal dose must be open to conducting the assistance; there is an option to appoint another doctor to conduct the assistance if the principal doctor is unable to do so for whatever reason.

5.2.3 Advanced will (Living Will)

Upon enacting and implementing legislation to regulate euthanasia and physician-assisted suicide, terminally ill patients should be able to include a provision in their Living Will that they should be euthanized if ever circumstances arise and allow. In so far as the legality of advanced wills is concerned, they are legally permitted in South Africa. An advanced directive facilitates the wishes of terminally ill patients in their state of unconsciousness.[383] This would enable the practices of euthanasia and physician-assisted suicide to be conducted with ease and the very much needed certainty. Terminally ill patients should be able to put forth their wishes to be euthanized by utilising such legislation. This instrument allows "competent adults to state, in advance, that they do not wish to be kept alive by medical treatment or machines in the latter stages of terminal illness."[384]

An advanced directive of a terminally ill patient will contain written, legal instructions relating to the patient's preferences for medical care if they are unable to make decisions for themselves. This will include a provision stating that the terminally ill patient may be euthanized if they are in a state of deteriorating health, and they are unable to speak for themselves. Moreover, it must be signed by the patient and two witnesses to avoid any sinister motives from outsiders. This terminally ill patient would have to appoint a curator or executor who shall be able to enforce the directive in a

[382] Sipunzi *Physician-Assisted Suicide in South Africa – A Constitutional* Perspective 22.
[383] Bogaert and Ogunbanjo 2013 *SALJ 33.*
[384] Van Der Merwe *An analysis of assisted dying and the practical implementation thereof in South African criminal law 43.*

court of law. To further make it permissible before the law, the patient must appoint a doctor and furnish him with a copy of the advanced directive as well.

BIBLIOGRAPHY

Literature

Bailey and Nienaber 2016 *SA Journal of Bioethics Law*

Bailey KN and Nienaber A "The right to physical integrity and informed refusal" 2016 *South African Journal of Bioethics Law* 54-58

Benatar D "A legal right to die is long overdue" *Cape Times* (4 November 2011) 11

Bhamjee 2010 *South African Law Journal*

Bhamjee S "Is the right to die with dignity constitutionally guaranteed?" 2010 *South African Law Journal* 333-352

Bogaert and Ogunbanjo 2013 *South African Law Journal*

*Bogaert DK and Ogunbanjo GA '*Voluntary active euthanasia: Is there a place for it modern day medicine?'' (2013) 50 (3) SALJ 33-40.

Carstens & Pearmain *Foundational Principles of South African Medical Law*

Cartsens P and Pearmin D *Foundational Principles of South African Medical Law* (LexisNexis Butterworths Durban 2007)

Cassell and Rich 2010 *Pain Medicine*

Cassell EJ and Rich BA "Intractable end-of-life suffering and the ethics of palliative sedation" 2010 *Pain Medicine* 435-438

Fried *et al* 1993 *Archives of Internal Medicine*

Fried TR *et al* "Limits of patient autonomy: Physician attitudes and practices regarding life-sustaining treatments and euthanasia" 1993 *Archives of Internal Medicine* 722-728

Chima 2018 *An investigation of informed consent in clinical practice in South Africa*

Chima SC "*An investigation of informed consent in clinical practice in South Africa* (LLD Thesis University of South Africa 2018)

De Lima *et al* 2017 *Journal of palliative medicine*

De Lima L *et al* "International association for hospice and palliative care position statement: Euthanasia and physician-assisted suicide" 2017 *Journal of Palliative Medicine* 8-14

Du Plessis 2002 *SA Journal of Human Rights*

Du Plessis M "Between Apology and Utopia -The Constitutional Court and Public Opinion" 2002 *SAJHR* 1-40

Ejikeme 2019 *A Review of Kanu Ikechukwu Anthony's 'Igwebuike as an Igbo-African*

Ejikeme PO "Modality of Peace and Conflict Resolution Perspectives on Igwebuike Philosophy" *Essays in Honour of Professor Kanu Ikechukwu Anthony* OSA 455-460

Grande 2000 *SALJ*

Grande K "Should assisted dying be considered?" 2000 South African Law Journal 66-70

Ganzini 2016 *Journal of Medical Ethics*

Ganzini L "Legal Physician-Assisted Death in Oregon" 2016 Journal of Medical Ethics 76-80

Gray and Vawda 2016 *South African Health Review*

Gray A and Vawda Y "Health policy and legislation" 2016 *South African Health Review* 3-15

Grisso T and Appelbaum PS *Assessing competence to consent to treatment*

Grisso T and Appelbaum PS Assessing competence to consent to treatment (A

guide for physicians and other health professionals Oxford University Press USA 1998)

Gostin 1997 *Journal of American Medical Association*

Gostin LO "Deciding Life and Death in the Courtroom: From Quinlan to Cruzan, Glucksberg, and Vacco—A Brief History and Analysis of Constitutional Protection of the Right to Die" 1997 *Journal of American Medical Association* 1523-1528

Jordaan 2011 *De Jure*

Jordaan L *"The* Legal Validity of an Advance Refusal of Medical Treatment in South African Law *(Part 1)"* (2011) 44 (1) De Jure 34-39

Jacobs and Hendricks 2018 *SA Medical Journal*

*Jacobs RK and Hendricks M "*Medical students' perspectives on euthanasia and physician-assisted suicide and their views on legalising these practices in South Africa" *2018 SA Medical Journal 484-489*

Jacobs and Hendricks 2018 *South African Medical Journal*

Jacobs RK and Hendricks M "Doctor-assisted suicide: What is the present legal position in South Africa?" 2018 *South African Medical Journal* 1-12

Koenane 2017 *Euthanasia in South Africa: Philosophical and theological*

Considerations 1-9

Koenane M L Euthanasia in South Africa: Philosophical and theological Considerations (2017) available at http://doi.org/10.4102/ve.v38i1.1549

Knoetze *The right to conscientious objection against administering euthanasia in the context of the right to freedom of religion*

Knoetze AS "*The right to conscientious objection against administering euthanasia in the context of the right to freedom of religion"* (Doctoral thesis University of the Free State 2018)

Ncayiyana 2012 *South African Medical Journal*

Ncayiyana J "Euthanasia – No dignity in death in the absence of an ethos of respect for human life" (2012) 106 (6) *South African Medical Journal* 334.

South African Law Commission 1999 PROJECT 86 REPORT

South African Law Commission *Euthanasia and the artificial preservation of life* (1999) Available at https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.

Slabbert and Van der Westhuizen 2007 *SAPL*

Slabbert M and Van der Westhuizen C "Death with Dignity in lieu of Euthanasia" 2007 *South Africa Public Law* 366-384

Krause 2012 *Obiter*

Krause S "*Going gently into that good night: The constitutionality of consent in cases of euthanasia"* (2012) 33 (1) Obiter 47-71

Knoetze AS *The right to conscientious objection against administering euthanasia in the context of the right to freedom of religion* (Doctoral thesis, University of the Free-State 2018)

Liebenberg 2005 *SAJHR*

Liebenberg S "The value of human dignity in interpreting socio-economic rights" (2005) 21 (1) *SAJHR* 1-31

Lyon 2015 Undergraduate Bioethics Journal

Lyon N ''Protecting patient's autonomy: Supporting the right to die" Undergraduate Bioethics Journal 5-10

McQuoid-Mason 2017 *South African Medical Journal*

McQuoid-Mason DJ "Assisted suicide and assisted voluntary euthanasia: Stransham-Ford High Court case overruled by the Appeal Court but the door is left open" 2017 *South African Medical Journal* 381-382

Ncayiyana 2012 *SAMJ*

*Ncayiyana DJ "*Euthanasia: No dignity in death in the absence of an ethos of respect for human lives*" 2012 SAMJ 334-334*

Nienaber and Bailey 2016 *SA Journal of Bioethics and Law*

Nienaber A and Bailey KN "The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go?" 2016 *SA Journal of Bioethics and Law 73-77.*

Nevhutalu *Patient's rights in South Africa's public health system*

Nevhutalu HK "Moral-critical perspectives" Patient's rights in South Africa's public health system (Doctoral thesis, Stellenbosch University 2016)

Olinger and Britz 2007 *International Information & Library Review*

Olinger HN and Britz JJ "Western privacy and/or Ubuntu? Some critical comments on the influences in the forthcoming data privacy bill in South Africa" (*2*007) 39 (1) *The International Information & Library Review 31-43*

Pellegrino *1994 Patient and Physician Autonomy*

Pellegrino ED "Conflicting rights and obligations in the physician-patient relationship"1994 Patient and Physician Autonomy 47

Ramcharan 2021 *AJIL*

Ramcharan BG "The concept and dimensions of the right to life" 2021 *AJIL 44-56*

Sipunzi 2016 *Physician-assisted suicide in South Africa: A constitutional perspective*

Sipunzi N *Physician-assisted suicide in South Africa: A constitutional perspective* (Doctoral thesis, University of KwaZulu-Natal 2016)

Schafer 2013 *International Journal of Law and Psychiatry*

Schafer A "Physician assisted suicide: The great Canadian euthanasia debate" (2013) 36 (5-6) *International Journal of Law and Psychiatry* 522-531

Paleker Euthanasia in South Africa: A normative analysis and application of dignity

Paleker F Euthanasia in South Africa: A normative analysis and application of dignity (LLM- Dissertation, University of the Witwatersrand 2016)

Van Der Merwe *An analysis of assisted dying and the practical implementation thereof in South African criminal law*

Van Der Merwe A *An analysis of assisted dying and the practical implementation thereof in South African criminal law (LLM-dissertation, University of Pretoria 2017)*

Verwey and Carstens 2014 *SAJHR*

Verwey H and Carstens PA "Extreme elective or cosmetic surgery and controversial patient choice: A constitutional analysis" 2014 *SAJHR* 89-110

Van der Walt 2015 *South African Law Journal*

Van der Walt G "I don't know how I want to go but I do know that I want

to be the one who decides" - The right to die - The high court of South Africa rules in Robert James Stransham-Ford and Minister of Justice and Correctional Services; The Minister of Health Professional Council of South Africa and the National Director of Public Prosecution" 2015 *South African Law Journal* 801-814

White et al 2022 *University of New South Wales Law Journal*

White B, Willmot L, Villar K and Hewitt J "Who is eligible for voluntary assisted dying?'' 2022 *University of New South Wales Law Journal''* 7-11

Yuill *2015 The unfreedom of assisted suicide*

Yuill K "The unfreedom of assisted suicide: How the right to die undermine autonomy" (2015) (1) 4 *Ethics, Medicine and Public Health 494-502*

CASE LAW

Canada

Sue Rodriguez v British Colombia 1993 3 SCR 519

Pretty v United Kingdom 2346/02

The Netherlands

Schoonheim v. The Netherlands 1984 5 DSC 334

Oregon State

Gonzales v. Oregon 2006 546 US 243

Oregon v. Ashcroft 368 F.3d 1118 (9th Cir. 2004)

United States v. Oakland Cannabis Buyers' Cooperative 532 US 483 2001

South Africa

Castell v De Greef 1994 (4) SA 408 (C)

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

Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others 2017 (3) SA 152 (SCA)

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

R v Peverett 1940 AD 213

S v De Bellocq 1975 (3) SA 538 (T)

S v Hartmann 1975 (3) SA 532 (C)

S v Nkwanyana 2003 1 SA 303 (WLD)

S v Makwanyane 1995 (3) SA 391 (CC)

S v Hartmann 1975 (3) SA 532 (C)

S v De Bellocq 1975 (3) SA 538 (T)

LEGISLATION

South Africa

Constitution of the Republic of South Africa, 1996.

Criminal Law Amendment Act 105 of 1997

The Netherlands

Criminal Code 3 of 1881

The Termination of Life Act 2002

Canada

Bill C-14

Medical Assistance in Dying Act 2016

Oregon State

Controlled Substances Act 1971

Death with Dignity Act 1997

Internet sources

Abrahams and Gross 2018 http://www.abgross.co.za

Abrahams and Gross 2018 *Euthanasia: Legal ambivalence*

Http://www.abgross.co.za Accessed 21 September 2020

Anon 2012 www.lifesitenews.com/blogs/euthanasia-is-out-of-control-in-the-netherlands-new-dutch-statistics.

Anonymous 2012 *Euthanasia is out of control in the Netherlands – New Dutch Statistics* www.lifesitenews.com/blogs/euthanasia-is-out-of-control-in-the-netherlands-new-dutch- statistics Accessed 24 February 2022

Francis 2016 www.dyingforchoice.com/resources/fact-files/netherlands-2015-euthanasia-report-card.

Francis N *Netherlands – 2015 euthanasia report card* www.dyingforchoice.com/resources/fact-files/netherlands-2015-euthanasia-report-card. Accessed 15 March 2022

Oosthuizen 2003 http//pubmed.nlm.nih.gov Death with Dignity (2017)

Oosthuizen H 2003 *Doctors can kill – Active euthanasia in South Africa* *http//pubmed.nlm.nih.gov Death with Dignity (2017)* Accessed 20 March 2022

Anon 2020 www.deathwithdignity.org/learn/access/#Going_Through_the_Process_of_Obtaining_Medications.

Anonymous 2020 Dying with dignity laws www.deathwithdignity.org/learn/access/#Going_Through_the_Process_of_Obtaining_Medications Accessed 25 March 2022

Anon Dignity in Dying (2014) "Lord Falconer's Assisted Dying Bill (2014)" *Campaign for Dignity in Dying*

Anonymous 2014 www.dignityindying.org.uk/assisted-dying/the-law/lord-falconers-assisted-dying-bill Accessed 30 March 2022

Quill and Brock 2008 https://link.springer.com/chapter/10.1007%2F978-1-4020-6496-8_5

Quill TE 2008 *Palliative options of last resort: A comparison of voluntarily*

Stopping eating and drinking, terminal sedation, physician-assisted suicide, And voluntary active euthanasia
http:/link.springer.com/chapter/10.1007%2F978-1-4020-6496-8 5 Accessed 20 September 2021

Robertson 2020 http://derebus.org.za/Still-waiting-for-an-answer:

Robertson HJD 2020 *Physician assisted suicide in South Africa* http://derebus.org.za/Still-waiting-for-an-answer Accessed 25 July 2021

Shoba 2019 http://www.dailymaverick.co.za/article/2019-04-30

Shoba S 2019 *Assisted suicide advocate Sean Davison pleads not guilty to third murder charge* http://www.dailymaverick.co.za/article/2019-04-30 Accessed 09 September 2020

Sheehan 2011 https://academic.oup.com/phe/article/4/3/226/1500725?login=true

Sheehan M 2011 Can Broad Consent be Informed Consent? https://academic.oup.com/phe/article/4/3/226/1500725?login=true Accessed 27 August 2021

Slabbert and Van der Westhuizen 2007 https://journals.co.za/doi/abs/10.10520/EJC97948

Slabbert M and Van der Westhuizen C 2007 Death with dignity in lieu of Euthanasia https://journals.co.za/doi/abs/10.10520/EJC97948 Accessed 22 August 2021