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DOCTOR OF PHILOSOPHY (PhD) IN PUBLIC LAW

The case for assisted dying/euthanasia in specific cases in South Africa with reference to the development of the South African and Canadian Jurisprudence under a Human Rights political order

by

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ABSTRACT

In this thesis, I argue that the present jurisprudence, particularly constitutional law and the common law of South Africa all lend support to the case for decriminalising physician assisted suicide through invoking a right to die with dignity (RDD). This argument is foundationally premised on the clear jurisprudence of the Constitutional Court which sets out the right to dignity and the value of dignity as the touchstone of the South African Constitution. The historical origin and development of the idea of dignity are traversed as well as how this idea found its way to the heart of our constitutional jurisprudence.

The study then expounds on the similarities between the South African Constitution and the Canadian Charter of Rights and Freedoms and by comparing each of their Limitations Clauses proceeds to demonstrate how our Constitutional Court may follow analogous principles and reasoning to decriminalise physician assisted suicide by taking a similar approach to that taken in the Supreme Court of Canada. The argument is developed to posit that the South African Constitution with its emphasis on dignity allows for an even more compelling rationale for the decriminalisation of assisted suicide than was available to the Supreme Court of Canada.

This thesis also analyses in some detail the present position of assisted suicide at common law and argues that when properly understood, though the legal position is confusing and contradictory, the common law is not in conflict with the potential decriminalisation of physician assisted suicide. Having clarified the present legal position and avenues for the development of the law, the main ethical arguments which inform and underlie the good morals which in turn underlies public policy, the so-called boni mores are considered. The point is made that the boni mores underlies our common law, and when this changes over time, our common law should follow suit.

Having concluded that a key element of a decriminalised regime must include sufficient safeguards to protect the weak and vulnerable in our society, an analysis of the law in jurisdictions that have decriminalised physician assisted suicide and/or

physician assisted euthanasia is undertaken which in turn culminates in a draft of proposed legislation for South Africa.

The thesis points to studies which suggest that the experience in jurisdictions that have enacted a permissive physician assisted suicide regime has been largely positive. People in those jurisdictions who have explicitly chosen to exercise the right to die with dignity have avoided finding themselves in the inhumane condition of being compelled against their will to suffer interminably and unnecessarily. Whilst permissive legislation where available has succeeded in the aforesaid, such legislation does not appear to have resulted in a drop in the overall protection of human rights and the exposure of the vulnerable to harm, as was argued would be the case by those who have historically opposed physician assisted dying legislation. These facts which have become available from early-adopting jurisdictions for several decades now, and from ever more jurisdictions as physician assisted dying legislation is being ever widely passed, now show that the greatest fears of opposers have not come to pass.

The study concludes that taking all of the above findings into consideration there appears to be a favourable legal framework and a preponderance of evidence to support a right to die with dignity in South Africa.

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DEDICATION

I dedicate to two great people who profoundly influenced my life:

For my late father Rev Ronald Douglas Brink who died before this research could be completed and who, despite vehemently not agreeing with its premise based on his personal beliefs, nonetheless supported me in the endeavour.

For the late Adv Dullah Omar, former South African Minister of Justice who in the pre-democratic era as a colleague at the University of the Western Cape inspired me to study law by his example and the way he lived according to the African spirit of ubuntu that was reflected in his sheer dedication and work ethic, as he worked tirelessly for the betterment of his nation.

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POEM ‘Why hold him back?’

He lay there crying in pain
He harboured a virus for long
No one knows how it came
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But finally the body gave up
Lost the fight against the invader
Deep yellow his eyes
A liver studded with cancer meats
Stretched down till the belly button
His arms licked dry by the disease.
He cries in pain
Intact are his senses still
But losing grip of reality slowly
He knows the time nears his end
His body is eaten up from inside
In deep pain he suffers thus
Asks forgiveness for crimes
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Maybe the result of lives past
The heinous crimes he must have done
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And thus, become a thing of the past.
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All he asks is the peace of death
Life —- you could not give back to him
And still… Hold him back…
As long as possible…

Is that what makes you humane?

Anonymous

CHAPTER 1
GENERAL INTRODUCTION

1.1 A brief history of euthanasia

According to the Oxford English Dictionary, the term 'euthanasia' arises early in the 17th century from the two Greek words '*εὐ'* meaning 'well' and ' *θάνατος' (thanatos)* meaning 'death' or in the sense of an 'easy death'.[1] Dowbiggin asserts that ancient Greek and Roman societies performed mercy killing and placed a positive value thereon which was viewed as a triumph over fate.[2] He proposes that the Hippocratic Oath that was traditionally taken as a rite of passage by physicians and which included an injunction against medical mercy killing was developed in protest against the frequency and excessive application of mercy killing in the years before Christianity became the dominant religion in the Western World.[3] The Hippocratic Oath included the phrase: 'Nor shall any man's entreaty prevail upon me to administer poison to anyone; neither will I counsel any man to do so.'[4]

Reeves suggests that our contemporary concept of the term arose from an essay by Samuel D. Williams published in the year 1870 called 'Euthanasia' in which he introduced a concept of 'medical mercy killing'. The consensus of both Victorian and modern critics is that this new meaning of euthanasia as a concept did not exist in the Victorian mind until medical science made the suppression of pain possible through isolating morphine from opium and the development of ether as an anaesthetic and

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[1] *The Oxford English Dictionary* (updated 2021) available at https://www-oed-com.ezproxy.uct.ac.za/view/Entry/65140 (accessed 5 December 2021).
[2] I Dowbiggin *A Concise History of Euthanasia: Life, Death, God, and Medicine* (2005) 9.
[3] Ibid 11.
[4] This formulation by A Zavala 'The history of euthanasia and physician-assisted suicide' (2015) 1(3) *Journal of Anesthesia History* 94.

Williams connected these innovations to death.[5] She also suggests that this was the moment that: 'As society developed new ways to suppress pain and extend life, so too did it, debatably, grow past the animal need to live purely for the sake of living.'[6]

The term 'euthanasia' has suffered due to negative associations arising out of its use by Nazi Germany during the holocaust. Of course, the holocaust was 'genocide' and not 'euthanasia'[7] which was used euphemistically at the time to justify mass murder despite those murdered being not only of Jewish descent together with other minorities, but also against the disabled and those described as 'unworthy of living' (this prejudice being described in modern parlance as 'ableism'). The stigma of the evil associated with the holocaust still attaches to the term 'euthanasia' to this day despite the many ethical arguments in support of assisted dying.

The parlance has developed in line with legal developments in particular that most jurisdictions that allow assisted death require that the person assisting be medically trained.[8] As such, the term 'physician assisted dying' (PAD) has come into common usage which can either be 'physician assisted suicide' (PAS) in which the medical physician assists the patient with the means to commit suicide or 'physician administered euthanasia' (PAE) where the physician also administers the lethal substance.

Euthanasia became recently topical due to the trial in the United States of America of the pathologist Jack Kevorkian in 1999 who assisted terminal patients to commit suicide.[9] As may be expected this practice raises many ethical arguments with complex issues at play. Furthermore, two distinct questions arise from this discussion which Benatar frames as: 'The one is whether these practices are morally acceptable, while the other is whether they ought (morally) to be legal.'[10]

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[5] N Reeves 'Euthanasia and (d)evolution in speculative fiction' (2017) 45(1) *Victorian Literature and Culture* 95 99.
[6] Ibid.
[7] DL Bergen *War and Genocide, a Concise History of the Holocaust* 3 ed (2016) 6.
[8] With the notable exception of Switzerland where the person giving assistance need not be medically trained as Art.115 of the Swiss Criminal Code only criminalises assistance with a selfish motive and as such does not specify that only a physician may offer the assistance.
[9] D Pappas *The Politics of Euthanasia and Assisted Suicide: A Comparative Case Study of Emerging Criminal Law and the Criminal Trials of Jack 'Dr. Death' Kevorkian* (unpublished Ph.D. Thesis. Arizona State University, 2011).
[10] D Benatar 'Assisted suicide, voluntary euthanasia and the right to life' in J Yorke (ed) *The right to life and the value of life* (2010) 291 292.

At about the same time that Kevorkian went on trial, the South African Law Commission released its report in 1998 on *Euthanasia and the artificial preservation of life*.[11] The commission describes the necessity of the report as follows:

> 'Worldwide increased importance is furthermore being attached to patient autonomy. The need has therefore arisen to consider the protection of a mentally competent patient's right to refuse medical treatment or to receive assistance, should he or she so require, in ending his or her unbearable suffering by the administering or supplying of a lethal substance to the patient.'[12]

Almost a quarter of a century later, its recommendations have not been acted upon.

1.2 The research question

The research question at the heart of this project is: 'Given that South Africa is a pluralistic society with changing views on the morality and ethics concerning dying and the moment of death, does the South African Constitution, common law, and jurisprudence support a case for decriminalising physician assisted death by invoking a "right to die with dignity" that arises from the values and rights underlying South African constitutional law and jurisprudence in a similar manner in which it was held to have arisen in Canada from its Charter of Rights and Freedoms'? The author is of the view and will show that this question may be answered in the affirmative and that in certain circumstances physician assisted dying may presently be considered lawful.

1.3 Methodology

The thesis is based on a doctrinal desktop study, drawing on materials from various jurisdictions, many of which are on public record. According to Oderkerk, the comparative research method entails employing a comparison between two or more things:

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[11] South African Law Commission Report (Project 86) *Euthanasia and the Artificial Preservation of Life* (1998) available at https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf (accessed 5 December 2021).
[12] Ibid page x.

> 'Two things are "comparable" if it makes sense to compare them in light of the aim of the comparison. If the aim of the research project is to regulate a certain factual situation or societal phenomenon of a certain legal system, it is only useful to compare objects that fulfill an equivalent function (in this example the function being "to regulate the societal phenomenon under consideration".[13]

The subject at hand to be compared with others is according to the research question — the approach to physician assisted dying within the legal system of South Africa. This approach lies collectively within its constitution, legislation, case law, and other legal precedents. Extensive use has been made of Canadian jurisprudence because of the close correlation between the South African Bill of Rights and the Canadian Charter which leads to similar approaches by the apex courts of the two jurisdictions and the outcomes of constitutional litigation. Other jurisdictions that will be used include those where assisted dying has been legalised.

In that law is not mere words on a page we need to look behind the law at the culture to which it applies. According to Eberle, this requires looking at elements within the culture such as,

> 'religion, history, geography, morals, custom, [and] philosophy or ideology, among other driving forces'.[14]

Where appropriate these elements will be acknowledged and discussed in context.

1.4 Presentation of the thesis

This introductory chapter is followed by chapter 2 that considers the current approach in South African law to the 'right-to-die with dignity'. In doing so, attention is given to the common law relating to murder, suicide and assisted suicide. Very few of these cases deal with a physician assisting in the death of a terminally ill patient upon request. Instead, these cases are relevant only in that they deal with various legal aspects of a competent patient's consent to medical treatment, the doctrine of double effect, assisted suicide cases, and euthanasia cases. In so doing the legal position

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[13] Oderkerk, M. 'The Need for a Methodological Framework for Comparative Legal Research: Sense and Nonsense of "Methodological Pluralism" in Comparative Law' (July 2015) 79(3) *The Rabel Journal of Comparative and International Private Law* 589 610.
[14] Eberle, E. J. 'The Methodology of Comparative Law' (2011) 16(1) *Roger Williams University Law Review* 51 52. Available at http://docs.rwu.edu/rwu_LR/vol16/iss1/2.

relating to physician assisted suicide and physician administered euthanasia is located within the legal framework of these collateral areas of law.

The conclusion of the analysis is amplified by the recent Supreme Court of Appeal order in *Minister of Justice v Estate Late Stransham-Ford* (hereafter referred to as *Stransham Ford SCA*)[15] in which it reversed the decision of the High Court in *Stransham-Ford v Minister of Justice and Correctional Services and Others* (hereafter referred to as *Stransham-Ford HC*).[16] In the appeal case, the Supreme Court pointed out that the bland statement by the judge in the court a quo that suicide assistance is unlawful in South African law, is not unqualifiedly true in that the *Grotjohn*[17] case does not conclude that assistance in suicide is always unlawful.

The constitutional case in respect of euthanasia is made in chapter 3. In the post-1996 Constitutional order, under a supreme constitution, the recognition of and protection of human dignity is the touchstone of the new legal order, it informs the right to life, which implies a subsidiary right namely the right to die with dignity. Human dignity is not only one of the three underlying values of the constitution being 'human dignity, equality and freedom'[18] but also one of the enshrined human rights[19] in the constitution. The origins and meaning of a right to dignity are discussed.

The implied right to die with dignity is limited to specific circumstances in which a competent person suffering from an unbearable and grievous medical condition which is either terminal or intractable, makes a request voluntarily and without undue influence to choose the manner and time of their death and is assisted by a medical practitioner either with the means to commit suicide or also with the administration of the lethal substance. A medical practitioner who agrees to assist must not suffer any criminal, civil or disciplinary consequences as a result of rendering such assistance in that a person requesting assistance can only be legally placed in a position

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[15] *Minister of Justice and others v Estate Late Stransham-Ford* 2017 (3) SA 152 (SCA) [Stransham-Ford SCA].
[16] *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP) [Stransham-Ford HC].
[17] *Ex parte Die Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A) [Grotjohn].
[18] Section 1 of the Constitution, 1996 provides: '1. The Republic of South Africa is one, sovereign, democratic state founded on the following values:
(*a*) Human dignity, the achievement of equality and the advancement of human rights and freedoms . . .'
[19] Ibid s 10 provides: 'Everyone has inherent dignity and the right to have their dignity respected and protected.'

to die with dignity if the assistance of the medical practitioner is not open to censure in circumstances where the practitioner acts within the empowering law.

The analysis explores the various ways in which the right to die with dignity may be founded from our constitutional jurisprudence. The right to die with dignity arises from the right to life[20] as informed by the constitutional value of dignity and the constitutional right to dignity. That is, that the right to life is a right to life with dignity and accordingly the right to terminate one's life is founded when it is no longer possible to live with dignity. The right to die with dignity also arises from the fact that death is an inexorable component of and consequence of mortal life; therefore implied in the right to life is logically incorporated a right to die with dignity at some point in the course of life should certain unfortunate otherwise inescapable circumstances arise.[21]

The right to die with dignity arises from the right to equality,[22] in that the right to equality may imply a right to assisted dying for those who are unable to take their own lives (especially where it is the result of a medical condition that has developed to the point of making suicide physically impossible) in circumstances where others without additional health impediments could physically do so. In circumstances where assisted dying is denied, a patient may choose to commit suicide at an earlier time in fear that physical incapacity could make it impossible at a later stage of their impediment.[23]

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[20] Ibid s 11 provides: 'Everyone has the right to life.'

[21] See *S v Makwanyane and Another* 1995 (3) SA 391 (CC) paras 326-327 where the relationship between the right to life and dignity is discussed.

[22] Section 9 of the Constitution op cit n18 provides:

'(1) Everyone is equal before the law and has the right to equal protection and benefit of the law.

(2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.

(3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

(4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.

(5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.'

[23] *Carter v Canada* 2015 SCC 5.

The right to die with dignity arises from the right to freedom and security[24] which includes the right not to be tortured in any way and not to be treated or punished in a cruel, inhuman or degrading way. This right also includes the right to bodily and psychological integrity, which includes the right to security in and control over the body. Where a person is in a position in which their freedom and security are undermined in a manner in which the only escape is to be assisted in suicide, a right to die with dignity is founded.[25]

The above arguments are developed with reference to South African case law[26] which despite remaining unsettled does nonetheless not exclude the possibility of the development of a constitutional right to die with dignity. Extensive use is also made of Canadian jurisprudence and in particular the recognition by its Supreme Court that the criminalisation of physician assisted death infringes on the fundamental rights to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice.

Two key questions that arise from this enquiry are discussed in chapters 4 and 5. In chapter 4 the question that is addressed is: do the ethical arguments against such a right being enshrined in law open themselves up to being sufficiently countered?

The ethical arguments both for and against physician assisted dying are discussed as these inform the legal convictions of the community or so-called boni mores of society which in turn influences the development of the common law over time as well as being considerations that a court must take into account when adjudicating on a decision relating to physician assisted death. In particular the Dutch and Belgian experience is discussed which offers lessons derived from the development of the law in these jurisdictions as early adopters of physician assisted

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[24] Section 12 of the Constitution op cit n18 provides:
'(1) Everyone has the right to freedom and security of the person, which includes the right—
(a) not to be deprived of freedom arbitrarily or without just cause;
(b) not to be detained without trial;
(c) to be free from all forms of violence from either public or private sources;
(d) not to be tortured in any way; and
(e) not to be treated or punished in a cruel, inhuman or degrading way.
(2) Everyone has the right to bodily and psychological integrity, which includes the right—
(a) 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.'

[25] *Carter v Canada* supra n23.

[26] *Stransham-Ford HC* supra n16; *Stransham-Ford SCA* supra n15.

death. This discussion concludes that the ethics and evidence in favour of physician assisted death in limited circumstances with the necessary safeguards in place is ethically defensible.

Five key ethical arguments against the legalisation of physician assisted dying are discussed. First, the 'slippery slope' argument is addressed which posits that if the law allows assisted suicide in specific limited cases that it is merely a matter of time before more allowable circumstances are included, ultimately leading to abuse and rampant killings of multiple classes of vulnerable persons. Secondly, that religious and theological beliefs that are strongly pro-preservation of life in all but a few circumstances including war, self-defence and punishment should be heeded and that assisted death is not an acceptable exception to the principle of preservation of life at all costs. Thirdly, that it would be contradictory to the role of medical practitioners whose apparent function would shift from being protectors of life to being agents of death. Also, certain arguments associated with the role of medical practitioners such as that the decision to terminate life is always subject to discretion, medical and judicial, and accordingly open to human error. Fourthly, that developments in palliative care would slow down to the detriment of such useful advances and that patients would choose assisted dying rather than palliative care without being aware that such care may well lead to a pain-free extension of their lives. Fifthly, that assisted dying conflates the means and the ends by killing the person suffering the pain rather than killing the pain itself.

However, there are also significant arguments in favour of introducing legislation that would accord the right to die with dignity to a limited class of requestors. Four key ethical arguments for the legalisation of euthanasia are discussed. First, the importance of personal autonomy and its moral imperatives where it is argued that a government should not have the power to prevent an autonomous person from freely choosing what should happen to their body or mind. That the only basis to limit the autonomy of a person is where it is necessary to protect society from some harm and that no such harm arises from properly delimited physician assisted death. Secondly, the transformative power of informed consent, or how informed consent can transform an otherwise unlawful assault into a lawful action. It is consent that has the power to transform that which is immoral into that which is morally acceptable. It follows that independent and informed consent should be allowed to transform the

assistance to suicide from murder or homicide to an act that is not wrongful and thereby lawful. Thirdly, the morality of benefitting a terminally ill person by relieving their interminable suffering (referred to as the beneficial consequence of mercy). It is argued that to abandon a terminally ill and suffering individual to suffer an inevitable slow and painful death is morally wrong and our law should recognise this by removing the blanket prohibition of assistance to suicide and allowing such assistance in specific delimited circumstances. Fourthly, the recognition of the moral equivalence between active and passive euthanasia in that there is no bright-line ethical distinction between a physician removing life-sustaining equipment from a patient as opposed to injecting a patient with a lethal substance if in each case the patient has given informed consent and there is foreseeability that the patient's death will follow.

The question addressed in chapter 5 is: which safeguards would be appropriate to put in place in South Africa? The purpose of requiring sufficient safeguards is to ensure that there is no abuse arising out of a right to die with dignity. To make such a determination the chapter analyses the safeguards in place in jurisdictions that have legalised physician assisted death which include Switzerland, the Northern Territory of Australia (in the period between 1995-1997), Oregon USA, the Netherlands, Belgium, Washington State USA, Luxembourg, Montana USA, Vermont USA, California USA, Colombia, Canada, Colorado USA, the State of Victoria in Australia, the District of Columbia USA, Hawaii USA, the State of Western Australia, Maine USA, New Jersey USA, Germany, and New Zealand.

The safeguards include such varied measures as multiple doctors being required to certify that a patient has freely and without undue influence repeatedly requested assistance in dying to ensure the voluntariness of the request; a procedural expiry period required from requests to the time at which the assistance may be effected; a professional assessment of the patient's state of mind by a psychiatrist to ensure that depression or other mental illness is not influencing the decision of the patient; procedural mechanisms to limit abuse and ensure that the patient is a major and competent; and an appointed authority empowered to collect all data and documentation in respect of physician assisted death and to provide statistical reports to an oversight review structure.

Chapter 6 includes a proposed right to die with dignity Bill for South Africa preceded by a commentary on the clauses contained therein.

Chapter 7 is the concluding chapter. It describes the research finding together with a discussion of challenges still to be faced and predictions as to legal progression. Here in addition to the authorities already referred to emphasis is placed on a key case currently before a division of the South African High Court.

1.5 Objectives and relevance of this research

Internationally there is renewed interest in the development of the law relating to physician assisted death. This is also the case in South Africa. There are four key reasons for the resurgence of the debate.

The first reason arises from the great leaps made by medical science that is now capable of keeping people alive ever longer. However, the quality of such an extended life can be horrific. As Dworkin has described it, the medical technology that doctors now wield are indeed able to sustain life for protracted periods but this is often at the cost of crippling and mutilating the patient, often through experimental operations.[27] This is a state that is to be dreaded, the state of being a 'scrupulously tended vegetable'.[28] Benatar makes the point that opponents of physician assisted dying suggest that palliation is the solution. However, not all people would consider the largely unconscious sedated experience of palliation as life, without pleasure and only continued indignity, as worth living. Some may consider such a state as worse than death.[29] It can now be reasonably said that the very advances in medical science that have added so much benefit and extension to our lives as sentient human beings has now turned a corner where it can be said to be extending our dying rather than our living.

The second reason is the adoption of the principle of constitutional supremacy[30] in South Africa including an entrenched Bill of Rights. This fundamental change also implies a drastic shift in the boni mores of society and to what is considered as an unlawful act. Recent rulings in South Africa and Canada point to judges recognising that some criminal laws are incompatible with constitutional rights.

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[27] R Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia* (1993) 180.
[28] Ibid.
[29] D Benatar op cit n10 295.
[30] Section 1 of the Constitution op cit n18.

This opens an exciting moment in legal development, which is freed from the narrow confines of quasi-religious and personal morality and instead requires the law to pass the clear and rigorous constitutional tests that I believe will require South Africa to pass legislation to decriminalise and regulate the legal consequences of physician assisted dying.

The third reason is that there are shifts over time in religious and conservative views as it appears that democracies have become progressively enlightened and more liberal on many social issues in the 21st century. This also leads to a shift in the boni mores and what is generally considered unlawful. This can be seen in chapter 5 from the ever-increasing number of jurisdictions that have adopted physician assisted dying legislation.

The fourth reason is that over time more evidence is available from permissive jurisdictions that were early adopters of physician assisted dying such as the Netherlands and Belgium that points to the success of safeguards and not a societal degeneration into the wanton killing of vulnerable persons.

The key aim of this study is to present a consistent and holistic argument that arises from a constitutional imperative that a right to die with dignity should exist, and by incorporating adequate responses to the arguments against euthanasia, thereby making a moral and legal case for the incorporation of a right to die with dignity in South Africa and to suggest that physician assisted dying legislation be passed to formally recognise and regulate such right.

On a practical human level, the decriminalisation of assisted dying will relieve the undignified and inhumane manner in which many people feel they are forced to suffer unnecessarily through a painful and degrading process. It would formally clarify the law thereby preventing people from getting unwanted treatments from doctors who insist on giving treatments for fear that failure to do so will result in malpractice suits. It would ensure uniform approaches by doctors in removal decisions of life support as well as sustenance and hydration. It would also ensure uniformity in respect of sufficient pain relief from analgesics. Finally, it will prevent applicants from having to approach a court on a case-by-case basis and thereby allow access to this most needed right.

The case of Adv Stransham-Ford[31] that is discussed in chapter 3 and his death before the order in his application could be handed down is a classic example of the great tragedies that play out on death beds every day in South Africa. It is time to restore the right to dignity promised in our Bill of Rights to the most vulnerable and helpless of us all and I shall accordingly argue that it is appropriate that legislation be passed to regulate the procedural mechanisms required to make such a right accessible.

I hope this work will contribute in some way to my country embarking on this most humane journey.

[31] *Stransham-Ford HC* supra n16; *Stransham-Ford SCA* supra n15.

CHAPTER 2
THE PRESENT LEGAL FRAMEWORK

2.1 Introduction

In this chapter, the present legal framework is discussed within which physician assistance in dying (PAD) is broadly located. There are very few reported cases that involve a physician in the context of deathbed physician assisted dying.[1] Accordingly, the relevant cases to be discussed deal with various associated legal principles including that of a competent patient's consent to medical treatment, the doctrine of double effect, assisted suicide cases, and euthanasia cases. The legal position relating to physician assisted death (PAD) that includes physician assisted suicide (PAS) and physician administered euthanasia (PAE) is located within the legal framework of these collateral areas of law.

The possibility that an error crept into the analysis of Fabricius J in the *Stransham-Ford* High Court case is also considered.[2] An analysis of the case law below supports the conclusion that this is an error that leaves the door open to an interpretation that voluntary euthanasia may not always be unlawful as held in the *Stransham-Ford* appeal judgment.[3]

Non-Voluntary Active Euthanasia occurs where the patient is unable to give consent either because the patient is mentally or physically unable to do so or is a minor. In the absence of consent, the practice is subject to abuse and difficult to categorise as justified killing. This form of euthanasia is not considered in this chapter.

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[1] With the exceptions of *Minister of Justice and others v Estate Late Stransham-Ford* 2017 (3) SA 152 (SCA) [Stransham-Ford SCA] and *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP) [Stransham-Ford HC] and arguably *S v Hartmann* 1975 (3) SA 532 (C). These cases are discussed below.
[2] *Stransham-Ford HC* supra n1.
[3] *Stransham-Ford SCA* supra n1.

2.2 A short summary of the principles of South African criminal law

To appreciate the cases to be discussed in context and to see how the common law may be amended to decriminalise physician assisted dying, the over-arching criminal law framework in South Africa is summarised below. South Africa is a common law jurisdiction and though most modern laws (including new crimes) are created by statute, the traditional common law derived from the Roman and Roman-Dutch eras remain applicable in its criminal law.

The principle of legality requires that a person may only be punished for contravening a clearly defined crime that was created by law that was in force prior to the contravention. Though this principle existed in the law before the enactment of the present Constitution, it is now enshrined therein.[4]

According to Burchell,

> '[the State] must prove, beyond [a] reasonable doubt, that the accused has committed (i) *voluntary conduct* which is *unlawful* (actus reus) and that this conduct was accompanied by (ii) *criminal capacity* and (iii) *fault* (sometimes referred to as mens rea)'.[5]

2.2.1 Voluntary conduct and causation

The conduct required is generally that of human beings though juristic entities can also commit certain crimes. The conduct can be either by commission (a positive act) or by omission (a failure to act when one has a duty to act).

In general, crimes are committed by actions and no crime is committed by a failure to act except in certain circumstances prescribed by the boni mores (the legal convictions of the community). The courts have held that the boni mores do not impose a general legal duty to protect another from harm.[6] Exceptions to the general rule include where a prior action by an accused caused possible danger, where an accused is in charge of a dangerous situation or object such as an animal, where the accused has a protective or special relationship with the person not to be harmed such as a

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[4] Section 1 and s 35(3)(*l*) of the Constitution of South Africa 1996.
[5] J Burchell *Principles of Criminal Law* 5 ed (2016) 51.
[6] *Minister van Polisise v Ewels* 1975 (3) SA 590 (A) 596.

doctor and patient, where the accused holds a public office that makes it a duty to prevent potential harm such as a member of the police service, and where a statute or a contract provides for a legal duty by the accused to protect against harm. These exceptions may be extended in accordance with the boni mores and the constitution.

The conduct must be voluntary, that is, an exercise of the accused's free conscious will. Somnambulism (involuntary acts whilst asleep), intoxication, provocation and emotional stress, and automatism[7] (except in certain cases of prior conduct) are not considered conduct for purposes of criminal liability.

Where the definitional elements of a crime refer to an unlawful consequence, then there must be a causal nexus between the conduct of the accused and the consequence. So, in order to be guilty of murder, one of the requirements is that the accused's conduct must have caused the death of the deceased. In order to satisfy the causal nexus requirement, two tests must be satisfied.

The first test is for factual causation (also known as the 'but-for' test) wherein the question is asked: 'But for the conduct of the accused, would the result still have occurred?' In a murder case, such a question could be: 'But for the accused shooting a gun, would the victim have died?' In this manner, it is determined whether the conduct of the accused is a sine qua non of the death of the victim. However, many distant acts may be found to factually cause an outcome with ever-increasing degrees of unfairness, for example the birth of the accused's mother is a factual cause of all subsequent conduct of the accused but it would be unfair to hold her liable for the conduct of her child. To limit the ambit of consequences for conduct only where it is fair and just a second test for legal causation follows.

In determining legal causation one or more the following theories may be applied: the individualisation theories where a main cause is identified (such as a proximate cause, a substantial cause, an efficient cause), the theory of adequate causation (where according to human experience, in the normal course of events, that act has the tendency to bring about that type of situation),[8] the forseeability theory (where a situation is reasonably foreseeable to a person of normal intelligence) and the intervening cause theory (where it is determined if a new intervening event broke

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[7] See discussion on automatism under heading 2.7.1.
[8] SV Hoctor *Snyman's Criminal Law* 7 ed (2020) 70.

the chain of causation sufficiently to prevent regarding the accused's conduct as the legal cause of the result).[9] According to the Appellate Division (as it then was) courts should apply whichever theory would result in the best outcome in light of policy considerations.[10] These considerations include the result being reasonable, fair and just.

2.2.2 Unlawfulness

Conduct is unlawful where it meets the definitional elements of the crime and is contrary to the legal conviction of society. Where society's boni mores find that the conduct is justified then it will be lawful despite meeting the definitional elements of the crime.

There is no closed list of potential defences excluding unlawfulness which is 'conduct which is contrary to the community's perception of justice or with the legal convictions of society'.[11] Common defences against unlawfulness include private defence, necessity, consent, official capacity, impossibility, obedience to superior orders, de minimis non curat lex (the law does not concern itself with trifles) and negotiorum gestio (presumed consent arising from spontaneous agency).

The defence of necessity is available to an accused who acts in protection of someone's life, body, property or other legitimate legal interest which is endangered by a threat of injury that has commenced or is imminent and cannot be avoided in any other way and provided the accused was not legally compelled to endure such injury. The interest warded off by the accused must be proportionate to the interest infringed. An example would be breaking the law by speeding to get a seriously ill person to the emergency room.

The defence of consent is only available to an accused where the complainant's consent is recognised in law as a possible defence to the crime charged and where such consent is real consent and given by a victim who was capable in law. Consent is a complete defence to certain charges such as theft and rape but is not available to

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[9] See discussion on causation and intervening causes under heading 2.6.2.
[10] *S v Mokgethi en andere* 1990 (1) SA 32 (A) 40.
[11] Hoctor op cit n8 81.

charges such as murder and statutory rape and any crime against the state such as treason or driving offences.[12]

2.2.3 Criminal capacity

According to Burchell, 'the test for determining whether an accused had criminal capacity is whether the accused had the capacity to appreciate the wrongfulness of his or her conduct and the capacity to act in accordance with this appreciation'.[13] Criminal capacity consists of two faculties, cognitive capacity and conative capacity. Cognitive capacity refers to whether the accused had the ability to form mens rea (a guilty mind) and conative capacity refers to whether the accused had the ability to control irrational acts and to act voluntarily. Four conditions can affect capacity being youth, pathological incapacity, intoxication, and provocation/emotional stress (non-pathological incapacity).

With regard to youth, children under the age of 10 are irrebuttably presumed to lack capacity, whilst children between the ages of 10 and 14 are presumed to lack capacity but the presumption may be rebutted. Children over the age of 14 are assessed for capacity in the same manner as adults.

Pathological incapacity refers to a lack of criminal capacity of the accused which is caused by a legally recognised pathological condition being suffered at the time of the commission of the crime. The burden of proof is on the accused on a balance of probabilities. If an accused is successful at proving this condition, the usual order is detention in a mental institution to be assessed for psychological treatment.

The legal position relating to non-pathological criminal incapacity in South African law was influenced by the assassination of the then Prime Minister Hendrik Verwoerd in 1966. It was held that the accused could not be tried as his mental illness resulted in his incapacity to appreciate the legal proceedings against him.[14] Following an outcry at this result, a commission of inquiry was held and its recommendations

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[12] The issue of consent is discussed further under headings 2.4.1 and 2.4.2.
[13] Burchell op cit n5 251.
[14] S Hoctor 'Non-pathological criminal incapacity relating to provocation or emotional stress – an overview of developments in South African law' (2019) 49(2) *South African Journal of Psychology* 177 180.

were passed into law through s 78 of the Criminal Procedure Act 51 of 1977 which provides that:

> '(1) A person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or intellectual disability which makes him or her incapable-
> *(a)* of appreciating the wrongfulness of his or her act or omission; or
> *(b)* of acting in accordance with an appreciation of the wrongfulness of his or her act or omission, shall not be criminally responsible for such act or omission.'

The case law has developed to include in the ambit of the above provision non-pathological incapacity that does not arise as a result of mental illness such as in *S v Laubscher*[15] where it was found that,

> 'admittedly Act 51 of 1977 does not define the concepts "mental illness" or "intellectual disability" but it is accepted in the case law that it relates to an illness or pathological disturbance of the mental faculties which may be of a permanent or temporary nature'.[16]

Several cases (unrelated to mercy-killing) successfully relied on the defence of non-pathological criminal incapacity and the accused therein were acquitted.[17] Cases dealing with mercy-killings are discussed under headings 2.7.1 and 2.7.2 as well as the case of *S v Eadie*[18] decided by the Supreme Court of Appeal in 2002, which appears to have changed the law relating to non-pathological criminal incapacity, this decision being handed down after the cases to be discussed were heard.

2.2.4 Fault (mens rea)

Fault, also referred to as a 'guilty mind' of the accused at the time of the commission of the crime is a required element to be proved by the state. There are two forms of fault being intention (dolus) and negligence.

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[15] 1988 (1) SA 163 (A).
[16] Ibid 167, translation by the author from the Afrikaans of the original which reads, 'Weliswaar gee Wet 51 van 1977 geen omskrywing van die begrippe 'geestesongesteldheid' of 'geestesgebrek' nie maar dit word in die regspraak aanvaar dat dit op 'n sieklike of patologiese versteuring van die geestesvermoëns betrekking het wat van 'n permanente of tydelike aard kan wees'.
[17] *S v Arnold* 1985 (3) SA 256 (C); *S v Campher* 1987 (1) SA 940 (A); *Sv Nursingh* 1995 (2) SACR 331 (D); *S v Moses* 1996 (1) SACR 701 (C).
[18] *S v Eadie* 2002 (3) SA 719 (SCA).

There are four forms of intention being dolus directus (where the accused's intention is to perpetrate the unlawful conduct or to cause the unlawful result), dolus indirectus (where the accused foresaw that the unlawful conduct or the unlawful result was substantially certain to result), dolus eventualis (where the accused foresaw that the unlawful result might occur and reconciled themselves with that possibility, and dolus indeterminatus that can apply to any of the other three forms of dolus where the target is generalised such as when a bomb is detonated in a crowded public place. If none of these forms of intention is present, that is if the accused did not foresee the possibility of their actions being prohibited even where such ignorance is unreasonable then mens rea is absent and the accused must be acquitted.

Negligence is a sufficient form of fault for certain crimes such as culpable homicide. Conduct is determined as negligent by comparing it to what a notional 'reasonable person' would have foreseen and the care that would have accompanied such a person's conduct in the same circumstances. Where what was foreseen and the care accompanying the conduct of the accused falls short of the 'reasonable person' then the accused acted negligently. Where the accused has specialised knowledge in the field concerned then the reasonable person with which the comparison is made is that of a reasonable person with that knowledge. So when determining if the actions of a physician whilst treating a patient is negligent, the accused physician's actions are compared with the actions of a 'reasonable physician' in the same circumstances.

2.2.5 Application of the principles

The example of a murder charge is used to demonstrate the applicable principles. The elements of murder in South African law are summarised per Kgomo J as follows:

> 'Murder is the unlawful and intentional causing of the death of another human being. The elements thereof are – (a) *causing the death*; (b) *of another person*; (c) *unlawfully*; and (d) *intentionally*. Murder may be caused through an act or omission which causes that death.'[19]

Where an accused faces a murder charge the state must prove these elements of the crime. That the victim in question is dead is an objective fact to be determined by

[19] *S v Agliotti* 2011 (2) SACR 437 (GSJ) para 10.

direct evidence. Careful consideration must be given to the causation element as both factual and legal causation must be proved. That is, it must be proved that but for the conduct of the accused, the victim would not be dead (factual causation) and that there is a sufficiently close connection to the conduct of the accused and the death of the victim to ascribe the death as being caused legally by the victim using one of the theories of legal causation.

Where the state achieves the above, a prima facie case has been made out. However, the accused can raise any of the legally acceptable justifications to exclude the unlawful element of the crime. The accused may even introduce a new ground of justification provided the court can be persuaded that in the circumstances the conduct of the accused is not contrary to the community's perception of justice or with the legal convictions of society.

The accused may also claim incapacity by proving either youthfulness, pathological incapacity, intoxication, or provocation/emotional stress (non-pathological incapacity). If the accused can show lack of criminal capacity a discharge must follow except in the case of pathological incapacity where the accused is usually detained at a mental institution.

Finally, the accused may claim the absence of the necessary fault element by claiming that there was no intention to commit the crime. If intention cannot be proved then the accused must be discharged unless the state can prove negligence in which case the accused may be found guilty of culpable homicide.

2.3 The incompetent patient

The key elements discussed below are the conditions under which a physician may remove life sustaining medical interventions and who may authorise it.

S v Williams[20] was an appeal case against a murder conviction. The accused shot the victim who was hospitalised with severe brain damage. After it was established that there was no brain activity the ventilator to which she was attached was uncoupled and she was declared to be deceased. The argument on appeal was that

[20] 1986 (4) SA 1188 (A).

the uncoupling of the ventilator caused the death of the victim and not the actions of the accused who shot her. The court disagreed and found that the ventilator was an attempt to prevent the natural consequence of the victim being shot, that is to avoid her death. This intervention failed and the removal of the ventilator accordingly resulted in completing the effect of the gunshot being the death of the victim. Accordingly, the uncoupling of the ventilator did not legally cause her death, rather the gunshot was the legal cause of her death. This is a case in point where a factual causal connection on the part of the physician does not necessarily imply a legal liability.[21]

In *Clarke v Hurst*[22] it was held that just as it was the case that legal liability by a physician arises from a failure to institute life-sustaining measures where there is a duty to do so, the corollary that discontinuing life-sustaining measures already instituted depends upon whether there is a duty not to discontinue. It follows that where the attempts at life-sustaining measures have failed there can be no point in continuing them and they may be legally discontinued.[23]

The court referred to *S v Williams*[24] where it was held that even though the medical measures were able to artificially restore respiration, circulation, and digestion that this could not be considered life in the human or animal context where there was no accompanying cortical and cerebral brain functioning. Accordingly, the legal convictions of society (the boni mores) would justify the withdrawal of medical measures sustaining merely biological functioning.[25]

In *Stransham-Ford SCA*[26] the Supreme Court of Appeal referred to *Clarke v Hurst*[27] and confirmed it as authority that in South Africa a doctor may cease treatment that is neither therapeutic nor palliative after consultation with those responsible for the patient and does not commit a criminal offence in doing so. The court cautioned that where the position is uncertain or whether there is disagreement as to how to

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[21] For further authority regarding this proposition see *Mokgethi* supra n10.
[22] 1992 (4) SA 630 (D); also see a more detailed discussion below in paragraphs 2.5 and 2.6.3.
[23] Ibid 658.
[24] Supra n20.
[25] *Clarke v Hurst* supra n22 658.
[26] *Stransham-Ford SCA* supra n1. This case is discussed in paragraph 2.8.2 and in further detail in chapter 3.
[27] Supra n22.

proceed it would be best to obtain a declaratory order from a court having jurisdiction as was the case in *Clarke v Hurst*.[28]

2.4 The competent patient

The cases and legislative provisions considered below are used to analyse the present legal position of a person who is fully lucid and legally capable of making intentional and conscious choices concerning treatment by a physician.

2.4.1 Capacity and consent to treatment

Consent must be given voluntarily and is invalid if the act consented to is unlawful. In *R v McCoy*,[29] an air hostess was punished by the manager where she was employed by caning her buttocks for failing to wear a seat belt. The accused relied on a letter, signed by the victim as consent. The court held that where an act was itself a crime the consent by the person harmed could not render it lawful.[30] It should be noted that this case does not deal with consent to treatment but is authority for the proposition that it is not possible to consent to an unlawful act. The court held that the caning was unlawful assault and therefore consent to it was not possible.

The case of *Castell v De Greef*[31] dealt with the right of a patient to refuse life-sustaining medical treatment. In an appeal to the full bench of the High Court, the medical negligence claim arose from a non-life-threatening procedure to remove a cancerous growth in a breast. Ackermann J confirmed that in South African law this was dealt with as a case of *volenti non fit injuri*a (to one consenting no wrong is done) which is a defence of consent to an otherwise unlawful assault and accordingly the enquiry required establishing whether proper consent had been given by the patient to the surgeon and whether such consent was properly informed consent.[32]

The judgment confirmed that any patient was entitled to decide whether they wanted to have an operation performed which entitlement arose from their

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[28] Ibid *Clarke v Hurst*, referred to in *Stransham-Ford SCA* supra n1 para 33.
[29] 1953 (2) SA 4 (SR).
[30] Ibid 7.
[31] 1994 (4) SA 408 (C).
[32] Ibid 420H read with 423C-D.

fundamental right to self-determination. The judge amplified this by stating that it remained the case even if in the view of the medical profession such decision by the patient was grossly unreasonable as such right to refuse arose from the patient's right to bodily integrity and autonomous moral agency.[33]

The judge then determined the necessary elements of informed consent and concluded that for consent to act as a defence in the context of *volenti non fit injuri*a certain elements must exist. These include that the consenting party must have knowledge and awareness of the nature and extent of the harm or risk, must have an appreciation for and understand the nature and extent of the harm or risk, and must have consented to the harm and assumed the harm or risk, and must have consented to the entire transaction inclusive of the consequences.[34]

In *R v Peverett*[35] the accused was convicted of the attempted murder of his mistress Edna Saunders. The judge reserved the following question of law which was transmitted to the Appellate Division for consideration: 'Whether the facts found established in law the offence with which the accused was charged, namely, attempt to commit murder?'

The two lovers had after much discussion decided that their plight was such that they would commit suicide together. They drove to a quiet place and the accused attached a tyre pump to the exhaust and into the vehicle. They then sealed the car and the accused started the vehicle. They were found unconscious the next morning and rushed to a hospital. Both survived despite Mrs Saunders nearly dying. Mr Peverett was charged with attempted murder and it is important to note that the charge was not one of aiding or abetting in an attempted suicide.

Watermeyer JA discussed two contentions advanced on behalf of the accused. The first contention is discussed here and the second is discussed below in the discussion dealing with intention relating to assisted suicide case law.[36] The first contention was:

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[33] Ibid 420I/J and 421C-E.
[34] Ibid 425H-I/J.
[35] 1940 AD 213.
[36] Under heading 2.6.1.

> 'That the lethal act, i.e. the breathing of the poisonous gas, was the voluntary act of Mrs. Saunders and was not the act of [the] accused, and consequently if she had died it could not have been said that the accused had caused her death.'

With regards to this contention, Watermeyer JA agreed that Mrs Saunders was at all times capable of and able to stop breathing the fumes by either switching off the car or exiting it if she had so wished. However, despite her ability at all times to prevent her death, it was still the case that the purpose of the accused in leading the gas into the vehicle was so that the gas would kill her (and him) and as such he had attempted to kill her.[37] The consent of Mrs Saunders to her death did not exonerate Mr Saunders from having attempted to kill her in that murder is an unlawful act.

This position was confirmed in *S v Robinson and others*[38] where the deceased conspired with three others including his wife that he be killed. The couple was in dire financial need and so the arrangement made was that upon his death his wife would obtain the proceeds of a life insurance policy from which she would pay the other two conspirators agreed sums of money. The question at the heart of the Appeal Court enquiry was whether the consent of the deceased in any way affected the murder convictions. Holmes JA found that criminal responsibility was not excluded by the fact that the murdered man consented to and arranged his murder, the judge relying on various authorities for his conclusion.[39] The court did, however, find that the request of the deceased was an extenuating circumstance. Holmes JA referring to his consent stated,

> '[i]t reduces the blameworthiness (as distinct from the legal culpability) of the killer, for the deceased is not deprived against his will of his right to live. Indeed, in my view the fact that the deceased in the present case wanted and arranged to be killed as a solution to his hopeless predicament is a cogent consideration, as far as extenuating circumstances are concerned'.[40]

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[37] *R v Peverett* supra n35 218.
[38] 1968 (1) SA 666 (A).
[39] He quotes as authority *Peverett* supra n35, and the following: *Die Suid-Afrikaanse Strafreg* by De Wet and Swanepoel, 2nd ed., p. 82. Moorman, *Misdaden* (Van Hasselt), 2.11.4, put it thus (translated by the author from the Afrikaans)— 'So it is apparent that someone is not master of his own life, so much so that he cannot give another the power to kill him.'
[40] *Robinson* supra n38 679.

Due to these extenuating circumstances, the Appeal Court set aside the death sentences replacing them with direct imprisonment for 15 years for each accused.

Further examples of such invalid consent extend to unnecessary and reckless experiments or statutorily prohibited acts such as an abortion outside of the legally prescribed limits. Accordingly, it is a lawful requirement that a fully informed person consent to or refuse any medical treatment and that such consent is valid as a defence to the physician performing such treatment and provided the treatment or its refusal is not contra bonos mores.

Sumner argues that two underlying values determine whether suicide in an end-of-life scenario is ethical being first, whether it is in the interest of the well-being of the patient; and second, whether it respects the autonomy of the patient. These values are satisfied when we have first, a request by the patient and not a substitute decision-maker; secondly, the patient must have decision-making capacity including the capacity to appreciate the nature and consequences of the request; thirdly, the request must be voluntary and free from undue influence or coercion; fourthly, there must be full disclosure such that the patient knows his diagnosis, prognosis and treatment options; and fifthly, that the patient has been diagnosed with a medical condition serious enough to warrant options which will hasten death.[41]

The National Health Act[42] gives effect to the constitutional right to freedom and security of the person which includes the right to bodily and psychological integrity and to 'security in and control over their body'.[43] The Act requires consent for any health service including medical treatment. Such consent can only be lawful if the consenting party has the necessary legal capacity and is fully informed with regards to their health status, the range of diagnostic procedures and treatment options available, the benefits, risks, costs and consequences, and the right to refuse health services and the consequences thereof.[44] There are only a few exceptions to explicit consent being required by the user which include when the user is unable to give informed consent and such consent is given by another, where the provision of a health service is authorised in terms of any law or court order or when a failure to treat the

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[41] LW Sumner *Assisted death: A study in ethics and law* (2011) 90.
[42] 61 of 2003.
[43] Section 12 of the Constitution of South Africa 1996.
[44] Section 6 of the National Health Act op cit n42.

user will result in a serious risk to public health, and where a delay in the provision of the health service to the user might result in his or her death or irreversible damage. It is also required in such circumstances that a health care provider takes all reasonable steps to obtain the user's informed consent.[45]

The Children's Act[46] deals with a range of matters relating to the rights of children under the constitution and provides for the conditions under which a minor may consent to medical treatment or a surgical operation. The Act provides that the age at which a minor may make certain decisions relating to his or her medical treatment is lowered under certain circumstances below the age of majority of 18 years.[47] Children over the age of 12 years may consent to treatment without further assistance required provided they have the necessary 'maturity to understand the benefits, risks, social and other implications of the treatment'.[48] Furthermore, if the treatment is a surgical operation, they may also consent but require the assistance of a parent or guardian in addition.[49]

The Act is unclear about whether a minor over the age of 12 years may refuse medical treatment and in particular whether such refusal would stand in the face of a parent or guardian insisting that such treatment or operation should proceed. It does, however, make provision in certain limited instances for the superintendent of a hospital, the minister, or the high court to give consent where otherwise consent is unobtainable[50] but does not address the issue of whether the refusal by the minor may be overridden by consent of another party.

2.4.2 Refusal of treatment by the patient

This section deals with the circumstances in which a patient may refuse treatment including the issues of competence and voluntariness. *Lange v Lange*[51] supports the view that a person must be competent to refuse treatment at the time of refusal.

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[45] Ibid ss 7-8.
[46] 38 of 2005.
[47] Ibid s 129.
[48] Ibid s 129(2).
[49] Ibid s 129(3).
[50] Ibid ss 129(6)-(9).
[51] 1945 AD 332.

Applying the principles underlying *McCoy*[52] the refusal must be voluntary and should not result in an unlawful consequence.

If treatment is voluntarily refused by a competent patient a medical practitioner may not treat a patient against their wishes even if the practitioner believes this to be in the best interests of the patient. In *Phillips v De Klerk*[53] the court held that the wishes of a patient, who freely chose to refuse a blood transfusion as it was contrary to their religious beliefs, should be respected.

It has been further held in *Lange v Lange*[54] that 'legal competency' was not only limited to understanding and appreciating a legal contract but also required that a person not be insane at the time of concluding such contract as such person would not have the necessary animus to do so.[55]

2.5 The peculiar case of double effect

The following discussion examines the doctrine of double effect in that it is used to justify the use of large doses of morphine to treat terminally ill patients despite it being foreseen that such medication may hasten the death of the patient. The principles underlying the doctrine of double effect appears to have been understood a long time before it was formally constructed as a doctrine. It appears that even in biblical (Old Testament) times there was a reference to similar principles as in the Old Testament story of Eleazar in the sixth chapter of the First Book of the Maccabees.[56]

The principle however only appears to begin to take formal form from the writings of the Catholic scholar St Thomas Aquinas[57] and thereafter develops in line with the development of moral theology.[58] Though there are many formulations of the

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[52] *McCoy* supra n29.
[53] Unreported 1983 TPD which is discussed in SA Strauss's *Doctor, Patient and the Law* 3 ed. (1991) 29-34.
[54] Supra n51.
[55] Ibid 342.
[56] Also spelt 'Machabees'.
[57] T Aquinas *Summa Theologica* (1911-1925) (trans. Fathers of the English Dominican Province) II-II, q.64, a.7.
[58] JT Mangan 'An historical analysis of the principle of double effect' (1949) 10 *Theological Studies* 40 42.

principle of double effect, the following construction by Mangan is considered a modern expression independent of theological considerations:

> 'A person may licitly perform an action that he foresees will produce a good and a bad effect provided that four conditions are verified at one and the same time:
>
> 1. that the action in itself from its very object be good or at least indifferent;
> 2. that the good effect and not the evil effect be intended;
> 3. that the good effect be not produced by means of the evil effect;
> 4. that there be a proportionately grave reason for permitting the evil effect.' [59]

The principle has been used to validate diverse acts including self-defence, justifiable killing, killing an enemy in war, abortion, the application of nuclear power, nuclear weapons, affirmative action, and material cooperation.

The argument in defence of morphine usage in high doses to treat terminally ill patients is considered below. First, it must be understood why such a principle is necessary to justify such usage of morphine. That euthanasia involves killing is at the core of the euthanasia debate. Ronald Lindsay explains that the prohibition against the killing of humans is at the centre of any system of morality and that such a system aims to promote the peaceful cooperation of human beings who live together. As such, any exception to the prohibition on killing humans must demonstrate exceptional circumstances.[60] However, the double effect doctrine is not a general argument in favour of all manifestations of euthanasia. It merely relates to the limited circumstances wherein the measures implemented that are intended to reduce pain in a terminally ill patient also has the foreseeable side-effect of hastening the patient's death.

The argument, applying Mangan's principles proceeds along the following lines. The action being the administration of morphine has as its object the relief of the pain of the patient which is a good act. The intention is to relieve pain which is a good effect. The effect intended is pain relief and (though foreseeable) is not to hasten the death of the patient. It is the administration of morphine that relieves the pain, not the death of the person.

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[59] Ibid 43.
[60] RA Lindsay 'Euthanasia' in Hugh LaFollette (ed) *The International Encyclopedia of Ethics* (2013) 1771 1771.

The most controversial element of the application of the test is proportionality. Detractors argue that death must always weigh proportionately more than any other consequence. However, in a proper case, the relief of the pain outweighs the effect of hastening death. Beabout argues that the good engendered by pain relief must always exceed the negative effects of morphine. It follows that if the negative side effects of the morphine exceed the pain relief benefit or if the patient was not terminal and could become addicted to the morphine then its administration cannot be justified. Medical personnel must therefore be careful to judge the point of proportionality carefully with regards to the circumstances of each patient.[61]

As pointed out earlier, this doctrine applies only to the limited instances where the double effect is applicable. Euthanasia in the larger sense of mercy killing wherein a person is given a lethal dose of a drug that is intended to kill the patient to relieve pain through the death of the patient fails the double effect ethical test as the death of the patient is the primary intention and not merely a foreseeable secondary consequence.[62]

In *Clarke v Hurst,*[63] the legal permissibility in South Africa of double effect was considered. The case dealt with Dr Clarke who whilst undergoing an operation went into cardiac arrest and stopped breathing. He was resuscitated only after he had suffered significant irreversible brain damage with the result that he was permanently comatose since the resuscitation with no prospect of recovery. Four years later his wife asked for a declaratory order allowing her to instruct his physicians to withdraw the nasogastric tube which fed him artificially and which would result in his death by starvation. She asked the court to declare that such an action would not be unlawful conduct.

In the course of its analysis, the court considered issues related to the hastening of a person's death and concluded that it is usually wrongful and is not ordinarily justified even in the case of a terminally ill person suffering unbearable pain. However, the court noted that this was no longer an absolute rule and that over time it has come

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[61] G Beabout 'Morphine use for terminal cancer patients: An application of the principle of double effect' in PA Woodward (ed) *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle* (1989) 308.
[62] D Marquis 'Doctrine of Double Effect' in Hugh LaFollette (ed) *The International Encyclopedia of Ethics* (2013) 1435 1436.
[63] *Clarke v Hurst* supra n22.

to be accepted that a physician may prescribe drugs to a terminally ill patient knowing that such drugs may shorten the patient's life provided that the purpose of the drugs was to relieve pain and not to kill the patient.[64]

This case is authoritative of the present position in South African law and was quoted with approval in the *Stransham Ford SCA* judgment:[65]

> 'Furthermore a medical practitioner commits no offence by prescribing drugs by way of palliative treatment for pain that the doctor knows will have the effect of hastening the patient's death. This is referred to as the "double effect", where the drugs serve the purpose for which they were prescribed, but have potentially detrimental side effects.'

The double effect doctrine validates the moral permissibility of prescribing drugs to relieve pain even in cases where it is foreseeable that the death of the patient may be hastened thereby. The *Stransham-Ford SCA* judgment confirms that the double effect approach to medical care is presently lawful in South Africa.[66]

2.6 Assisted suicide case law

The following discussion examines the legal position where a terminally ill patient requests not merely the cessation of treatment but requests a third party (usually a medical professional) to assist by providing the means which the patient will use to commit suicide.[67] It is important to note that neither suicide nor attempted suicide is a criminal offence[68] and that the lawfulness or otherwise being discussed here is not that

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[64] Ibid 656.
[65] *Stransham-Ford SCA* supra n1 para 34.
[66] Ibid.
[67] This set of facts is to be distinguished from the scenario relating to physician administered euthanasia (PAE) also known as voluntary active euthanasia where the third party does not merely supply but also administers the lethal agent.
[68] *In Ex parte Die Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A)[Grotjohn] at 363 Steyn, H.R. held that (translated by the author from the Afrikaans): 'It is common cause that, apart from the single case mentioned in 1781 in R v Peverett, 1940 AD 213 on p. 214, as far as is known, no attempt has been made to prosecute for an attempted suicide. If, according to latter Roman-Dutch law, such an attempt was still a crime in certain circumstances, then it has fallen into complete disuse here. It therefore appears that, although the question was left open in the Peverett case, it was rightly found in the Gordon case, Supra, and in the present case, that suicide is not a crime.'

See also Burchell op cit n5 582: 'There are apparently records of prosecutions and convictions for attempted suicide in South Africa during the regime of the Dutch East India Company at the Cape, but no reported cases thereafter … . It can therefore now be accepted that in South African law neither suicide nor attempted suicide is a crime.'

of a person committing suicide but rather that of the person who assists another in committing suicide.

The cases discussed below did not take place in the context of a patient and doctor deathbed scenario. The accused were not physicians (which is not to say that in principle assistance in dying is necessarily limited only to physicians) and not all deceased (or survivors of an attempted death) were terminally ill requestors of assistance. However, the cases are useful indicators of how the South African courts might approach the legal position of a person accused of assisting another in preparation, encouragement or placement of such person with the means to commit suicide and in that respect, is analogous to the position of a physician who gives a terminal patient a toxic drug upon request.

The elements of murder in South African law are summarised per Kgomo J as follows:

> 'Murder is the unlawful and intentional causing of the death of another human being. The elements thereof are – (a) *causing the death*; (b) *of another person*; (c) *unlawfully*; and (d) *intentionally*. Murder may be caused through an act or omission which causes that death.'[69]

The key elements developed through the applicable case law discussed hereunder are intent, causation and unlawfulness.

Also see detailed analysis of the Roman and Roman-Dutch Law according to the respected jurists over time showing how suicide progressively became decriminalised at common law at 359-363 of *Grotjohn*; *S v Gordon* 1962 (4) SA 727 (N) para 729H. In Southern Rhodesia (now Zimbabwe) law it was held in *R v Nbakwa* infra n74 at 560 by Beadle, J that 'the *Attorney General's* records show that there has been no prosecution for attempted suicide in the history of Southern Rhodesia; that the *Attorney General* does not prosecute for this offence; and that, if the basis of this charge were to rest on the legal premises that suicide was a crime in Southern Rhodesia, the *Attorney General* would prefer not to proceed with the case'.

[69] *S v Agliotti* supra n19.

2.6.1 Intention

In *R v Peverett*[70] which was previously discussed under the section on capacity and consent to treatment,[71] a contention relating to the nature of intention was raised. The contention read:

> '[T]hat, even if some act of the accused was in the eye of the law the cause of the breathing by Mrs. Saunders of poisonous gas, yet the accused had no intention to kill, and therefore was not guilty of attempted murder.'[72]

This contention was raised because the accused did not desire the death of his lover. The judge of appeal held that intent is what is required to be proven and that 'intent' must be distinguished in law from 'desire'. The accused may not have desired the death of Mrs Saunders but he did as indicated by his actions, intend her death.[73] The appeal court accordingly upheld the conviction. Notably, the sentence of the trial court which was confirmed was a nominal fine of £30 (Thirty Pounds).

2.6.2 Causation and intervening causes

In *R v Nbakwa*[74] a child of the accused had died of natural causes but the accused nonetheless blamed his mother (the 'deceased') for the death of the child by her witchcraft. The accused reminded his mother that she had promised that she would die on the same day that his child had died but that this had not come to pass. He proceeded to assist her by tying a thin rope around the rafter of a hut and made a noose at the other end. The deceased asked for further help by helping her up to reach the noose but the accused refused. The deceased then asked for an item to be placed under the noose for her to stand on. The accused obliged by placing a block of wood thereunder and retreated to a place where he still had sight of her. The deceased proceeded to place the noose around her neck and kicked the block of wood away thereby hanging herself.

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[70] Supra n35.
[71] Under heading 2.4.1.
[72] Supra n35 218.
[73] Ibid 219.
[74] 1956 (2) SA 557 (SR).

Beadle J found that by putting the noose over her head, climbing onto and then kicking away the block she was the direct cause of her death. He concluded that the acts of the accused were insufficient to render it an attempt at her murder. At best these acts could not be characterised as any more than acts of preparation.[75] The court accordingly acquitted the accused on the basis that his deeds were mere preparatory acts and that a novus actus interveniens[76] interrupted the chain of causation, and therefore the accused did not cause the death of the deceased.

In *S v Gordon*[77] the accused and the deceased were colleagues and lovers. The wife of the accused had discovered their affair and gone to the school at which they both taught to cause a public scene. Out of embarrassment, the lovers decided upon a suicide pact wherein they agreed that they would end their lives by taking toxic tablets. They parked on a beach and took the tablets with coffee. The accused passed out and when he awoke it was apparent that his lover had already died. He decided to drown himself and took the dead body with him. He failed in this attempt and was accused of murder. It was common cause that the deceased had died as a result of ingesting the toxic tablets and had not drowned.

Henning J distinguished the facts of the present case from those in *R v Peverett*[78] wherein all the preparations were made for the (attempted) suicide of the lovers in that case by the accused, including the final act of starting the engine to supply the toxic fumes to the interior of the vehicle. He held on the other hand that the facts in the present case were similar to those found in the matter of *R v Nbakwa*[79] in that the final act, in that case, which was the placing of the noose herself around her neck and her kicking away the block of wood amounted to a novus actus interveniens. Similarly, in the present case, the accused had merely supplied the means to commit

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[75] Ibid 559.
[76] See discussion on intervening causative factors (novus actus interveniens) by SV Hoctor 'Causation' in WA Joubert (ed) *The Law of South Africa (Criminal Law)* 3ed (2021) 11 para 32, '[w]here it is clear that various factors contributed causatively to a given harmful event, the approach of the courts is usually to determine whether an intervening causative factor (novus actus interveniens or causa nova), independent of and unconnected with the accused's act, may be regarded as interrupting the causal connection between the accused's act and the harmful event. Certain concrete situations have repeatedly arisen in murder and culpable homicide cases, and certain specific guidelines have emerged in this regard'.
[77] 1962 (4) SA 727 (N).
[78] Supra n35, discussed above under 2.4.1.
[79] Supra n74, discussed above under 2.6.2.

suicide whereafter the deceased had voluntarily and independently performed the act of swallowing the tablets. Accordingly, the accused did not kill her. He concluded,

> '[o]ne might say that the accused, as it were, provided the deceased with a loaded pistol to enable her to shoot herself. She took the pistol, aimed it at herself and pulled the trigger. It is not a case of qui facit per alium facit per se'.[80]

The legal issues discussed above first came before the Appellate Division in *Grotjohn*[81] and heralded an expanded view of the principles at play. In this case, the accused and the deceased who was his wife had a very strained relationship. The accused was partially lame and a manic depressive and was having an affair. The marital relationship could be said to be at a breaking point. After a protracted argument, the deceased said that she would shoot herself. The accused loaded the gun and gave it to her with the words, 'shoot yourself if you wish as you are a burden'.[82] The deceased took the gun and with the words 'I will'.[83] proceeded to shoot herself dead.

In *Grotjohn*[84] the court a quo had applied the dictum in the case of *S v Gordon*[85] in that the final act being, in this case, the taking of a gun and then shooting herself was held to be an intervening cause. The Minister of Justice then transmitted (as was provided for in the then applicable Criminal Procedure Act)[86] the following two questions to the Appellate Division (as it then was) under case *Ex parte Die Minister van Justisie: In re S v Grotjohn*[87] to the Appeal Court to be decided,

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[80] *S v Gordon* supra n77 731; Henning J, in effect emphasised that we are not confronted here with an instance of agency, see *Desai's Trustee v Hack* 1910 TS 499 wherein Innes, CJ held at 507 that 'The maxim *qui facit per alium facit per se* is of course well established, and it is founded upon considerations of public policy. If a man directs another to do a certain act, or authorises him to perform a general class of transactions, then, in regard to the matter expressly directed, and all dealings within the scope of the general authority, the principal is responsible for the acts of his agent done on his behalf.'

[81] Supra n68.

[82] Ibid 359 (translated by the author from the Afrikaans).

[83] Ibid (translated by the author from the Afrikaans).

[84] Ibid.

[85] Supra n77.

[86] Section 385 of the Criminal Procedure Act 56 of 1955 then in force read as follows: 'Whenever the Minister has any doubt as to the correctness of any decision given by any superior court in any criminal case on a question of law, he may submit that decision to the Appellate Division of the Supreme Court and cause the matter to be argued before it, in order that it may determine the said question for the future guidance of all courts.'

[87] Supra n68.

1. Does a person commit a crime who encourages another, helps or places them in a position to kill him or herself?

2. If yes, which crime?[88]

The court held that in determining whether a person who encourages another, helps and places them in a position to kill him or herself, commits a crime; the answer is to be found on the specific facts of each case. It follows that just because the final act was performed by the deceased this does not mean that a person who assists another to commit suicide did not commit a crime. Such a final act must be a voluntary and independent action to result in an effective break in causation. Furthermore, the answer to the second question was that such crime could be murder, attempted murder or culpable homicide.[89]

Some nine years after the *Grotjohn*[90] Appellate Division dictum was handed down it was applied in *S v Hibbert*.[91] The accused and his wife ('the deceased') had a strained relationship due to the deceased's heavy drinking. They had not been talking to each other for a while and one evening when he arrived home an argument resulted over spilt coffee. The deceased announced that she wanted to commit suicide whereupon the accused asked her how she intended to do so. She said she would shoot herself. The accused took her to the room where a kist with a rifle was stored. He obtained the key from the deceased and unlocked the kist. He then assembled the rifle which was in three parts, whereafter he obtained a similar calibre bullet from a pistol magazine which was stored in a cupboard in the pocket of his army jacket. He

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[88] *Grotjohn* supra n68 359 (translated by the author from the Afrikaans).
[89] The reasoning of Steyn HR in the *Grotjohn Appeal* is plain from the following at 363 (translated by the author from the Afrikaans): 'From the fact that neither suicide nor attempted suicide is a crime, it does not follow that the answer to the first question posed must always be in the negative. The person who encourages, helps or enables another to kill himself is engaged, not with his own life or body, but with that of another, and whether he commits a crime, must be judged according to the relevant principles of our criminal law. In the *Gordon* case and in the present case, the accused were acquitted on the grounds that the various acts that caused the death were the deceased's voluntary and "independent" acts. In each of these cases, the conduct of the accused in one case involved the conclusion of a suicide agreement and the acquisition and handing over of the tablets, and in the other case the loading of the gun and the handing over thereof with the accompanying remark had an effect on the events that came to an end with the death of the deceased. However, the Court apparently took the view that the last act of the deceased was a voluntary and "independent" act which, as a later accruing cause, decisively interrupted the causality of the preceding events, in so far as the accused's actions could be involved. … I would however not support a general statement that the final "voluntary and independent" act of the person committing suicide must always lead to the acquittal of the accused, without reservation and without regard to the independence of the act.'
[90] Supra n68.
[91] *S v Hibbert* 1979 (4) SA 717 (D).

unlocked the cupboard, removed the magazine, removed a bullet from the magazine and then proceeded to load the rifle by inserting the bullet. He then handed the loaded weapon to the deceased who promptly aimed it at her forehead and pulled the trigger. She died shortly thereafter from the head wound.

Shearer J held that the accused must have appreciated that the injury or death of the deceased could follow his actions of preparing and handing over the loaded weapon to her. He concluded that the mere pulling of the trigger by the deceased was insufficient to interrupt the causation of the accused's acts as it was not an independent cause of action. Accordingly, he found the necessary intention on the part of the accused together with the mere pulling of the trigger by the deceased insufficient to amount to a novus actus interveniens and accordingly the accused was found guilty of murder.[92] Though the Judge referred to the facts of the *Nbakwa*[93] case, he did not distinguish the principles applied there from the present case. Despite having found the accused guilty of murder the nominal sentence imposed was that of imprisonment of 4 years all of which was suspended for 5 years.[94]

S v Agliotti[95] highlighted the contradictory nature of the cases relating to assisted suicide and euthanasia. In this case, the accused was amongst other charges also charged with the murder of one Brett Kebble, a well-known businessman. It was common cause that the deceased who had serious pending legal problems had requested that he be killed so that his family would benefit from a life insurance claim. The prosecution alluded to the issue of assisted suicide and its possible application to the matter. The court noted that,

> 'euthanasia is believed to be practised within the patient world, albeit not so openly or with clear-cut lawful and/or legal authority, assisted suicide is still a very fluid situation in South Africa as well as in other parts of the world where countries are still trying to grapple with what it is or whether it should be permitted or not'.[96]

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[92] Ibid 722.
[93] Supra n74. In the judgment the case is misspelt as '*R v Mbakwa*' whereas the correct name reference is *R v Nbakwa.*
[94] On condition that he not be convicted of an offence involving an assault committed during the period of suspension in respect of which he be sentenced to imprisonment without the option of a fine.
[95] Supra n19.
[96] Ibid paras 12-14.

The court remarked that the cases relevant to assisted suicide and euthanasia were inconsistent and contradictory and that though the initial view was that a person who supplied drugs or a weapon knowing that such person would use the methods supplied to kill himself was guilty of an offence, later cases contradicted this view.[97]

Kgomo J then proceeded to point out that *R v Peverett*[98] was dealt with differently to *R v Nbakwa*[99] and stated that these cases demonstrated 'inconsistent views in contradictory judgments'.[100] The judge then proceeds to demonstrate how the principle in *R v Nbakwa*[101] was followed in *S v Gordon*[102] after which followed the principle laid down in the *Grotjohn* appeal[103] that just because the final act resulting in death is that of the deceased does not mean that such an act interrupts the chain of causation. The judge then noted how this new principle was then applied in the *Hibbert*[104] case wherein the accused was convicted of murder for handing a loaded gun to his wife who then shot herself.[105]

The court a quo in *Grotjohn*[106] had discharged the accused on the same basis as the principles set out in *Gordon*[107] and concluded that despite the accused loading and handing a gun to the deceased with words encouraging her to shoot herself; that the final act being the firing of the gun by the deceased constituted a novus actus interveniens.[108] This appears to be a clear contradiction as the factual matrix between the *Grotjohn*[109] and *Hibbert*[110] cases appear almost indistinguishable in that both accused loaded and handed a gun to a deceased, and both deceased persons pointed and fired the gun at themselves resulting in death. However, in the court a quo in *S v Grotjohn*[111] a novus actus interveniens was found as quoted in the Appellate Division finding per Steyn HR that (translated by the author from the Afrikaans):

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[97] Ibid paras 19-20.
[98] Supra n35.
[99] Supra n74.
[100] Supra n69 para 20.
[101] Supra n74.
[102] Supra n77.
[103] Supra n68.
[104] Supra n91.
[105] Ultimately Agliotti (the accused) was discharged on technical grounds.
[106] Unreported, per judgment in the WLD on the 13 February 1969.
[107] Supra n77.
[108] See *Grotjohn Appeal* supra n68 359.
[109] Ibid.
[110] Supra n91.
[111] Supra n106.

> 'In the present matter it was not his action of handing the loaded gun to the deceased which caused her death, rather it was her own independent and voluntary action to fire the gun. … Moreover, whereas suicide is not a crime under our law, neither can incitement nor persuasion to commit suicide be a crime as the unlawfulness element is absent.'[112]

Whereas in *Hibbert,* despite the similarity of the facts to *Grotjohn* no novus actus interveniens was found by Shearer J. Though Shearer J discussed the principles arising from *Grotjohn* he appears to have ignored the fact that *Grotjohn* himself was acquitted on similar facts. There appears to be no logical reason why the quotation above from the *Hibbert* case could not have been applied verbatim to the *Grotjohn* case.

Due to the inconsistencies in the case law, it is at the very least conceivable that in a proper case the Supreme Court of Appeal or the Constitutional Court could clarify the position relating to the element of causation to the effect that physician assisted suicide is excluded from sanction. Though I will return to this theme in the discussion below on the *Stransham-Ford HC*[113] case it bears mentioning here that such a conclusion may logically be derived from the ratio in the *Grotjohn Appeal* case where Steyn HR stated that (translated by the author from the Afrikaans),

> 'I would however not support a general statement that the final "voluntary and independent" act of the person committing suicide must always lead to the acquittal of the accused, without reservation and without regard to the independence of the act'.[114]

The judge makes the point that it would not always be the case that merely because the deceased performed the final act in a suicide that the accused would always be found not guilty as this is determined by the nature of the independence of the act. A corollary of this approach is that it is not always unlawful to assist in a suicide in that if a sufficiently voluntary and sufficiently independent act of the deceased had been carried out, it would follow that no crime would have been committed through such assistance. This leaves the door open for a court to hold that in the very specific deathbed physician assisted suicide scenario that the element of causation may be

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[112] *Grotjohn Appeal* supra n68 355.
[113] Supra n1.
[114] *Grotjohn* supra n68 363.

absent. How and under which conditions such a finding may result is open to speculation.

2.6.3 Unlawfulness (wrongfulness) and the boni mores

It is to be noted that in the cases above where the accused persons were found guilty the sentences were nominal. In *Peverett*[115] the accused was sentenced to pay a fine of £30 on a conviction of attempted murder, and in *Hibbert,*[116] the conviction was for murder and the sentence handed down was imprisonment for 4 years all of which was suspended for 5 years.[117]

This raises the peculiar result that the accused persons in these matters were found guilty of arguably some of the gravest charges under law, that of murder and attempted murder, yet the sentences handed down were nominal. This discrepancy is amplified by the fact that at the time of all of the cases discussed up to and including *Hibbert*,[118] the death penalty was a competent sentence in South Africa[119] and was only abolished in 1995.[120] The reason for this unusual outcome is that the boni mores of our society has shifted but that our law has not yet caught up. As Thirion J held in *Clarke v Hurst,*[121] the wrongfulness of withdrawing the artificial feeding of the patient depends upon whether the boni mores of society, that is its present legal convictions, would consider it reasonable, even though such discontinuance would ultimately result in the patient's death.[122] This opens the debate as to whether wrongfulness as an element to the crime of murder may no longer be present in the case of a mercy killing and in particular a physician assisted death were there to be broad agreement that the boni mores of society had shifted regarding wrongfulness in this context since the

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[115] Supra n35.
[116] Supra n91.
[117] On condition that he not be convicted of an offence involving an assault committed during the period of suspension in respect of which he would be sentenced to imprisonment without the option of a fine.
[118] Supra n91.
[119] In terms of the then in force s 277 of the Criminal Procedure Act 51 of 1977 that was amended by the Criminal Law Amendment Act 105 of 1997 which repealed all laws providing for the death penalty which came into operation on the 13 November 1998 as per judgment of the Constitutional Court (see *Makwanyane* infra n120).
[120] Per *S v Makwanyane and Another* 1995 (3) SA 391 (CC).
[121] *Clarke v Hurst* supra n22; also see a more detailed discussion of this case above under heading 2.5 and 2.6.3.
[122] Ibid 653; see also G Kemp 'Specific crimes: Murder, assisted suicide and the euthanasia debate' (2011) 4 *Juta's Quarterly Review of South African Law (Criminal Law)* para 2.3.

Roman-Dutch roots of the common law and amplified by the advent of constitutional democracy.

An opportunity to consider this issue arose in the *Stransham-Ford SCA*[123] but Wallis JA declined to deal with it on several bases including that insufficient opportunity was available to the court to consider all the relevant issues. In my opinion, there should have been sufficient opportunity for the court to have the necessary insight. Davis and Youens agree:

> 'The issues which were raised from the case of Mr. Stransham-Ford had been sufficient for the court to consider, under the circumstances, whether existing law should be developed. It therefore appears that this was a case, in the court's view, which was best dealt with by Parliament where a comprehensive debate could take place prior to any new legislation being introduced.'[124]

In respect of the above case law, it is time for a clear and rational resolution to the inconsistencies and irrationality of the outcomes presently playing out. This is particularly important as all the case law on the topic, except the *Stransham-Ford*[125] and *Agliotti*[126] cases were heard before the implementation of the Bill of Rights which coincides with the most drastic shift of the boni mores of South Africa in its legal history.

2.7 Euthanasia case law

In the preceding discussion on assisted suicide, the focus was on the position of someone who provides the means of suicide to a person who then uses such means to commit suicide. In the present discussion, we examine the legal position of a person who does not merely provide such means but also completes the act of killing a person. Once again, other than the two *Stransham-Ford*[127] judgments (and arguably the *S v Hartmann*[128] judgment) none of these cases takes place in the context of a terminally ill patient on a deathbed requesting that a doctor administers a lethal agent, and so is

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[123] Supra n1.
[124] DM Davis & P Youens '6.6 Euthanasia' in MH Cheadle, D Davis & NRL Haysom (eds) *South African Constitutional Law: The Bill of Rights* (Last Updated May 2017) para 6.6.1.
[125] Supra n1.
[126] Supra n19.
[127] Supra n1.
[128] Supra n1.

accordingly only instructive to the limited degree of how 'mercy killing' has been approached by our courts.

2.7.1 No legal culpability found due to emotional mental state

In each of the following two 'mercy killing' cases, the court found that the extreme emotional mental state of the accused exonerated them from legal culpability.

In *R v Davidow,*[129] the emotional state of the accused is described by Strauss[130] as being in a state of 'extreme tension'. The accused dearly loved his mother and had made various attempts to cure her and reduce her pain. He had even through sheer desperation asked a friend to assist by giving her a lethal injection but the friend had refused. Meanwhile, his mother frequently stated that she could no longer bear the excruciating pain and wished to be dead. This had the effect of causing the accused to burst into tears and to weep in his sleep. Finally, in hospital, he had a 'severe emotional outburst' which led to him shooting her with a revolver resulting in her death. The accused was found to have been in an extreme emotional state and that he accordingly acted automatically and involuntarily. He was accordingly found not guilty.

Similarly, in *S v McBride*[131] the accused who was 67 years old dearly loved his wife and had watched her rapidly declining health for some time. At the same time, the accused was struggling financially and the accused was faced with shortly being unable to pay their rent. He had hoped that he would be able to hide their deteriorating financial position from her until she died (which event both he and his sister believed would not be more than a year away) but he was beginning to run out of time. On the day in question, he had left his office early as his wife had asked him to return home as she felt sick. On the way home, his vehicle had collided with a pedestrian who had to be taken to hospital and he (mistakenly) believed that he would have to pay an impossible sum towards insurance excess. He decided the only way for them to escape this dire state of affairs was for him to shoot her and thereafter himself. He shot his

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[129] *R v Davidow* 1955 WLD unreported, discussed in HP van Dyk 'Die davidow-saak' (The davidow case) (1956) 19(4) *Tydskrif vir Hedendaagse RomeinsHollandse Reg (Journal for Contemporary Roman-Dutch Law)* 286-288.
[130] SA Strauss 'Euthanasia: A South African view' in A Carmi (ed) *MedicoLegal Library 2: Euthanasia* (1984) 83 86.
[131] 1979 (4) SA 313 (W).

wife dead but whilst trying to put their affairs in order thereafter, he was arrested and charged with her murder before he could execute the suicide.

McEwan J referring to the evidence of the mental health witnesses found that their evidence was clear that the accused was 'incapable by reason of mental illness of exercising any rational control over his actions'[132] and that it was 'not uncommon for a person suffering from endogenous depression to regard the taking of the life of another, particularly of a person whom he loves, as an act of altruism'.[133] The accused was found not guilty by reason of mental illness and the sentence prescribed was that the accused be detained in a mental hospital or prison pending a determination by the president, however, in the circumstances of this case the court felt it justifiable to add the following recommendation:

> 'That a transcript of the evidence in this case and of this judgment be furnished to the authorities concerned with a request that the earliest reasonably possible consideration be given to the question of the release of the accused from detention subject to suitable conditions.'[134]

It is important to note that in this case there was no request by, or consent to be killed on the part of the deceased. The decision to do so was purely that of the accused, albeit in a state of temporary mental illness. Furthermore, the court went to the extent of requesting the authorities to consider his release from the mental institution at the earliest reasonably possible time as in its opinion he no longer suffered from the mental illness.

Both mercy killing cases above resulted in minor consequences for the accused. Davidow was acquitted and McBride was detained at a mental institution with a request from the court that he be released as early as possible. These findings appear to reflect a sense by these courts of an insubstantial degree of wrongfulness associated with the context in which the actions of the accused occurred.

After the above cases, the judgment in the Supreme Court of Appeal was handed down in *S v Eadie*.[135] This judgment held that there is no difference between non-pathological incapacity that arises from emotional stress (or provocation) and

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[132] Ibid 322.
[133] Ibid.
[134] Ibid 324.
[135] Supra n18.

sane automatism. This implies that future accused persons cannot rely on the subjective test of non-pathological mental incapacity alone as a sufficient exculpatory basis but must now show evidence that they acted like an automaton to pass the objective test for conduct.[136] This judgment is considered controversial and possibly incorrect as Hoctor frames it,

> 'the defence of sane automatism, which relates to conduct, has been conflated with the defence of non-pathological incapacity, which relates to state of mind; the objective test (for conduct) has been conflated with the subjective test (for state of mind); and there has arguably been a drastic narrowing of the incapacity defence in the context of conative capacity'.[137]

It remains to be seen whether this dictum will stand were an appropriate case to challenge it.

2.7.2 Legal culpability found despite emotional mental state but extenuating circumstances applied at the sentencing stage

In South Africa, the common law mandatory death penalty for murder applied until the 'doctrine of extenuating circumstances' was passed into law in 1935.[138] The doctrine did not allow for a purely discretionary sentence but instead required that a judge could only pass a sentence other than death if a mitigating factor was found and articulated which in effect meant a presumption in favour of the death penalty applied thereby placing the burden of proof against the presumption on the accused.[139]

Before 1997, other than that at the local and district level a magistrate's court was historically limited to the type of punishment and maximum sentences that it was

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[136] Ibid para 57 which reads, 'there is no distinction between sane automatism and non-pathological incapacity due to emotional stress and provocation. Decisions of this Court make that clear. I am, however, not persuaded that the second leg of the test expounded in *Laubscher's* case should fall away. It appears logical that when it has been shown that an accused has the ability to appreciate the difference between right and wrong, in order to escape liability, he would have to successfully raise involuntariness as a defence. However, the result is the same if an accused's verified defence is that his psyche had disintegrated to such an extent that he was unable to exercise control over his movements and that he acted as an automaton - his acts would then have been unconscious *and* involuntary. In the present contest, the two are flip sides of the same coin.'

[137] S Hoctor op cit n14 183.

[138] Section 61 of the Criminal Procedure and Evidence (Amendment) Act 46 of 1935.

[139] A Novak 'Capital sentencing discretion in Southern Africa: A human rights perspective on the doctrine of extenuating circumstances in death penalty cases' (2014) 14(1) *African Human Rights Law Journal* 24 26.

competent to impose, there was otherwise an 'unfettered discretion when imposing sentence'[140] by South African courts. Vague principles developed through the case law.[141] The following cases were heard in this period in which all the accused are found guilty of murder or attempted murder despite the mental and emotional state they exhibited leading up to their actions. This shows the reluctance of the courts to condone such 'mercy killings'. In all of these cases, the emotional state of the accused that arose from their concern for the person they had cared for is taken into account at the sentencing stage with the effect being that nominal sentences are handed down.

In *S v De Bellocq*[142] despite the accused being found guilty, the court went to the extent of contriving an order which resulted in no effective sentence being handed down. The case involved a couple who were immigrants and where the wife was pregnant with a much-wanted child upon their arrival in South Africa. Soon after the birth of the child, it was confirmed to her that the child suffered from a rare severe debilitating disease. The child was already severely mentally deficient and had to be fed artificially. The child's mother ('the accused'), had been a medical student and was well aware of the disease prognosis. Whilst bathing the child she suddenly decided it would be better for the child to die rather than suffer without any hope of normal life and she proceeded to drown the child. The court found her guilty of murder citing that despite her emotional state of mind, her confession clearly showed intent and further that her state of mind could not reduce her intent. Furthermore, the law did not allow any person to be killed by another irrespective of the fact that the child was gravely mentally deficient or gravely ill. Accordingly, the court held that murder was the appropriate conviction and not culpable homicide. It is self-evident that there was no question as to the consent of the deceased who was an infant and accordingly incapable of consenting.

She was however sentenced on her own recognisances on condition that she would make herself available for sentencing at any time within the following six months if the court required her to appear.[143] It was expected that by that time the

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[140] SS Terblanche 'Sentencing in South Africa: Dominated by minimum sentences' (2020) 33(1) *South African Journal of Criminal Justice* 4 14.
[141] *S v Zinn* 1969 (2) SA 537 (A), see the so-called 'Triad of Zinn' set out at 540 G–H.
[142] *S v De Bellocq* 1975 (3) SA 538 (T).
[143] Ibid 359.

couple would have left the country and accordingly no sentence was ever passed on her.

A similar stance was taken in *S v Hartmann,*[144] where the accused was a medical doctor and the son of the deceased who was 87 years of age at the time of his death. The deceased had been suffering from cancer that had spread to his bones. The accused had his father moved to a hospital where he could provide medical treatment. His father became completely bedridden, had developed blood clots and was being fed intravenously. The accused instructed a nurse to administer a large dose of morphine. An hour later the accused himself administered a similar dose. Shortly thereafter he administered a lethal dose of pentothal. His father died seconds later.

Van Winsen J noted that the accused had asked his father whether he wished to sleep and that there was a suggestion that his father had nodded perceptibly. The judge dismissed that this was an accession to him being injected with a fatal dose of pentothal as it could not be established that this was in fact what was meant by the nod, or whether in fact, the patient was sufficiently lucid to understand the question and respond appropriately nor even if same had occurred. More importantly, the judge pointed out that even if it were to be accepted that the patient had given permission, that such consent is not a defence to murder. The judge cited *R v Peverett*[145] and *S v Robinson and Others*[146] in support of this contention.

The judge then commented on the legal position relating to the court's powers in respect of 'mercy-killing' and confirmed that in his view despite mercy-killing being the subject of ongoing and heated public debate and despite it being considered by some as unfeeling and harsh, South African law remains substantially similar to all western countries and that a change in the law is up to the legislature:

> 'The Courts, in appropriate circumstances, can mitigate but they cannot legislate. For the aforegoing reasons we accordingly find the accused guilty as charged.'[147]

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[144] Supra n1.
[145] Supra n35, discussed above under 2.4.1.
[146] Supra n38, discussed above under 2.4.1.
[147] *Hartmann* supra n1 535. It is to be noted that this order was made in 1975 and that the statement of the judge relating to the similarity of law in all Western countries would not be true today.

Despite the murder conviction the sentence imposed was nominal and rather cryptically designed to ensure the nominal result,[148] in the words of the judge:

> 'The accused will be detained until the rising of the Court and the balance of the sentence is suspended for one year on condition that he does not during that period commit an offence involving the intentional infliction of bodily injury.'[149]

In the case of *S v Marengo,*[150] the court applied the same ratio. In this case, the accused was a 45-year-old woman who had assisted her father aged 81 with all his daily needs for several years after he had been diagnosed with cancer. He relied upon her entirely and refused to either be admitted to a home or for her to engage private nursing services in their home. He suffered immensely in this time and his deterioration both mentally and physically left her helpless. Her father always kept a loaded gun on his bedside table and overcome with anguish and confusion she grabbed the weapon and shot him in the head at close range. She immediately contacted the police and pleaded guilty at trial.

The judge went to great pains to point out her personal circumstances which included being raised as an immigrant and fearful of outside influences, with only one former friend who had subsequently left the city and that she had never been on a social date. Accordingly, psychologically she suffered from psychosocial stress, depression, anxiety and sleep and appetite disturbance and was constantly angry and frustrated. The judge then went on to point out that euthanasia was unlawful and that in his opinion should not be allowed in a civilised society. He accordingly cautioned that such cases must not be taken too lightly including the importance of the deterrent effect of sentences but that each matter is to be considered on its facts.[151] Finally, the judge quoted the ratio in *S v Hartmann*[152] with approval and determined the cases to

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[148] Such wording of the sentence was necessary in that s 352(2)*(a)*(i) of the Criminal Procedure Act 56 of 1955 then in effect, read with its fourth schedule provided that on a conviction for murder, imprisonment could not be wholly suspended. It appears the judge went to great lengths to comply only with the letter of the law whilst ensuring he imposed a nominal sentence by detaining the accused only until the rising of the court.
[149] *Hartmann* supra n1 537.
[150] *S v Marengo* 1991 (2) SACR 43 (W).
[151] Ibid 787.
[152] Supra n1, discussed above under the present heading.

be similar. Accordingly, a sentence was imposed of three years imprisonment suspended on conditions for five years.[153]

It is important to note that though the deceased was terminally ill, and the judge considered this a case of mercy killing, it does not appear that the deceased had at any time asked to be killed. Despite the murder conviction the sentence imposed was once again nominal being entirely suspended.

Though the accused was found guilty of attempted murder, a similarly entirely suspended nominal sentence was imposed in *S v Smorenburg*[154] due to the serious emotional trauma she had suffered. The accused, a hospital nurse at the time of the offences injected two terminally ill patients in her ward with a large dose of insulin. Both patients died subsequently but as it could not be proved for technical reasons that the injection in each case caused the death of the two patients, she was charged with attempted murder. She pleaded guilty to both charges and explained that she was disturbed by working with the terminally ill patients as although she did everything possible for them, she felt helpless by her inability to adequately relieve the pain, indignity, and emotional suffering experienced by them. She had requested a transfer to the casualty ward which was not possible; had requested assistance from a psychologist but could not bring herself to discuss her emotions; had registered for a course in nursing psychiatry; and, had even considered leaving the nursing profession. Ultimately feeling trapped and desiring desperately to relieve the suffering of two of her patients she obtained the insulin from the ward fridge and injected large doses intramuscularly which she had learned was a method used by Austrian nurses performing pain-free euthanasia.

The judge considered several factors in respect of the sentence including that the accused had no previous convictions, that she was an exceptional nurse and was well respected, and that she had shown remorse. He also referred to her act of deregistering herself as a nurse which was itself a punishment of abandoning her beloved occupation. Also, that she acted on the strong motive to assist these two

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[153] The conditions being:
'1. that she does not during this period commit an offence involving an intentional infliction of bodily injury on any person and/or;
2. that during the said period she submits herself to the supervision of a social worker appointed by the Department of Health Services and Welfare.'
[154] *S v Smorenburg* 1992 (2) SACR 389 (C).

patients which she believed that they desired to have an end put to their suffering and indignity whilst she was undergoing serious emotional trauma.[155]

The court after finding her guilty of attempted murder on both charges based on her guilty plea imposed the following nominal sentence:

> 'On each count the accused is sentenced to three months' imprisonment totally suspended for 12 months on condition that she is not convicted of a contravention of s 16(1) read with s 27(1) and (2) and s 44 of the Nursing Act 50 of 1978, committed during the period of suspension.'[156]

In the year 2000, the South African Law Commission released a report[157] in which it noted the disparity in sentencing in South Africa generally and proposed guidelines. On 1 May 1997, the Criminal Law Amendment Act[158] came into operation regulating minimum sentences for a variety of criminal offences. These minimum sentences are however not mandatory and may be avoided where there is 'substantial and compelling circumstances'.[159] In *S v Dodo*[160] the Constitutional Court endorsed the step-by-step approach described in the Supreme Court of Appeal in *S v Malgas*[161] as to what constituted 'substantial and compelling circumstances'.[162] This guidance points out that a court's discretion is limited but not eliminated and that the legislature has prescribed the minimum sentences that should ordinarily be imposed where there is no weighty justification for an alternative sentence. Such justification must be truly convincing and not based on flimsy reasons, or speculative hypotheses, or motivated by undue sympathy. Neither must they be motivated by general aversions to imprisonment, or doubts by the sentencer as to the efficacy of minimum sentence policy, or marginal distinctions between the personal circumstances or the degree of

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[155] Ibid 398-399.
[156] Ibid 404; these sections of the Act (now repealed by s 60 of the Nursing Act 33 of 2005) made it an offence for a person not registered as a nurse to make use of a nursing title or to hold or permit themself to be held out as a registered nurse, or who wears a badge or other distinguishing device or any misleading imitation thereof prescribed in respect of a registered nurse.
[157] South African Law Commission (Project 82) Report: *Sentencing (A New Sentencing Framework)* (2000) available at https://www.justice.gov.za/Salrc/reports/r_prj82_sentencing%20_2000dec.pdf (accessed 13 December 2021).
[158] Criminal Law Amendment Act 105 of 1997.
[159] Ibid s 51(3) which provides '*(a)* If any court referred to in subsection (1) or (2) is satisfied that substantial and compelling circumstances exist which justify the imposition of a lesser sentence than the sentence prescribed in those subsections, it shall enter those circumstances on the record of the proceedings and may thereupon impose such lesser sentence'.
[160] 2001 (3) SA 382 (CC).
[161] 2001 (2) SA 1222 (SCA).
[162] Supra n160.

the participation of offenders. Nonetheless, all other factors usually considered in the sentencing analysis must continue to be taken into account and not only those usually applied in appeals against sentence. Where a court is convinced that the prescribed sentence is disproportionate to the crime, the convicted person and society such that an injustice would result, the court is entitled to impose a lesser sentence.[163]

The following 'mercy killing' case found the necessary 'substantial and compelling circumstances' were present. In *S v Nkwanyana*[164] the court followed the approach of finding the accused guilty of murder but imposing a similarly entirely suspended nominal sentence because the deceased had domineered the accused into killing her. In this case, the deceased who suffered from anorexia nervosa, and the accused were good friends for five years and a trust relationship ensued. The deceased's mental health deteriorated and she had on several occasions attempted suicide but failed. The deceased told the accused that she was deeply unhappy and lived in misery and wanted to die but was fearful of a further failed suicide. She began requesting him to kill her repeatedly, ever more insistently. Finally, she said that if he would not help her, she would find someone else. He feared that someone else may hurt her and decided it was better if he assisted. The accused procured a firearm which was paid for by the deceased. After praying, the deceased asked him to go ahead and he shot her dead as they had agreed. Mental health witnesses confirmed that the deceased had suffered from and had been diagnosed with a major depressive disorder as well as major or acute depression. They also testified to at least three previous suicide attempts.

Judge Makhanya turned his attention to the issue of the consent of the deceased to her killing and noted that,

> 'there is no doubt in my mind that the crimes of which the accused has been found guilty by the court are very serious crimes, especially the count relating to murder, and for this he must be on the receiving end of the full wrath of the law. The fact that the deceased consented in her demise is irrelevant for the purposes of the conviction'.[165]

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[163] Ibid para 11.
[164] *S v Nkwanyana* 2003 (1) SA 303 (W).
[165] Ibid 308.

The judge noted however that,

> '[o]n the other hand, our courts have not failed to take a firm stand regarding the finding of extenuating factors on a murder charge where the deceased has consented to his or her own killing'.[166]

The court found that the deceased intended and planned her death and she domineered the accused in that she was from a sophisticated and stable background whereas he was from a broken and poor family. She had also helped him financially over the years of their friendship.

The sentence imposed on the count of murder was 5 years imprisonment, wholly suspended for 5 years (on certain conditions); and on the counts of possession of a firearm and possession of ammunition the sentence was 24 months imprisonment, wholly suspended for 3 years (on certain conditions).[167] Despite the murder conviction the sentence imposed was nominal being entirely suspended. Had the minimum sentence been applied he would have been imprisoned for life[168] which suggests that this judgment also reflected a sense by the court of an insubstantial degree of wrongfulness associated with the context in which the act of the accused occurred.

It appears that in light of the case law, were a physician to be convicted of physician administered euthanasia in South Africa now, to a competent person suffering from an unbearable and grievous medical condition which is either terminal or intractable and where such person made a request freely and without undue influence to choose the manner and time of his or her death that such a physician can expect that the courts are likely to convict for murder but hand down a nominal sentence. The recent case[169] of Prof Sean Davison (a biotechnician who is not a physician) followed this pattern. He was convicted of three murders all of which were assistance in 'mercy killings' to which he pleaded guilty. He was sentenced to an effective 3 years house arrest, and to 8 years imprisonment, which was suspended for 5 years.[170]

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[166] Ibid.
[167] Ibid 13.
[168] Section 51(1) of the Criminal Law Amendment Act op cit n158.
[169] Unreported Western Cape High Court 2019.
[170] JM Heckmann & AS Amaler 'Public policy in ALS/MND Care: South African perspective' in RH Blank, JE Kurent & D Oliver (eds) *Public Policy in ALS/MND Care an International Perspective* (2020) 242.

2.8 The first South African application to die with dignity and its appeal to the Supreme Court of Appeal

2.8.1 The first South African application to die with dignity

Stransham-Ford v Minister of Justice and Correctional Services and Others[171] is the first deathbed request for physician assistance in dying by a terminally ill patient considered by a South African court. The decision of the High Court was overturned on appeal. This journey is examined below.

2.8.1.1 Preliminary remarks

In his preliminary remarks, Fabricius J pointed out that this was an urgent application before him as a single judge and that it would be preferable for a minimum of eight judges in the Constitutional Court to ultimately pronounce on the relevant issues relating to it. Furthermore, the ideal situation would be for the legislature to consider the issues and produce a Bill that could be scrutinised by the courts.[172]

The judge then referred to the Law Commission Report[173] published in 1998 and pointed out that by then sixteen years had passed without the Minister of Health or the legislature taking the matter any further and suggested that it required serious consideration.

2.8.1.2 The Applicant

The court noted that the applicant, Adv Stransham-Ford, was not only of sound mind but was also highly qualified in the legal profession and possessed extensive experience placing him in a position to determine why and what he required.[174] It was common cause that the applicant suffered from stage four cancer and would die from

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[171] *Stransham-Ford HC* supra n1.
[172] Ibid para 1.
[173] South African Law Commission Report (Project 86) op cit n157.
[174] *Stransham-Ford HC* supra n1 para 2.

his disease within a few weeks of the hearing and that he had a very low quality of life.[175]

The applicant sought the following order (numbered as in the original):

> ' 2. Declaring that the Applicant may request a medical practitioner, registered as such in terms of the Health Professions Act 56 of 1974 ("a medical practitioner"), to end his life or to enable the Applicant to end his life by the administration or provision of some or other lethal agent;
>
> 3. Declaring that the medical practitioner who administers or provides some or other lethal agent to the Applicant, as contemplated in prayer 2 supra, shall not be held accountable and shall be free from any civil, criminal or disciplinary liability that may otherwise have arisen from:
>
> 3.1 The administration or provision of some or other lethal agent to the Applicant;
>
> 3.2 The cessation of the Applicant's life as a result of the administration or provision of some or other lethal agent to the Applicant;
>
> 4. To the extent required developing the common law, by declaring the conduct in prayers 2. and 3. supra, lawful and constitutional in the circumstances of this matter'.[176]

The court identified the five issues arising as follows: first, '[i]s it conceivable that the health of a person may deteriorate to a level, where he would be justified in wishing to take his own life ("the sufferer")'; secondly, '[o]ught the sufferer be permitted to take his own life'; thirdly, '[s]hould another person be allowed to assist the sufferer to end his life ("the Samaritan")'; fourthly, '[m]ay this person be a medical practitioner'; and fifthly, '[w]hich safeguards need to be in place'?[177]

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[175] The applicant's quality of life was described as follows: 'Suffers from severe pain, nausea, vomiting, stomach cramps, constipation, disorientation, weight loss, loss of appetite, high blood pressure, increased weakness and frailty related to the kidney metastasis. He is unable to get out of bed and has injections and drips. Endures anxiety. Cannot sleep without morphine or other painkillers. Uses pain medication, which makes him somnolent.' (Numbering removed and punctuation amended)
[176] *Stransham-Ford HC* supra n1 para 4.
[177] Ibid para 5.

2.8.1.3 The High Court's conclusion as to the current law

The court held that:

> 'The current legal position is that assisted suicide or active voluntary euthanasia is unlawful.
> See: *S v De Bellocq* 1975 (3) SA 538 (T) at 539d; and *S v Marengo* 1991 (2) SACR 43 (W) 47A B; and *Ex parte Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A).'[178]

This is a wholly inadequate analysis of the pertaining case law. In particular, *Grotjohn*[179] was himself found not guilty and the Appeal Court referral merely stated that it would not always be the case that merely because the deceased performed the final act in a suicide that the accused would always be found not guilty. In other words, it stopped short of saying that it is always unlawful to assist in a suicide which appears to be the interpretation of Judge Fabricius in this conclusion.

Furthermore, the court did not refer to the case of *Nbakwa*[180] nor *Gordon*[181] (as well as the actual finding against Grotjohn himself in the court a quo) where a novus actus interveniens was found to be present. Nor were the other judgments referred to by the court in support of its conclusion that assisted or active voluntary euthanasia was unlawful subject to analysis. The *Hartmann*[182] case of 1975 which supports the court's conclusion also appears to be excluded from the cases considered as well as the most recent relevant case of *Hibbert*[183] decided in 1979 and which best supports the court's contention is completely excluded from the court's analysis! The upshot of the failure to properly analyse the present law led to the glib conclusion of unlawfulness and is one of the bases which put the judgment on course for a successful appeal.

For most of the rest of the judgment, the application of the Bill of Rights is discussed, analysed and applied. These portions of the judgment will be dealt with in chapter 3.

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[178] Ibid para 10.
[179] Supra n68.
[180] Supra n74.
[181] Supra n77.
[182] Supra n1.
[183] Supra n91.

Ultimately the judge concluded that in applying the rights contained in the Bill of Rights to our present law, the common law crimes of murder and culpable homicide by their absolute prohibition against assisted dying, are overbroad by unjustifiably limiting the applicant's rights to dignity, and freedom to bodily and psychological integrity and accordingly granted an order which despite being substantially different to the order requested by the applicant nonetheless affirms that a doctor may assist by either providing and/or administering a lethal agent, which is to authorise either physician assisted suicide (PAS) or physician administered euthanasia (PAE).[184]

2.8.2 The appeal to the Supreme Court of Appeal

In the *Minister of Justice and Correctional Services and Others v Estate Late Stransham- Ford,*[185] Wallis JA upheld the appeal thereby setting aside the High Court's order. The judge referred to three key and inter-related reasons why the appeal must be upheld. First, the appeal court noted that Adv Stransham-Ford died two hours before the order was made. It noted that immediately upon his death the cause of action in the application ceased to exist which meant that no order should have been handed down alternatively, if the order had already been handed down it should have been

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[184] *Stransham-Ford HC* supra n1 para 26 the court ordered:
'1. IT IS DECLARED THAT:
1.1 The Applicant is a mentally competent adult;
1.2 The Applicant has freely and voluntarily, and without undue influence requested the court to authorize that he be assisted in an act of suicide;
1.3 The Applicant is terminally ill and suffering intractably and has a severely curtailed life expectancy of some weeks only;
1.4 The Applicant is entitled to be assisted by a qualified medical doctor, who is willing to do so, to end his life, either by the administration of a lethal agent or by providing the Applicant with the necessary lethal agent to administer himself;
1.5 No medical doctor is obliged to accede to the request of the Applicant;
1.6 The medical doctor who accedes to the request of the Applicant shall not be acting unlawfully, and hence, shall not be subject to prosecution by the Fourth Respondent or subject to disciplinary proceedings by the Third Respondent for assisting the Applicant.
2. This 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.
3. The common law crimes of murder or culpable homicide in the context of assisted suicide by medical practitioners, insofar as they provide for an absolute prohibition, unjustifiably limit the Applicant's constitutional rights to human dignity, (S.10) and freedom to bodily and psychological integrity (S.12(2) (b), read with S.1 and 7), and to that extent are declared to be overbroad and in conflict with the said provisions of the Bill of Rights.
4. Except as stipulated above, the common law crimes of murder and culpable homicide in the context of assisted suicide by medical practitioners are not affected.'
[185] *Stransham-Ford SCA* supra n1.

immediately recalled by the judge upon coming to hear of the fact of the applicant's premature death. No claim would have passed to his estate in the matter before the court to pursue the litigation as the estate lacked locus standi (standing). Secondly, the presentation of the matter lacked a complete and in-depth analysis of the law in this complex arena both locally and internationally as well as the constitutional and common law dimensions thereof. Thirdly, the decision made was both founded on a wrong and restricted factual basis as being brought on an urgent basis it failed to comply with the Uniform Rules of Court that deprived all interested parties a proper opportunity to be heard. The appeal court concluded that in light of the above it was inappropriate for the court a quo to have taken it upon itself to reconsider the application of the common law crimes of murder and culpable homicide.[186]

2.8.2.1 The effect of the death of the applicant before the making of the order

Wallis JA pointed out that from the founding affidavit it was clear that the applicant brought the application in his personal capacity and that he was requesting the court to acknowledge his personal fundamental human rights being human dignity; non-treatment in a cruel, inhuman or degrading way; and to his bodily and psychological dignity; and, as a consequence thereof, to order personal relief to him. Such relief was intended to take the form of allowing him to die with the assistance and/or administration of a lethal substance by a doctor, without such doctor suffering any criminal or professional consequences that may otherwise have followed on from such assistance. The court pointed out that the High Court ordered actions that were no longer pertinent in that he had already died. In particular paragraphs 1.1, 1.3, 1.4 and 1.5[187] could only make sense if the applicant was still alive, whilst paragraph 1.2 related to the state of mind of the living applicant at the time he launched the proceedings. Furthermore, there could no longer be any question of a doctor being allowed to escape the consequences of actions that would otherwise flow when in fact no doctor could perform the act of assisting in his death as he had already died. Finally, in that paragraph 4[188] was specifically constructed to apply to this applicant alone, and in that he had already died, the application had been overtaken by the prevailing

[186] Ibid para 5.
[187] See wording of the order n184.
[188] See wording of the order n184.

circumstances. Wallis JA acceded that neither Fabricius J nor the applicant's legal team was aware at the time judgment was delivered that the applicant had already died, but pointed out that the Health Professional Council of South Africa[189] had requested of the judge, before reasons for the order were given, to recall his order. He refused to recall the order on the basis that it had broader societal implications.

Wallis JA then proceeded to discuss the law relating to causes of actions that are extinguished upon the death of the applicant and then concludes that this application was duly extinguished and that no claim could pass to his estate.

Since a High Court must contain itself to matters which 'present live issues for determination', it was beyond its jurisdiction to hand down a judgment that had become moot.[190] This is unlike the position in an appellate court or the Constitutional Court as these courts may make findings and orders even where a matter has become moot to ensure that where a lower court has raised an issue which has widespread implications, that if such order is incorrect, the issue may be addressed to adjudicate correctly thereupon.[191]

2.8.2.2 No full and proper examination of the present state of our law

The Supreme Court of Appeal noting the incompleteness of the conclusion of the High Court in its statement that 'assisted suicide or active voluntary euthanasia is unlawful'[192] proceeded to confirm the settled law concerning this topic being that '[n]either suicide nor attempted suicide is a crime in South Africa';[193] that '[a] person may refuse treatment that would otherwise prolong life';[194] and that '[w]here a patient does not have mental and legal capacity, a court may order the withdrawal of medical treatment or artificial nutrition and hydration';[195] and finally that 'a medical practitioner commits no offence by prescribing drugs by way of palliative treatment

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[189] The Health Professional Council of South Africa was the Third Respondent in the court a quo.
[190] See *Fischer and another v Ramahlele and another* 2014 (4) SA 614 (SCA) paras 13 and 14.
[191] *Stransham-Ford SCA* supra n1 para 25.
[192] *Stransham-Ford HC* supra n1 para 10.
[193] *Stransham-Ford SCA* supra n1 para 30; cited *R v Peverel*t discussed above under heading 2.4.1.
[194] Ibid para 31; cited *Stoffberg v Elliott* 1923 CPD 148 149-150.
[195] Ibid para 32 cited *Clarke v Hurst* supra n22; also see discussion relating to withdrawal of medical treatment under heading 2.3.

for pain that the doctor knows will have the additional effect of hastening the patient's death'.[196]

The judge then turned his attention to the legal position in respect of 'mercy killing' and after analysing the *Hartmann*[197] and *de Belloq*[198] cases concluded that it undoubtedly constituted murder. However, the judge was at pains to point out that neither of these two cases nor the *Marengo*[199] case (which was also referred to in the court a quo) dealt with either physician assisted suicide or physician administered euthanasia in that these were not cases of suicide nor had the deceased requested to die. The only relevance of these cases therefore to euthanasia is the legal question of whether the consent of the deceased alters the legal consequences of the conduct of a doctor who assists a patient to die or administers a lethal agent. The judge then referred to the case of *S v Robinson*[200] and from that ratio found that consent is not a defence where a person intentionally kills another.

Wallis JA concluded that as the law presently stands, physician administered euthanasia constitutes the crime of murder[201] but that the circumstances would significantly affect the sentence handed down. The judge then pointed out that as the present law is clear that consent is not a defence to intentional killing, the relief sought by the applicant is a direct challenge to that principle of the common law. The court a quo would have had to deal directly with such a challenge by identifying and dealing with the principles as they now exist and then to determine exceptions or departures therefrom. It would have had to take into account the fact that only four countries had by then allowed for physician administered euthanasia which was being requested by the applicant. The court a quo had failed to identify the necessary issues and enter into a detailed consideration of the applicable principles consequently, it was not in a position to order a profound change to existing law and accordingly its order had to be set aside.[202]

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[196] Ibid para 34; cited *Clarke v Hurst* discussed above.
[197] Supra n1 discussed above under heading 2.7.2.
[198] Supra n142 discussed above under heading 2.7.2.
[199] Supra n150 discussed above under heading 2.7.2.
[200] Supra n38 discussed above under heading 2.4.1.
[201] *Stransham-Ford SCA* supra n1 para 40.
[202] Ibid para 41.

The judge went on to consider the case law and pointed out that in *Grotjohn,*[203] the court made it very clear that it did not find that every person who encourages, helps or enables the suicide of another commits a crime. Instead:

> 'Whether they will depends on the facts of the case and issues of intention (mens rea), unlawfulness and causation. It follows that it cannot be said that in the current state of our law PAS is in all circumstances unlawful. The judge's statement to that effect went too far.'[204]

The judge then proceeded to look at various ways in which the common law could be amended to accommodate physician assisted suicide if a proper case were to come before it and amplifies his view that the present case was not an appropriate one to explore these issues as neither the arguments presented nor the evidence were sufficient.

2.8.2.3 The factual record was inadequate

The court proceeded to note that due to the shortened periods applicable to the matter resulting from it being brought before the court as an urgent application, no medical examination could be done on behalf of the respondents and there was very little other medical evidence. It noted that Adv Stransham-Ford was able to continue practising as an advocate until six weeks before he died. The applicant had also asked his doctor whether he could change his mind about assisted death or whether he was obliged to proceed with it. There was also the question of his state of mind when he signed his affidavit. In short, the judge found the factual record hopelessly inadequate and held that for this reason alone the appeal should succeed.

This case will be further discussed in the next chapter regarding the effect of the Bill of Rights on the relevant common law.

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[203] Supra n68 discussed above under heading 2.6.2.
[204] *Stransham-Ford SCA* supra n1 para 54.

2.9 Conclusions relating to euthanasia case law

In the light of the comments of Judge Wallis regarding the *Grotjohn*[205] case to the effect that not all assistance in suicide may be unlawful, it is possible (though not necessarily desirable) that if an appropriate case were to come before the courts that after an in-depth analysis of the implications of physician administered euthanasia that a principled amendment to the common law may be made.

The elements of the crime of murder[206] which may be amended relate to the element of *causation* (where the manner of physician assisted death makes provision for a novus actus interveniens); or to *unlawfulness* (if it is found that euthanasia is no longer against the boni mores of society); or to *intention/mens rea* (in a similar manner in which the double effect foreseeability of death is not considered a form of *dolus eventualis*). Three other approaches to a defence against unlawfulness are first, a *special defence* specifically for medical practitioners;[207] secondly, a defence of *necessity;*[208] or thirdly, a defence of *consent*[209] in limited prescribed circumstances. Williams suggests that the 'anomalies, inequalities and inconsistencies' that occur in cases relating to end of life decisions such as the allowance of double effect cases and acts of omission cases arise from the focus of the criminal law being on intention and causation alone.[210] The better approach is to ensure common law defences specifically for medical practitioners thereby incorporating the very essence of the distinctions required being consent and assistance. This approach would also remove uncertainty, replace the label of murder with lawful medical homicide and more generally ensure that the proper underlying principles attach to the legal exception.[211] These amendments though they may be initially ordered by a court would ideally be provided for in an Act of parliament that would define the exceptions to the law relating to murder and homicide.

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[205] Supra n68 discussed above under heading 2.6.2.
[206] These elements are set out under heading 2.6.
[207] As in Colombia as authorised by *Republic of Colombia Constitutional Court*, Sentence # c-239/97, Ref. Expedient # D-1490, May 20, 1997.
[208] As in the Netherlands before it passed legislation as authorised by *Queen v Ms Geertruida Postma* (District court of Leeuwarden) 1973 Nederlandse Jurisprudentie No. 183.
[209] As in the state of Montana (USA) as authorised by *Baxter v Montana* 2009 MT 449.
[210] G Williams *Intention and Causation in Medical Non-Killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide* (2007) 192.
[211] Ibid 193.

I agree with both lead judges in the two *Stransham-Ford*[212] cases that the most desirable means of amending the law relating to assisted suicide and euthanasia would be by legislation and that the legislature should be urged to settle the complex legal issues by passing widely discussed legislation. But the question then arises as to what the duty of our courts is when faced with a legislature that has made no move to consider such amendment since the publication of the South African Law Commission Report in 1998.[213] These constitutional obligations are discussed in the next chapter but it suffices to say at this point that where the legislature fails, our courts indeed are under a duty to develop the common law to bring it in line with constitutional imperatives.[214] It follows that should an appropriate case come before our courts the common law should be appropriately developed. The challenge is that many applicants wishing to die are terminally ill and a protracted examination of the issues before a court may lead to further applicants dying before an order is handed down as happened to the late Adv Stransham-Ford.

In Canada in the case of *Carter v Canada*[215] that will be discussed in more detail in the next chapter, the Supreme Court of Canada ordered that the offending portions of the Criminal Code be suspended as follows,

> 'The appeal is allowed. We would issue the following declaration, which is suspended for 12 months:
> Section 241(*b*) and s.14 of the *Criminal Code* unjustifiably infringe s.7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.'

Neither s 14[216] of the Canadian Criminal Code which provides that consent to murder is not lawful nor s 241(b)[217] which makes aiding or abetting a person to commit suicide

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[212] Supra n1.
[213] South African Law Commission Report op cit n157.
[214] Such a duty provided for in s 8 and s 39 of the Constitution op cit n43.
[215] *Carter v Canada* 2015 SCC 5 [Supreme Court Appeal] para 147.
[216] Which read: 'No person is entitled to consent to have death inflicted on them, and such consent does not affect the criminal responsibility of any person who inflicts death on the person who gave consent.'
[217] Which read: 'Everyone who (a) counsels a person to commit suicide, or (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.'

a crime, was immediately amended by the order. But the suspension of the order made it possible for the legislature in that jurisdiction to amend these sections to comply with the order of invalidity and to make the penal code constitutionally valid as a result. In South Africa, a similar effect would be achieved if the Constitutional Court ordered a suspension of the finding that the common law relating to murder was unconstitutional, thereby allowing the necessary time for the legislature to pass a regulating statute.

Finally, in that it may cure the poor longevity of potential applicants in such cases, it bears mentioning that in the *Stransham-Ford* Appeal,[218] Wallis J referred to the possibility of a class action whilst discussing the nature of the applicant's approach,

> '[w]hile he obviously recognised as an advocate that any judgment he secured might have some precedential effect, he did not purport to bring the application in the general public interest or as a member of a group or class of persons. Had he done so, different allegations would have needed to be made and it is conceivable that he would have had to cite other potentially interested parties, such as organisations representing the aged, persons suffering from disability, specialist branches of the medical profession and medical aid schemes'.[219]

A legislative intervention would by far be the most desirable and appropriate in a democracy facing such a complex and controversial topic. However, a court may develop the common law or make a declaration of invalidity suspended which may compel the legislature to act. The context within which the South African Constitutional Court may make such an order is discussed in the next chapter.

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[218] Supra n1.
[219] Ibid para 14.

CHAPTER 3
THE CONSTITUTIONAL RIGHT TO DIE WITH DIGNITY

This chapter discusses the impact of the rights-based constitutional framework on South African law and argues that it is imperative that the common law is seen through this new lens. It also locates the underlying values and rights in the democratic constitution as central in determining the direction in which all law must develop and analyses the values of dignity, equality and freedom. Focusing on the value of dignity in the constitution it proceeds to describe the philosophical and historical development of this value from its secular Kantian roots and how it emerged as the Constitution's cornerstone. The right to life is then considered in conjunction with the right to die with dignity. The limitations clause in the South African Constitution[1] is compared with that found in the Canadian Charter of Rights and Freedoms[2] identifying similarities. In this context, the Canadian cases of *Rodriguez*[3] and *Carter*[4] are analysed. The lessons that can be learnt from the Canadian experience, as well as the direction given in the *Stransham-Ford* cases discussed in the previous chapter, are combined to obtain insights as to how the law in South Africa related to physician assisted dying may be developed.

3.1 The imperatives of a rights-based Constitution

The democratic era in South Africa ushered in a constitution that can only be described as a watershed in the country's history. The Constitution is the supreme law of the land and any law inconsistent with it is invalid and all obligations which it imposes

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[1] Constitution of South Africa 1996.
[2] Canadian Charter of Rights and Freedoms, Part 1 of the Constitution Act 1982, being Schedule B to the *Canada Act 1982* (UK), c 11 ['the Canadian Charter'].
[3] *Rodriguez v British Columbia (Attorney General)* [1993] 3 S.C.R. 519 discussed under heading 3.2.2.
[4] *Carter v Canada* 2015 SCC 5 [Supreme Court of Appeal] discussed below under heading 3.2.4.

must be fulfilled.[5] Furthermore, chapter 2 of the Constitution contains an entrenched and justiciable Bill of Rights which 'enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom'.[6]

3.1.1 The supremacy of the Constitution

Section 1(*c*) of the Constitution identifies the '[s]upremacy of the constitution and the rule of law' as a founding value of the constitution.[7] Section 2 of the Constitution provides that law inconsistent with the Constitution is invalid 'and that obligations imposed by it must be fulfilled'. Any law which runs counter to the values and rights in the Constitution (subject to the limitations clause) must be amended or struck down to the extent of its invalidity.[8] Devenish describes the import of this 'supremacy' as an 'epochal break' with constitutionality since the year 1910 (the year in which the Union of South Africa was formed) and argues that it requires a 'paradigmatic shift in jurisprudential theory'.[9]

3.1.2 The effect of the inclusion of underlying values on the Constitution

Section 1(*a*) of the Constitution also proclaims, inter alia, '[h]uman dignity, the achievement of equality and the advancement of human rights and freedoms' as founding values.

Section 7 of the Constitution locates the Bill of Rights as the 'cornerstone of democracy in South Africa' and provides for the rights protected in the Bill of Rights to be subject to a limitation under the so-called 'limitations clause' contained in s 36 or limitations contained elsewhere in the Bill of Rights.

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[5] Section 2 of the Constitution op cit n1.
[6] Ibid s 7(1).
[7] Section 1 reads: 'The Republic of South Africa is one, sovereign, democratic state founded on the following values: (*a*) Human dignity, the achievement of equality and the advancement of human rights and freedoms. (*b*) Non-racialism and non-sexism. (*c*) Supremacy of the constitution and the rule of law. (*d*) Universal adult suffrage, a national common voters roll, regular elections and a multi-party system of democratic government, to ensure accountability, responsiveness and openness.'
[8] Section 36 of the Constitution op cit n1discussed under heading 3.1.6.
[9] GE Devenish *A Commentary on the South African Bill of Rights* (1999) 10. See also Halton Cheadle & Dennis Davis 'Introduction' in Cheadle, Davis & Haysom (eds) *South African Constitutional Law: The Bill of Rights* 1-2.

Section 8 of the Constitution provides inter alia that the Bill of Rights applies to all law and binds the three branches of the state, and in particular that a court 'to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right' and that a court 'may develop rules of the common law to limit the right, provided that the limitation is in accordance with s 36(1)' (the limitations clause).

The inclusion of underlying values directly into the Constitution has the effect of bringing into being an 'objective normative value system' in a similar way to that of the German Basic Law, against which all law is to be tested. This system guides all areas of law in the three branches of state[10] and is mandated by s 39(2)[11] of the Constitution. The common law must be developed in alignment with this objective normative value system.[12] These values underlying the Constitution are its very foundational essence which is premised on universal and underlying morals and norms. Devenish describes this as 'a new political and social morality that finds meaningful expression in a libertarian and egalitarian constitution'.[13]

The Constitution is accordingly the supreme law and is based on the three underlying values of human dignity, equality and freedom with which all law must be consistent.

3.1.3 The values of human dignity, equality and freedom

McCrudden proposes that the realisation of the necessity of a mechanism for incorporating human rights into legal instruments, which occurred after the defeat of Nazism in Germany, was a key influence on and led to the incorporation of the idea of dignity into the German Basic Law and from there into other modern constitutions including that of South Africa.[14]

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[10] BVerfGE 39, 1 - *Schwangerschaftsabbruch* at 41 as cited by Kentridge, AJ in *Du Plessis and Others v De Klerk and Another* 1996 (3) SA 850 (CC) para 94.
[11] Section 39 (2) reads: 'When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.'
[12] *Carmichele v Minister of Safety and Security and Another* 2001 (4) SA 938 (CC) para 54.
[13] Devenish op cit n9 12.
[14] C McCrudden 'Human dignity and judicial interpretation of human rights' (1 September 2008) 19(4) *European Journal of International Law* 655 673.

Rautenbach and du Plessis[15] amplify this point by suggesting that the final South African Constitution 1996, is more similar to its German counterpart than the transitional South African Constitution 1993 and that the explicit references to human dignity are strikingly similar to the German Basic Law.[16]

The concept of human dignity can be traced back to Classical Antiquity where we find the Latin words 'dignitas' and 'dignus' used in Roman and Greek writings by which was meant 'worthiness for honour and esteem'. [17] Later the concept is found in the Christian Bible where it is understood to mean 'made in the image of God' and in reference to man's elevated position over nature according to the Christian worldview.[18] The holy book of Islam, the Qur'an also explicitly refers to human dignity in verse 17:70 which reads:

> 'NOW, INDEED, We have conferred dignity on the children of Adam, and borne them over land and sea, and provided for them sustenance out of the good things of life, and favoured them far above most of Our creation.'[19]

However, there is general agreement amongst scholars that the origin of the modern idea of 'human dignity' which is expressed in the German Basic Law (*Grundgesetz*) and which was transmitted into the South African Constitution found its origin in the ethical philosophy espoused by the Prussian philosopher Immanuel Kant.[20] As Bognetti remarks,

> '[m]ost appropriately, the father of the modern concept of human dignity is considered to be *Kant*, with his theory that man is a morally autonomous being, who as such

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[15] C Rautenbach & L du Plessis 'In the name of comparative constitutional jurisprudence: The consideration of German precedents by South African Constitutional Court judges' (2013) 14(8) *German Law Journal* 1539.

[16] The author is also aware of the direct impact on the South African Constitution made by the late Dr Zola Sidney Skweyiya when the author assisted with research at the University of the Western Cape (Centre for Development Studies) on behalf of the African National Congress (ANC) Constitutional Committee of which Skweyiya was chairperson. The research was made in preparation for the various positions that the ANC would take at the Convention for a Democratic South Africa (CODESA) talks and later negotiations in the early 1990s at the end of apartheid. Skweyiya had obtained his doctoral degree in law at the University of Leipzig in the then German Democratic Republic. He returned to South Africa in 1990, the same year as the German reunification and many of the principles of German constitutionalism found their way into the SA Constitution directly due to his influence.

[17] A Schulman 'Human Dignity and Bioethics' in A Schulman, FD Davis & DC Dennett et al *Bioethics and the question of human dignity: Essays commissioned by the President's Council on Bioethics* (2008) 3.

[18] Ibid.

[19] M Asad *The message of the Qur'an* (2008) 17:70.

[20] As described in his seminal works *Groundwork of the Metaphysic of Morals* (1785*), Critique of Practical Reason* (1788), and *Metaphysics of Morals* (1797) and from which flows the moral

> deserves respect and must never be treated, in general and especially by the law, as only a means to contingent ends but always (also) as an end unto himself'.[21]

It is clear from the earlier South African Constitutional Court cases that the formulation of human dignity is confirmed as cast in the Kantian model:

> 'We are emerging from a period of our history during which the humanity of the majority of the inhabitants of this country was denied. They were treated as not having inherent worth; as objects whose identities could be arbitrarily defined by those in power rather than as persons of infinite worth. In short, they were denied recognition of their inherent dignity.'[22]

Later Constitutional Court cases go further and use the very terminology used by Kant when he is translated to English:

> 'Human beings are not **commodities** to which a **price** can be attached; they are creatures **with inherent and infinite worth**; they ought to be treated as **ends in themselves, never merely as means to an end**. Where the length of a sentence, which has been imposed because of its general deterrent effect on others, bears no relation to the gravity of the offence … the offender is being used essentially as **a means to another end** and the offender's **dignity** assailed.' [23](my emphases)

The terminology used is unmistakably that of Kant. His premise and his profound contribution was the idea that human dignity and the duty to act ethically arose from reason and logic alone and was an entirely secular framing of the idea of human dignity and ethics which generated a clear ethical code which in turn did not require deference to a deity as previous treatments arising from theological perspectives had required. For this reason, it was a well-suited point of departure for a modern secular state to embrace.

'categorical imperatives' described in the three formulae: 1. The formula of the Universal Law: 'Act only in accordance with that maxim through which you can at the same time will that it become a universal law'; 2. The formula of Humanity as an end in itself: 'So act that you use humanity, whether in your own person or that of another, always at the same time as an end, never merely as a means'; 3. The formula of Autonomy: 'Choose only in such a way that the maxims of your choice are also included as universal law in the same volition'. See Wood op cit n26 at page numbered 'xx'.

[21] G Bognetti 'The concept of human dignity in European and U.S. constitutionalism' in G Nolte (ed) *European and US constitutionalism* (Science and Technique of Democracy No. 37) Council of Europe (2005) 75 79.

[22] *Prinsloo v Van der Linde and Another* 1997 (3) SA 1012 (CC) para 31-32.

[23] *S v Dodo* 2001 (3) SA 382 (CC) para 38.

The contribution of Kant to this notion cannot however be stated without also acknowledging the similar concept introduced by Karl Marx albeit that Marx was born almost a century after Kant. Love explains that Marx uses the idea that freedom arises from rational conscious choice exercised through self-determination and argues that this notion of freedom resonates with Kant's sense of autonomy.[24]

In that Kant's treatment purports to derive a principled ethical basis from nothing other than reason and logic, it is well-suited to courts, which when immersed in such contexts, perceive themselves as applying pure reason and logic to a problem within an internally consistent paradigm. Rautenbach and du Plessis contend that purist South African jurists believe in 'principled legal thinking' similar to how the German concept *Begriffsjuriprudenz* operates. This is the idea that law is an internally consistent logical system wherein a legal problem can be solved through deductive reasoning alone within a system of generally accepted norms.[25]

It is of course ironic that Kant himself drew what would today be considered very unsatisfactory conclusions from the application of his ethics. These included that the death penalty is ethical; that sexual intercourse is 'a degradation of humanity'; that the temperament of women and their intellectual endowments make them unsuited to be treated as equal to men in the public sphere; and that there exist four human races being (1) White, (2) 'Yellow Indian', (3) Negro, and (4) 'copper-red American'. These races are ranked in descending order with respect to their innate abilities to perfect human nature (they are however equal in human dignity). Most disturbingly, he thought we can only expect human nature to progress through the White race.[26]

How is it that views such as these are ascribed to the father of the secular idea of human dignity, which is amplified as the very essence of the South African Constitution? The answer is found in the realisation that the original idea of secular inherent human dignity starts with Kant in the early enlightenment and his ideas have grown through that period and thereafter into a form which modern-day liberal-minded people find not merely acceptable but desirable. As Wood eloquently articulates:

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[24] SM Love 'Kant after Marx' (2017) 22(4) *Kantian Review* 579 508.
[25] C Rautenbach & L du Plessis op cit n15 1545.
[26] See AW Wood *Kant's Ethical Thought* (1999) 2.

> ' "Enlightenment", as Kant understood it, is a gradual process through which not only individuals but even an entire public attains maturity and increases self-understanding through critical reflection and open communication. If this is what enlightenment is, then it would speak badly for the Enlightenment if two hundred years later the movement's heirs had not been able to make some important corrections in Kant's own beliefs about morality, society, and politics. It would speak well both for the movement and for Kant's principles if such corrections followed a trajectory marked out by those principles. And in fact, they do. Kant's views about gender and race offend us not merely because we now see them as false (for not all errors of past ages are *morally offensive* to us), but rather because we see them as demeaning to the *human dignity* of women and non-whites.'[27]

We can conclude that the school of thought which underpins the modern South African, German and Canadian Constitutions used a liberalised development of Kantian ethics much more than that the philosopher had ever expressed himself. Ironically, a modern Kantian approach to Kant's initial conclusions results in a familiar and desirable modern approach.

The essential element of his ethics that has remained intact is the idea that all people are worthy of inherent dignity which he concludes by the application of reason must therefore imply that all people have equal dignity and moral autonomy which flows therefrom. It is no doubt this key element of his philosophy that attracted post-Nazi Germany and post-Apartheid South Africa to adopt his approach after their recent and tragic histories.

The South African Constitutional Court confirms its acceptance of the centrality of dignity in its approach. O'Regan J stated in *Makwanyane* (dealing with the unconstitutionality of the death penalty) that recognising and protecting human dignity 'is the touchstone of the new political order' and (quoting Ronald Dworkin) '[b]ecause we honour dignity, we demand democracy'.[28] In the later Constitutional Court judgment of *Dawood v Minister of Home Affairs,* the court held that human dignity not only informs constitutional adjudication but is important in interpreting

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[27] Ibid 4.
[28] *S v Makwanyane and Another* 1995 (3) SA 391 (CC) para 329-330.

other rights and as a value is central in limitations analysis and is itself a justiciable and enforceable right.[29]

Currie and de Waal point out that, as a value dignity 'informs the content of all the concrete rights and plays a role in the balancing process necessary to bring different rights and values into harmony' and its purpose is not merely to protect liberty against the state but also to ensure that the state achieves the goals of both dignity and equality.[30] Haysom goes further and affirms that the Constitution would itself be negated without human dignity as a value. He suggests that repealing or negating this value would destroy the very foundation of the Constitution itself.[31]

3.1.4 The rights which imply a right to die with dignity

3.1.4.1 The right to die with dignity and the right to life

Section 10 of the Constitution asserts a right to dignity[32] and s 11 a right to life.[33] The relationship between these two rights is eloquently described in *Makwanyane* by O'Regan J and is central to this thesis:

> 'The right to life is, in one sense, antecedent to all the other rights in the Constitution. Without life in the sense of existence, it would not be possible to exercise rights or to be the bearer of them. But the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity… . The right to life, thus understood, incorporates the right to dignity. So the rights to human dignity and life are entwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished.'[34]

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[29] *Dawood and Another v Minister of Home Affairs and Others* 2000 (3) SA 936 (CC) para 35.
[30] I Currie & J de Waal *The Bill of rights handbook* 6 ed (2013) 251.
[31] NRL Haysom 'Dignity' in Cheadle, Davis & Haysom op cit n9 para 5.2.1.
[32] Section 10 of the Constitution op cit n1 reads: 'Everyone has inherent dignity and the right to have their dignity respected and protected.'
[33] Section 11 of the Constitution op cit n1 reads: 'Everyone has the right to life.'
[34] Supra n28 para 326-327.

Flowing from this understanding: that the right to life is the right to live as a human being and to share in the full experience of humanity and not merely as the right to existence, makes it clear that the right to life without dignity is not what the Constitution protects. It follows that the Constitution is protecting a certain quality of life from the experience of the living person which includes such a person's experience of a dignified life. The corollary to this view is that should the quality of life of a person be undignified, then the right to life informed by the value of dignity requires that such person be entitled to end their life in a dignified manner. To force a person to die in a manner which that person considers undignified is a contravention of the value and right to dignity of every person and as death is an inexorable component of and consequence of mortal life, the right to life logically incorporates a right to die with dignity.

3.1.4.2 The right to die with dignity and the right to equality

The right to die with dignity may also arise in relation to the Constitutional right to equality.[35] A person who due to illness or other physical incapacity is physically unable to take their own life in circumstances where others without these additional health impediments can do so may argue that their rights are infringed in that they are not being treated equally to a person physically able to take their own life. In *Carter v Canada* the Canadian Supreme Court referring to the judge in the court a quo demonstrated how a court reasons along these lines:

> 'She first asked whether the prohibition violated the s. 15 equality guarantee. She found that the provisions imposed a disproportionate burden on persons with physical disabilities, as only they are restricted to self-imposed starvation and dehydration in order to take their own lives (para. 1076). This distinction, she found, is discriminatory and not justified under s. 1.'[36]

However, the Supreme Court of Canada did not pronounce on this question in its judgment as the appeal was granted on other grounds and accordingly it did not have to engage further with this issue directly.

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[35] Section 9(1) of the Constitution op cit n1 provides: 'Everyone is equal before the law and has the right to equal protection and benefit of the law.'
[36] *Carter v Canada* supra n4 para 29; discussed under heading 3.2.4.

3.1.4.3 The right to die with dignity and the right to freedom and security

It may be postulated that the right to die with dignity arises from the s 12 right to freedom and security of the person[37] in that nobody including the state may impinge on the personal security arising out of decision-making over one's body and the psychological stress of not having the option of assisted suicide. In *Carter,*[38] the Canadian Supreme Court, referring to the trial judge showed how a court might reason concerning the s 7 Charter rights to 'life, liberty and security of the person'.[39] They held that the judge below had found that the prohibition on physician assistance impacted all three of the protected interests and that the patient's rights included non-interference with fundamental, personal and important medical decision-making. The Supreme Court noted that the trial judge had concluded that 'Ms. Taylor's right to life was engaged insofar as the prohibition might force her to take her life earlier than she otherwise would if she had access to a physician-assisted death'.[40]

It is important to note that s 7 of the Canadian Charter[41] rights differ from s 12[42] of the South African Bill of Rights which provides for '[f]reedom and security of the person' (which includes security in and control over their body). Despite the difference in the wording of the rights, they are sufficiently analogous to show how a court might approach the issue.

In art.12 of the Colombian Constitution, the analogous right protects against 'cruel, inhuman, or degrading treatment'[43] and this right was the basis upon which a

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[37] Section 12 of the Constitution op cit n1 reads: '(1) Everyone has the right to freedom and security of the person, which includes the right— (*a*) not to be deprived of freedom arbitrarily or without just cause; (*b*) not to be detained without trial; (*c*) to be free from all forms of violence from either public or private sources; (*d*) not to be tortured in any way; and (*e*) not to be treated or punished in a cruel, inhuman or degrading way.
(2) Everyone has the right to bodily and psychological integrity, which includes the right— (*a*) 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.'
[38] Supra n4, discussed under heading 3.2.4.
[39] Section 7 of the Canadian Charter op cit n2 provides: '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.'
[40] Supra n4 30.
[41] Canadian Charter op cit n2.
[42] See s 12 provisions quoted in n37.
[43] See art.12 provisions quoted in n46.

person forced by the criminalisation of assistance in dying to continue to live in an undignified manner was found to be unconstitutional.[44]

3.1.5 Constitutional litigation and the right to die with dignity

To succeed based on a 'right to die with dignity' principle through constitutional litigation in South Africa, it is necessary to demonstrate that the limitation brought about by law which makes assisted suicide unlawful is not reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom as required by s 36 of the South African Constitution. This in turn requires the application of a proportionality test on the rights limited as against the law which is sought to be impugned.

Before proceeding to analyse how our limitations clause may be applied to the right to die with dignity principle it is important to recognise that only three countries have ever had the right recognised through the process of constitutional litigation, these being Canada, Colombia and Germany.[45] The Canadian jurisprudence is dealt with in some detail below. The approach taken by the Colombian court shows strong similarities to that of Canada. In particular, the Colombian Constitutional Court found in 1997 that:

> 'The fundamental right to dignity implies, then, the right to die with dignity, since to condemn a person to continue living for a short period of time, when he is not willing to and while suffering deeply is equivalent not only to a cruel and inhuman treatment, prohibited by the Constitution (CP Art.12)[46] but also to an annulment of his dignity and autonomy as a moral subject. The person would be reduced to an instrument of preserving life as an abstract value.'[47]

The result was that the court found that the portion of the Criminal Code which criminalised euthanasia was unconstitutional as it did not make exceptions that would take into account the human dignity of the patient. Accordingly, a medical doctor did

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[44] See further discussion hereof under heading 3.1.5.
[45] The American States of Montana in 2009 and New Mexico in 2014 also recognised this right based on their state constitutions.
[46] Article 12 of the Colombian Constitution 1991 provides as follows: 'No one will be subjected to forced sequestration, torture, cruel, inhuman, or degrading treatment or punishment.'
[47] *Republic of Colombia Constitutional Court, Sentence* # c-239/97, Ref. Expedient # D-1490, May 20, 1997. The right was granted subject to the Colombian Congress confirming the practice guidelines.

not commit an offence if the doctor knowing the medical circumstances of the patient believed euthanasia to be appropriate provided there was informed consent of such patient.

3.1.6 Limitations clauses and proportionality tests

3.1.6.1 The South African proportionality test

Section 36 of the South African Constitution provides for a 'limitations clause'.[48] This clause has application whenever a right that is protected in the Bill of Rights is in some manner limited in any way by law. It prescribes the mechanism by which such limitation is to be tested to qualify as a reasonable and justifiable limitation on the right. If it fails the test the right may not be so limited. There is general agreement that the essence of a limitations clause is a proportionality test of the cost of limiting the right versus the benefit gained from the law resulting in such limitation of the right or as phrased in the parlance of Canadian Constitutional jurisprudence as 'balancing salutary and deleterious effects of the legislation'.[49] Rautenbach explains that proportionality requires a 'due relation' in measuring the 'harm imposed' against the 'benefit achieved'. Exactly what kind of relationship is required is unclear from the meaning of 'proportionality' but we can conclude that there must be a link between the limitation and the purpose and that this must be demonstrable in an accountable culture which requires that if people are to be harmed by the reduction of their rights that those responsible must at minimum show 'plausible reasons'.[50]

In South Africa, the *Makwanyane*[51] judgment (that declared the death penalty unconstitutional) was handed down in June 1995 and dramatically influenced the

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[48] Section 36 reads: '(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including— (*a*) the nature of the right; (*b*) the importance of the purpose of the limitation; (*c*) the nature and extent of the limitation; (*d*) the relation between the limitation and its purpose; and (*e*) less restrictive means to achieve the purpose. (2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.'
[49] *Carter v Canada* [2012] BCSC 886 [the Trial Court] para 936, discussed under heading 3.2.4.
[50] IM Rautenbach 'Proportionality and the limitation clauses of the South African Bill of Rights' (2014) 7(1) *Potchefstroom Electronic Law Journal* 2229 2233 available at http://'dx.doi.org/10.4314/pelj.v17i6.01 (accessed 13 December 2021).
[51] Supra n28.

'final Constitution' (which is the present Constitution, duly amended).[52] At that time, the court had to interpret the so-called 'interim Constitution'[53] then in effect and in particular s 33 which contained its limitations clause.[54] Justice Chaskalson held that in applying that limitations clause,

> 'in the balancing process, the relevant considerations will include the nature of the right that is limited, and its importance to an open and democratic society based on freedom and equality; the purpose for which the right is limited and the importance of that purpose to such a society; the extent of the limitation, its efficacy, and particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question'.[55]

Though the wording of the factors to be considered in s 36 of the final Constitution appear to draw heavily on the wording used in *Makwanyane,*[56] that judgment draws in turn heavily on the Canadian jurisprudence and in particular on *R v Oakes.*[57] However, despite the wording of s 36[58] which clearly sets out the factors to be applied, the Constitutional Court fails to apply them rigorously and instead opts for a globular value analysis approach. This globular approach has been widely criticised (the views of some critics are discussed below) in that it fails to apply a rigorous analytical process to the limitations analysis. Instead, it replaces the rigour with conclusions loosely based on ill-defined values. As such it allows each case to be decided without reference to precedent and fails to develop an ever-evolving understanding of the content of rights and how they compare with each other.

Boggenpoel and Draga et al identify four key analytical problems relating to the all-at-once approach:

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[52] Op cit n1.
[53] Act 200 of 1993, the 'interim Constitution'.
[54] Section 33 of the interim Constitution ibid read: '(1) The rights entrenched in this Chapter may be limited by law of general application, provided that such limitation- (*a*) shall be permissible only to the extent that it is-(i) reasonable; and (ii) justifiable in an open and democratic society based on freedom and equality; and (*b*) shall not negate the essential content of the right in question, and provided further that any limitation to- (*aa*) a right entrenched in section 10, 11, 12, 14 (1), 21, 25 or 30 (1) (*d*) or (*e*) or (2); or (*bb*) a right entrenched in section 15, 16, 17, 18, 23 or 24, in so far as such right relates to free and fair political activity, shall, in addition to being reasonable as required in paragraph (a) (i), also be necessary.'
[55] Supra n28 para 104.
[56] Ibid.
[57] *R v Oakes* [1986] 1 S.C.R 103 see paras 68-71; see also H Cheadle 'Limitation of rights' in Cheadle, Davis & Haysom op cit n9 30-12.
[58] Of the final Constitution op cit n1, see s 36 quoted in n48.

> 'First, the all-at-once approach is illogical. A limiting measure that does not serve a legitimate purpose or does not achieve that purpose can never satisfy the requirement of proportionality. Second, and related to this, the all-at-once approach makes extra work for a court. Once a court has found that a limiting measure does not serve a legitimate purpose or does not achieve that purpose, it is not necessary to go further and the limitation analysis can be terminated. Third, the all-at-once approach is less analytically sound. Questions that are initially addressed separately are often lumped together and resolved using the all-inclusive language of balancing and proportionality, glossing over the nuances of the decision-making process. Fourth, the all-at-once approach reduces precedential value by making the balance struck too case-specific.'[59]

Woolman contends that this approach which he refers to as public reasoning leads to a lack of analytical rigour. He argues that such analysis results in serious negative consequences in that there is no direct application of the Bill of Rights but rather a vague application of the three badly defined values of dignity, equality and freedom.[60] The Constitutional Court also relies heavily on s 39(2) of the Constitution[61] when called upon to determine the constitutionality of existing law using the vague concepts of 'spirit, purport and objects' contained therein. The effect of this approach is to fail to give meaningful content and relative weight to the specific rights being dealt with. This results in an inability to determine where and why the rule being challenged succeeds or fails and impossible to predict the outcome of future challenges. This results in a Bill of Rights 'increasingly denuded of meaning'.[62]

3.1.6.2 The Canadian proportionality test

The Canadian Charter of Rights and Freedoms[63] also provides for a limitations clause in s 1.[64] Canadian jurists describe it as the 'reasonable limits' clause. There are

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[59] Z Boggenpoel, L Draga et al 'The Bill of Rights and the enforcement of the Constitution' in P de Vos & W Freedman (eds) *South African Constitutional Law in Context* (2020) 553.
[60] S Woolman 'The amazing vanishing Bill of Rights' (2007) 124(4) *South African Law Journal* 762 762.
[61] See text of s 39(2) at n11.
[62] Woolman op cit n60 at 763.
[63] Op cit n2.
[64] Section 1 reads: 'The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.'

therefore significant similarities between the constitutional mechanisms used by the Supreme Court of Canada and the South African Constitutional Court. Both use instruments that protect human rights and both resolve tensions between the law that appear to limit those rights by application of a limitations clause whereby the costs and benefits of the limitation of a right are to be balanced in the determination of whether such limitation of the right is justified and should be allowed.

In Canada, judges apply the test as a structured, sequence of enquiries as opposed to South African judges who fail to follow the structured sequence contained in s 36(1) based on *Oakes* and instead subject the limitation analysis to a loose value-based approach. Jackson describes Canada's structured sequenced approach as having three key characteristics. First, it places the burden of justification on the government; secondly, it tests if the challenged act is indeed authorised by law and if so whether the government purpose is of sufficient importance. Only once these questions have been answered in favour of the limiting action does the true proportionality test follow. Thirdly, the true 'proportionality as such' test is performed where the court reconsiders the right being infringed and the government purpose both in their theoretical gravity and relative weight.[65]

3.2 The Canadian case law leading to the decriminalisation of assisted suicide in certain circumstances

The Canadian method of analysis used to determine whether a legal limitation on a Charter right is saved by s 1 of the Charter of Rights and Freedoms[66] began development by the Canadian Supreme Court in 1985 in *R v Big M Drug Mart.*[67] The method developed thereafter into what is known to this day as the '*Oakes* test', so-named after the accused in a subsequent Supreme Court of Canada case *R v Oakes.*[68] Cases heard thereafter have further developed the limitation's jurisprudence.[69] The

[65] VC Jackson 'Constitutional law in an age of proportionality' (2015) 124(8) *Yale Law Journal* 3094 3100.
[66] Op cit n2.
[67] *R v Big M Drug Mart* [1985] 1 S.C.R. 295.
[68] Supra n57.
[69] See discussion under heading 3.2.3.

discussion below begins with setting out the context and development of the '*Oakes'* test followed by a discussion of the cases dealing with physician assisted dying.

3.2.1 The development of limitations analysis

The Supreme Court of Canada had for the first time an opportunity to develop a limitations analysis jurisprudence in the case of *R v Big M Drug Mart Ltd.*[70] The company had charges brought against it arising from alleged contravention of the *Lords Day Ac*t[71] which prohibited the sale of goods on a Sunday. The trial court had acquitted the accused on all charges, and the Appeal Court had also dismissed the appeal against the trial court verdict. The constitutional question before the Supreme Court of Canada was whether the *Lord's Day Act*[72] infringed the right to freedom of conscience and religion protected in s 2[73] of the Charter and if so whether it could be found a justified infringement based on s 1[74] of the Charter.

The court developed a three-part test and pointed out that it would need to: first, determine which government interests and policy considerations would be recognised as sufficiently important to qualify as a justifiable reason for the limitation of a Constitutional right; and secondly, engage in a proportional consideration relating to the importance of the right and the reason for its limitation; and thirdly, determine whether the means sought would lead to the limitation of the right as little as possible.[75]

In the case of *R v Oakes*,[76] the accused was approached by police and searched outside a pub. He was found to be in possession of 8g of hashish oil (the street value of which was estimated at C$150) as well as having on him C$600 in cash. He was charged under s 8 of the then Narcotic Control Act, the relevant portion of which provided that,

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[70] Supra n67.
[71] Lord's Day Act, R.S.C. 1970, c. L-13, s. 4.
[72] Ibid.
[73] Section 2(*a*) of the Charter op cit n2 reads: 'Everyone has the following fundamental freedoms: (*a*) freedom of conscience and religion.'
…
[74] See text of s 1 at n64.
[75] Supra n67 para 139.
[76] *S*upra n57.

> 'if the court finds that the accused was in possession of the narcotic … he shall be given an opportunity of establishing that he was not in possession of the narcotic for the purpose of trafficking if the accused fails to establish that he was not in … possession of the narcotic for the purpose of trafficking, he shall be convicted of the offence as charged …'.[77]

This was a reverse onus provision in that it shifted the onus onto the accused to prove that he was not trafficking. The accused contended that this was in contravention of s 11(*d*) of the Charter.[78]

The court noted that the Charter rights are not entirely inviolable but may be limited under certain conditions provided for in s 1 thereof. However, the criteria to limit constitutionally guaranteed rights imposed a stringent standard of justification.[79]

The judge then set out the test in some detail. The *Oakes* test is commonly formulated as follows:

1. There must be a pressing and substantial objective
2. The means must be proportional
   - 2.1 The means must be rationally connected to the objective
   - 2.2 There must be minimal impairment of rights
   - 2.3 There must be proportionality between the infringement and objective.

3.2.2 The first Canadian right to die with dignity case

In the case of *Rodriguez v British Columbia (AG)*,[80] the sole appellant in this challenge was Sue Rodriguez who suffered from the disease amyotrophic lateral sclerosis more commonly known as Lou Gehrig's disease. She was expected to live no longer than 14 months but almost certainly much less. She would lose her physical abilities progressively including the ability to swallow, to speak and later to walk or move in any way. Ultimately, she would be confined to her deathbed. In the meantime,

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[77] Narcotic Control Act, R.S.C. 1970, c. N-1 (Canada).
[78] Section 11(*d*) of the Charter op cit n2 reads: 'Any persons charged with an offence has the right …
(*d*) to be presumed innocent until proven guilty according to law in a fair and public hearing by an independent and impartial tribunal.'
[79] *S*upra n57 paras 65-66.
[80] Supra n3.

however, she wished to continue to enjoy her life until at some time there would be no further enjoyment to be had. Accordingly, she expected that at some stage in this process she would want to take her own life but she feared that at that stage she would no longer be able to do so physically without assistance. She accordingly wished to procure the assistance of a professional physician to assist her in setting up the technological means by which she would be able to accomplish that result at some point in the future after she had decided that the time was right for her.

Section 241 of the Canadian Criminal Code then applicable, stood in her way as it prohibited anyone from counselling a person to commit suicide, or aiding or abetting a person to commit suicide, whether suicide ensued or not, and thus such person assisting her would be guilty of an indictable offence and liable to imprisonment for a term up to fourteen years.[81] She accordingly sought to impugn s 241 by applying to the Supreme Court of British Columbia for an order that s 241(*b*) of the Criminal Code be declared invalid in that it violated her rights under s 7[82], s 12[83] and s 15(1)[84] of the Canadian Charter.[85] The court refused to grant her application and the British Columbia Court of Appeal confirmed that decision. She then proceeded to appeal to the Supreme Court of Canada. Nine judges heard the appeal with five concurring on the majority judgment delivered by Sopinka J. There were two dissenting judgments by single judges and a third dissenting judgment supported by two judges.

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[81] Section 241 of the Criminal Code at that time read: 'Every one who (*a*) counsels a person to commit suicide, or (*b*) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.'
Read with s 22(3) of the Criminal Code which defines 'counsel' to include 'procure' as well as s 14 which read: '[N]o person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.'
[82] See text of s 7 at n39.
[83] Section 12 reads: **'**Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.'
[84] Section 15(1) reads: 'Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.'
[85] Op cit n2.

3.2.2.1 Summary of the majority judgment per Sopinka J

(La Forest, Gonthier, Jacobucci and Major JJ concurring)

From the wording of this judgment, it is clear that the judge had the benefit of reading at least two of the minority judgments and to a large degree, his judgment is written in the form of a reply to these judgments. In his opening remarks, Sopinka J states that his disagreement with these judgments arises from four key issues. First, to agree with the minority judgments would result in recognising a constitutional right 'beyond that of any country in the Western World'.[86] Secondly, it fails to impose sufficient safeguards as required under Dutch law or as proposed in certain states in the United States of America being Washington and California. Thirdly, that the conditions imposed are vague and possibly even unenforceable in certain respects in particular that there is not even a suggestion that the suicide assistant must be a registered physician and that due to possible resistance by members of the medical profession to assist in such activities that a speciality may arise on similar lines as those of the 'macabre' Dr Kevorkian. Fourthly, that the proposed safeguards are couched as mere guidelines that would leave the choice to individual judges to decide whether to grant or withhold the right to commit assisted suicide.[87]

Sopinka J went on to discuss each of the Charter rights which the applicant claimed she was deprived of by the operation of s 241(*b*) of the Criminal Code.

Examination of s 241(*b*) in light of s 7 of the Charter:

Section 7 reads:

> *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.*

Sopinka J found that the applicant's rights to liberty and security were engaged but that these could not be divorced from the sanctity of life, which was one of the triumvirate of s 7 rights protected and that none of these values prevailed a priori over the others. He proceeded to test whether the infringement on the applicant's rights to

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[86] *Rodriguez* supra n3 582.
[87] Ibid.

her liberty and security of the person fell within the exception provided for in s 7, that is whether such deprivation was in accordance with the principles of fundamental justice.

He found that the preservation of human life was acknowledged as a fundamental value not only in Canada but generally in Western democracies and that the state interest was to protect the weak and vulnerable. Even though the absolutist nature of this protection had shifted over time he concluded it was not in conflict with the state interest. Furthermore, he found third party assistance was morally wrong and abuses impossible to prevent without an absolute prohibition as it was difficult or impossible to otherwise put in place sufficient safeguards for those excepted. Furthermore, were there to be such an exception this could lead to a slippery slope of progressively further exceptions being made, thereby eroding the protections of the vulnerable and the state interest. Sopinka J concluded that absolute prohibition could not be considered unfair or in conflict with the principles of fundamental justice.[88]

Accordingly, it was not necessary to test the prohibition on assisted dying against s 7 rights under the reasonable limits test of s 1.

Examination of s 241(*b*) in light of s 12 of the Charter:

Section 12 reads:

> *Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.*

Sopinka J considered what effect s 241 had on the 'treatment or punishment' of the Applicant. He concluded that the effect of the legislation was (according to the Applicant) to either commit suicide before she would otherwise have chosen to (for fear that if she waited too long she would no longer be physically capable of committing suicide unaided) or to be forced to prolong her life after the moment at which she would have wanted to (it then being too late to commit suicide unaided). He decided that this position could not be considered 'punishment' within the meaning of s 12. To determine if this could be considered a 'cruel and unusual treatment' he examined the nature of acts that have already been established as constituting a 'treatment'. These included lobotomization, castration, deportation, strip searches and

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[88] Ibid 605.

imposed medical care of mentally ill patients. He concluded that what the Applicant was being compelled to endure was not akin to these and that she was accordingly not being subject to a 'treatment' in the sense of the aforesaid but merely subject to the edicts of the Criminal Code not dissimilar to anyone else even though due to her circumstances the impact might be more onerous.[89]

He accordingly found that her s 12 rights were not infringed.

Examination of s 241(*b*) in light of s 15 of the Charter:

Section 15 reads:

> *Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.*

Sopinka J identified questions which he believed arose from the claim but chose not to settle these issues and instead to assume that s 15 was indeed infringed. In doing so it became necessary to test the prohibition against the limitations clause.[90]

He found that there is a 'clearly pressing and substantive legislative objective' that is grounded in the protection of life which in turn is a fundamental Charter right and value. He furthermore found that there is a rational connection between prohibiting assistance in suicide and protecting life. Also, no halfway measure would protect life yet allow for an exception in that there is no way to prevent abuses if exceptions exist. There was a further fear of a slippery slope if an initial exception were to be made for terminally ill persons that could lead to further exceptions over time. Finally, in that most Western democracies appear to agree that the only way to prevent abuse and therefore to protect life was a blanket prohibition on assisted suicide this answered the question of minimal impairment and overbreadth.[91] Accordingly, the prohibition passed the limitations test.[92]

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[89] Ibid 608.
[90] Ibid 612.
[91] This claim was true in 1993 at the time of the judgment but is certainly false today following the adoption of physician assisted dying law in multiple jurisdictions.
[92] Supra n3 612-615.

In summary, the applicant's s 7 rights were found not to be contravened in that the prohibition fell into the exception of being in accordance with natural justice. The s 12 rights were not contravened as the effect of the prohibition was found to be neither a punishment nor a treatment as envisaged by that section. The judge gave the benefit of the doubt to the Applicant and assumed that her s 15 rights were infringed by s 241. Accordingly, this infringement of her rights had to be tested against the s 1 limitations clause to determine if the prohibition survived 'such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society'. The judge considered that it did survive the limitations clause as it was demonstrably justified in a free and democratic society.

Accordingly, it was found that the blanket prohibition of assisted suicide did not contravene the applicant's constitutional rights and the appeal was dismissed.

3.2.2.2 Summary of the minority judgment per La Mer CJ

Examination of s 241(*b*) in light of s 15 of the Charter:

This minority judgment reflected on the s 15 equality right alone and found that the prohibition could not survive the minimal impairment leg of the limitations clause in that the government could not satisfy the constitutional obligation to impair the rights of persons with physical disabilities as little as reasonably possible.[93]

3.2.2.3 Summary of the minority judgment per McLachlin J

(L'Heureux-Dubé J concurring)

Examination s 241(*b*) in light of s 7 of the Charter:

This minority judgment found that the distinction between suicide and assisted suicide is arbitrary. It proceeded to find that the purpose of the s 7 right was to safeguard the security of the person from state interference that includes decisions regarding their body.[94] Because the legislative scheme does not criminalise suicide but does criminalise assistance in suicide this unfairly denies some persons (those who cannot

[93] Ibid 530-580.
[94] Ibid 618.

commit suicide unaided) rights to make decisions regarding their bodies and as such denies them their s 7 rights. This cannot be saved by s 1 as a key principle of fundamental justice is that every person must be treated fairly at law and the legislative scheme is unfair by only limiting the rights of some arbitrarily.[95]

3.2.2.4 Summary of the minority judgment per Cory J

Examination of s 241(*b*) in light of s 7 of the Charter:

Cory J reflected upon the importance of dignity which the Supreme Court of Canada has recognised in its jurisprudence and pointed out how s 7 that grants the right to life, liberty and security of the person emphasises inherent human dignity. He eloquently concluded that,

> '[t]he life of an individual must include dying. Dying is the final act in the drama of life. If, as I believe, dying is an integral part of living, then as a part of life it is entitled to the constitutional protection provided by s. 7. It follows that the right to die with dignity should be as well protected as is any other aspect of the right to life. State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity'.[96]

He concludes that the Applicant should be entitled to end her life with assistance and with the same courage and dignity with which she lived her life.[97]

3.2.3 Developments in limitations analysis between *Rodriguez* and *Carter*

In the intervening twenty-two years between the judgments of *Rodriguez*[98] and *Carter,*[99] the *Oakes* test had been significantly refined. These developments provide some of the reasons for the divergent outcomes in these two cases.

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[95] Ibid 616-629.
[96] Ibid 630.
[97] Ibid.
[98] Supra n3.
[99] Supra n2.

3.2.3.1 Development of the final stage of the *Oakes* test

In the case of *Alberta v Hutterian Brethren of Wilson Colony,*[100] the majority of the Supreme Court endorsed a final stage to the *Oakes* test of balancing the detrimental impact of the restriction on the s 7 rights and the public benefits of the law. Though in the *Carter*[101] case, the law had failed the limitations test before this final leg of the test was reached it is instructive to show how the test had developed in the period between *Rodriguez*[102] and *Carter.*[103] The effect of this judgment was that the final leg of the test now required a balancing of the public benefit against the deleterious effects on the individuals or groups actually affected by the limitation of the right and a deliberate measuring of the degree of that impairment on those affected.[104]

3.2.3.2 Development of the application of 'overbreadth'

In *R v Heywood*[105] the proportionality requirement of the *Oakes* test was developed through 'overbreadth' jurisprudence.

The Supreme Court described 'overbreadth' as applicable when the means that a law imposes is too 'sweeping' in relation to its objective.[106] A court must decide whether the means applied by the law is necessary for the state to achieve its legitimate objective. If the means are determined to be broader than is necessary to achieve the legitimate purpose then the principles of fundamental justice will be violated as some applications of the law will be either arbitrary or disproportionate.[107]

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[100] *Alberta v Hutterain Bretren of Wilson Colony* 2009 SCC 37.
[101] Supra n4.
[102] Supra n3.
[103] Supra n4.
[104] The above discussion is by no means a comprehensive setting out of other developments of the test that falls outside the purview of this discussion, for a more systematic statement on the *Oakes* test development in the first two decades see S Choudry 'So what is the real legacy of *Oakes*? Two decades of proportionality analysis under the Canadian *Charter*'s section 1' (2006) 35(2d) *Supreme Court Law Review* 501, available at http://ssrn.com/abstract=930436 (accessed 14 December 2021).
[105] *R v Heywood* [1994] 3 S.C.R. 761.
[106] Ibid 764.
[107] Ibid.

3.2.3.3 Development of the application of 'gross disproportionality'

In *R v Malmo-Levine*[108] the proportionality requirement of the *Oakes* test was developed through the jurisprudence of 'gross disproportionality'.

The court held that any imposition by the state of legal control is subject to the limitation imposed by the constitutional standard of 'gross disproportionality', that is the state may not impose legislation that results in grossly disproportionate outcomes.[109] In the result, the court confirmed that gross disproportionality was a principle of fundamental justice to be taken into account when applying the s 7 rights.

In *Canada (Attorney General) v PHS Community Services Society,*[110] the 'gross disproportionality' jurisprudence discussed above was confirmed including that gross disproportionality was a principle of fundamental justice to be taken into account whenever s 7 rights are engaged.

3.2.4 The successful Canadian right to die with dignity case

The Supreme Court of Canada decision in *Carter v Canada*[111] ultimately decriminalised assisted suicide in certain limited circumstances and under specific conditions within the borders of Canada. The court of first instance presided over a summary trial in the Supreme Court of British Columbia[112] (the trial court). The decision of the trial court was overturned on appeal to the British Columbia Court of Appeal[113] (the appeal court decision) by two judges concurring and one dissenting. The appeal court decision was again reversed by the Supreme Court[114] of Canada (Supreme Court decision).

There were five plaintiffs.[115] One of the plaintiffs was Ms Gloria Taylor who suffered from a terminal neurodegenerative disease known as amyotrophic lateral

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[108] *R v Malmo-Levine* [2003] 3 R.C.S. 571.
[109] Ibid para 575.
[110] *Canada (Attorney General) v PHS Community Services Society* [2012] 244 CRR (2d) 209.
[111] Supra n4.
[112] Supra n49.
[113] *Carter v Canada (AG)* [2013] BCCA 435 [the Appeal Court].
[114] Supra n4.
[115] The order in which the Plaintiffs are cited in the record differs from the treatment in this analysis.

sclerosis.[116] She wished the court to order that she could legally obtain a physician-assisted death at a time of her choosing, which she expected would be when she could no longer bear to continue to suffer. The disease is known to lead to progressive muscle weakness resulting in paralysis. At first, patients lose their ability to use their limbs and walk and later are unable to speak or swallow and ultimately are unable to breathe.[117] Throughout this process and until death such a patient has full sensation and cognition. Two other plaintiffs were Ms Lee Carter and her husband Mr Hollis Johnson who had helped Ms Kathleen Carter, the mother of Ms Lee Carter to die by assisted death in Switzerland and who wished their legal position under Canadian criminal law clarified such that they need no longer fear prosecution in Canada for their part in assisting at Ms Kathleen Carter's death. A further plaintiff was Dr William Schoichet who was the family physician of Ms Taylor and who confirmed that he would be willing to assist her to commit suicide at the time of her choosing if the court were to order such assistance lawful. The final plaintiff was the British Columbia Civil Liberties Association in respect of its public interest standing.

Similar legislation as in the *Rodriguez*[118] matter prevented Ms Taylor from obtaining assistance being (as the sections then read) s 241 read together with s 22(3) and s 14 of the Canadian Criminal Code.[119] For completeness the following sections of the Criminal Code (as it then read) were also challenged in that together they formed

[116] Also known as Lou Gehrig's disease, the same disease which Sue Rodriguez had suffered from in the *Rodriguez* case discussed above under heading 3.2.2.
[117] Supra n49 para 47.
[118] Supra n3.
[119] The text of ss 241, 22(3) and 14 of the Criminal Code are provided at n81.

the complete matrix of the criminalisation of assisted suicide in Canada: s 21(1)(*b*),[120] s 21(2),[121] ss 22(1) - 22(2),[122] and s 222.[123]

However, unlike in *Rodriguez* where the application was to impugn these sections of the Code in that it violated fundamental rights under s 7, s 12 and s 15(1) of the Canadian Charter,[124] the plaintiffs chose to impugn the relevant sections of the Criminal Code only under s 7 (life, liberty and security of the person) and s 15(1) (equal protection and equal benefit of the law without discrimination) of the Canadian Charter.

3.2.4.1 Based on similar facts, why was the Carter order divergent to Rodriguez?

The trial judge noted that the adjudicative facts in this matter were not distinguishable from *Rodriguez* 'in any meaningful way'.[125] The party in each case that wished to end their lives by assisted suicide suffered from the same terminal illness, both had similar prognoses and feared the process of their death in a manner they both found to be too

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[120] Section 21(1) reads: 'Every one is a party to an offence who
(a) actually commits it;
(b) does or omits to do anything for the purpose of aiding any person to commit it; or
(c) abets any person in committing it.'

[121] Section 21(2) reads: 'Where two or more persons form an intention in common to carry out an unlawful purpose and to assist each other therein and any one of them, in carrying out the common purpose, commits an offence, each of them who knew or ought to have known that the commission of the offence would be a probable consequence of carrying out the common purpose is a party to that offence.'

[122] Section 22(1) reads: 'Where a person counsels another person to be a party to an offence and that other person is afterwards a party to that offence, the person who counselled is a party to that offence, notwithstanding that the offence was committed in a way different from that which was counselled.'

Section 22(2) reads: 'Every one who counsels another person to be a party to an offence is a party to every offence that the other commits in consequence of the counselling that the person who counselled knew or ought to have known was likely to be committed in consequence of the counselling.'

[123] Section 222 reads: '(1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.
(2) Homicide is culpable or not culpable.
(3) Homicide that is not culpable is not an offence.
(4) Culpable homicide is murder or manslaughter or infanticide.
(5) A person commits culpable homicide when he causes the death of a human being,
(*a*) by means of an unlawful act;
(*b*) by criminal negligence;
(*c*) by causing that human being, by threats or fear of violence or by deception, to do anything that causes his death; or
(*d*) by wilfully frightening that human being, in the case of a child or sick person.
(6) Notwithstanding anything in this section, a person does not commit homicide within the meaning of this Act by reason only that he causes the death of a human being by procuring, by false evidence, the conviction and death of that human being by sentence of the law.'

[124] Op cit n2.

[125] Supra n49 para 941.

horrific to contemplate. Furthermore, both were of the view that being prohibited by criminal provisions from obtaining assisted suicide violated their fundamental Charter rights. In light of these similarities, one might rightly ask how the opposite finding to the *Rodriguez* case was achieved in the *Carter* trial court as well as ultimately upheld in the Supreme Court of Canada.

The answer lies in the many differences between the cases which are not related to the adjudicative facts and which are discussed below.

3.2.4.1.1 The legislative and social facts are different

A period of nineteen years had passed from the Supreme Court decision in *Rodriguez* until the trial court judgment in *Carter* and a further three years until the Supreme Court handed down its decision. In this intervening period which exceeded two decades, the trial judge noted that dramatic shifts in the legislative and social facts had taken place resulting in a record of experience in jurisdictions that had allowed a more permissive assisted suicide regime. Also, in this intervening period, both public opinion and medical ethics had shifted dramatically.[126]

The fear of abuse and the view that it was impossible to ensure sufficient safeguards had effectively been countered by the practical experiences of other jurisdictions. Such fears were foremost in the minds of the *Rodriguez* judges.[127] The same fear is evidenced and used in support of the reasoning of Sopinka J as to why the limitation of s 15 equality rights are saved by the s 1 limitations clause.[128] By the time *Carter* was heard the international experience proved otherwise, that is that it did not appear to be the case that abuse was evident and that the safeguards appeared sufficient to protect the weak and vulnerable.[129]

A presumption operated in the minds of the *Rodriguez* court judges at both of the following key points in the constitutional analysis: First, the determination of whether s 7 rights were limited in accordance with the principles of fundamental justice, and secondly, whether s 15 rights which were limited were saved on a s 1

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[126] Ibid para 942.
[127] Supra n3 608.
[128] Ibid 613.
[129] Supra n49 paras 944-945.

analysis in that there were no other less minimal means available and that accordingly the limitation complied with the requirements of proportionality. This presumption was that to achieve the goals of protection of the vulnerable nothing less than a blanket ban on assisted suicide was necessary to ensure that no 'slippery slope' developed that would place the vulnerable at risk of abuse. By the time of *Carter,* this presumption had been demonstrably proven untrue in multiple jurisdictions.

3.2.4.1.2 Distinctly new legal approaches are evident in the s 7 challenge

In *Rodriguez,* the elements of the s 7 rights which were considered were that of liberty and security of the person and not the right to life directly. Though the majority judgment made it clear that the right to life is a value to be taken into account when determining a possible infringement of s 7 it deals with the right to life in a manner that militates against a right to die.

In determining a possible infringement of s 7 it is clear that only liberty and security of the person was considered in the analysis of Sopinka J and not the right to life itself.[130] Judge Sopinka only refers to the sanctity of life as a Charter value[131] but not to the plaintiff's deprivation of her right to life. Furthermore, according to Sopinka J the sanctity of life value militated against the claim of the plaintiff as is evident in the following statement:

> 'Even when death appears imminent, seeking to control the manner and timing of one's death constitutes a conscious choice of death over life. It follows that life as a value is engaged even in the case of the terminally ill who seek to choose death over life.'[132]

In contrast to the above, in *Carter,* the plaintiffs placed the right to life centrally in their approach. They argued that the legislation which prevented assisted suicide infringed on the right to life by causing Gloria Taylor to commit suicide earlier than she otherwise would have chosen. This was to ensure that she did so before she became

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[130] Supra n3 583.
[131] Ibid 584 where Sopinka J makes the following remark, '[t]he appellant seeks a remedy which would assure her some control over the time and manner of her death. While she supports her claim on the ground that her liberty and security of the person interests are engaged, a consideration of these interests cannot be divorced from the sanctity of life, which is one of the three Charter values protected by s. 7'.
[132] Ibid 585.

physically incapable of doing so without assistance. Had she been lawfully able to call on assistance in her suicide after becoming physically incapable of committing suicide unassisted, she would delay that decision to a much later date. From this approach, it is clear that her right to life is directly limited by the legislation and not merely tangentially in respect of her liberty and security interests and unlike in *Rodríguez* her right to life does not run counter to her right to die.[133]

A further distinction in approach arises from the two plaintiffs Lee Carter and Hollis Johnson. Their interests under s 7 were quite distinct from that of Sue Rodriguez or Gloria Taylor in that their interests in liberty and security of the person arose from the possibility of arrest and conviction with the possibility of incarceration for their assistance in the death of Kathleen Carter. The analysis undertaken in *Rodriguez* would accordingly be insufficient to deal with their possible right deprivations.[134]

A broader all-encompassing analysis of the s 7 rights deprivations was accordingly required to determine the *Carter* findings.

3.2.4.1.3 Developments in Canadian Constitutional jurisprudence

As discussed above, the cases that were decided after *Rodriguez* but before *Carter* significantly affected the jurisprudential approaches and the tests for constitutionality which had first originated in the *Oakes* test. *Alberta v Hutterian Brethren of Wilson Colony*[135] developed the jurisprudence to take into account a further leg to the *Oakes* Test;[136] *R v Heywood*[137] introduced and incorporated a new principle of fundamental justice namely 'overbreadth' of law which limited any s 7 right, and the judgments in *R v Malmo-Levine*[138] as well as *PHS Community Services Society*[139] similarly introduced and incorporated a further new principle of fundamental justice being that of 'gross disproportionality'.

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[133] Supra n49 para 1322.
[134] Ibid para 1002.
[135] Supra n100 37.
[136] This leg of the test did form part of the original *Oakes* test but appeared to not have been applied in later case law until this case refocused attention on this leg of the test.
[137] Supra n105 761.
[138] Supra n108 571.
[139] Supra n110 209.

3.2.4.1.4 Developments in ethics

In *Rodriguez*, Sopinka J found a clear legal distinction between the then acceptable double effect end of life practice and what he considered the criminal act of assisted suicide. For him, the intention of the physician to assist in the suicide of a patient was sufficient to distinguish that act as criminal as opposed to the physician who assisted with pain relief despite the foreseeability of death as a secondary consequence. Whether there was an ethical distinction to be found between these two sets of facts was not considered in his judgment.[140]

By contrast, the *Carter* trial court after hearing the position of multiple ethicists could not find any ethical distinction between the existing end of life practices such as the doctrine of double effect and physician assisted suicide. Smith J held that in the circumstances before her the distinction vanishes where the patient's decision to commit suicide is rational, autonomous, in the best interests of the patient, and the request for assistance is properly informed. She concludes that in these circumstances the physician is merely providing the means for the patient to do something which itself is entirely ethically permissible.[141]

3.2.4.2 The unanimous judgment of the Supreme Court of Canada in *Carter v Canada (Attorney General)*

> (McLachlin C.J. and LeBel, Abella, Rothstein, Cromwell, Moldaver, Karakatsanis, Wagner and Gascon JJ., all concurring)

3.2.4.2.1 The context and the *stare decisis* doctrine

This unanimous judgment agreed in most material respects with the trial court and overturned the appeal court's decision. The trial court had found that sections of the Criminal Code resulted in a blanket ban of assisted suicide which limited Ms Gloria Taylor's rights to life, liberty and security of her person and which did so in a manner that was not in accordance with the principles of fundamental justice in that the

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[140] Supra n3 607.
[141] Supra n49 paras 336-339.

prohibition was overbroad and grossly disproportionate. Furthermore, that such limitation of her s 7 rights was not saved by s 1 in that the prohibition was not minimally impairing in that a carefully crafted regime could allow for exceptions to the blanket prohibition whilst continuing to prevent abuse.

The trial court found Ms Gloria Taylor's s 15 equality rights unconstitutionally limited in that it could not be demonstrably shown that an absolute prohibition on assisted suicide was necessary to protect the weak and vulnerable whereas an almost-absolute prohibition would also protect the persons intended without discriminating against those who are grievously and irremediably ill and competent adult persons who are fully informed, non-ambivalent, and free from coercion or duress. As such Ms Taylor's equality rights were not minimally limited.

The appeal court made various findings including that the trial court was not entitled to revisit the issue of assisted dying in that the *Rodriguez*[142] case had settled this question and as such the principle of stare decisis did not leave the matter open unless it came before the Supreme Court of Appeal once again. Accordingly, the Appeal Court overturned the trial court decision.

The Supreme Court held however that a lower court judge was entitled to revisit a matter previously settled by a higher court in either of two situations being either, 'where a new legal issue is raised' or 'where there is a change in the circumstances or evidence that fundamentally shifts the parameters of the debate …'. The court concluded that both of these conditions had been met.[143]

The Supreme Court went on to point out that there were significant changes in the legal approach to s 7 since *Rodriguez*[144] was decided and there was new evidence supporting the claim that the risk of abuse arising out of legalising assisted suicide could be effectively limited.[145] The Court emphasised how this case approached s 7 from a different conceptual point of view and that the fundamental principles of

[142] Supra n3.
[143] Supra n4 para 44.
[144] Supra n3.
[145] Supra n4 para 45.

overbreadth and gross disproportionality had advanced since *Rodriguez*[146] was decided.[147]

The Supreme Court noted that the 'matrix of legislative and social facts' in the case before them differed from that which was before the *Rodriguez*[148] court in that first, there was at that stage general acceptance of a clear moral distinction between active and passive euthanasia; secondly, the generally held view that it was impossible to find a 'halfway measure' which would ensure that the vulnerable would be protected; and, thirdly that there was at that time 'substantial consensus' in Western countries that the only way to prevent a slippery slope was to maintain a complete prohibition on assisted death.[149]

However, the Supreme Court disagreed with the trial judge's conclusion that the changes to proportionality jurisprudence arising from *Hutterian Brethren*[150] were enough to revisit the s 15 equality claim, they did find that on the whole however the 'fundamental change in facts' allowed her to also reconsider that claim.[151] The court then turned its attention to the constitutionality analysis.

3.2.4.2.2 Examination of s 241(*b*) in light of s 7 of the Charter

Unlike the decision in *Rodriguez,*[152] the Supreme Court confirmed that Ms Taylor's right to life was engaged in that the Criminal Code had the effect of forcing her to take her life prematurely for fear that she would not be able to do so later if she delayed her decision beyond the point that she could no longer physically do so unaided. Accordingly, it follows that under this formulation, the Code would deprive her directly of life.

The court paused to point out that in respect of the quality of life and the right to die debate that the life interest (in the right to life, liberty and security) extends beyond mere physical existence but to how a person values their own lived experience.

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[146] Supra n3.
[147] Supra n4 para 46.
[148] Supra n3.
[149] Supra n4 para 47.
[150] Supra n100.
[151] Supra n4 para 48.
[152] Supra n3.

It is personal to each individual at which point for them their life becomes valueless. However, they rejected the 'quality of life' approach and agreed with the trial court that the right to life was a 'right not to die' and did not involve issues of the quality of life. Such issues relating to autonomy and quality of life are treated in the case law as liberty and security interests and the Supreme Court found no reason to change this approach.[153]

The Supreme Court agreed with the trial judge that the prohibition on assisted dying limited Ms Taylor's rights to liberty and security of the person in that it interfered with her 'fundamentally important and personal decision-making'. This limited her control of her body and caused her pain and psychological stress.[154] It also agreed that an 'individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy'. Further, it pointed out that people in such situations were able to request 'palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment' but that they were unable to legally request physician assisted dying. In that this denial interferes with their ability to make decisions concerning their bodily integrity and their medical care, this impacts on their liberty and security of the person interests.[155]

Having found that certain provisions of the Criminal Code impinge on interests protected by s 7 of the Charter the Supreme Court turned its attention to whether such deprivation was in accordance with principles of fundamental justice.

The court pointed out that there was no closed list of these principles but that over time the Supreme Court had attempted to define the minimum constitutional requirements with which a law that impinges on any s 7 interest must comply. The key requirements are that such a law must not be arbitrary, or overbroad, or that the consequences of the law not be grossly disproportionate.[156]

The court noted that these requirements must be compared to the object of the law in question. They pointed out that the trial court had relied on *Rodriguez*[157] to conclude that the object in the present matter was to protect vulnerable people from

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[153] Supra n4 paras 60-62.
[154] Ibid para 65.
[155] Ibid para 66.
[156] Ibid para 77.
[157] Supra n3.

being induced to commit suicide at a time of weakness. They agreed with this formulation despite Canada having argued that they believed the object is simply 'the preservation of life' but the court was of the view that such a formulation would be to state the object too broadly.[158]

The court then drew specific attention to the fact that at this stage of the analysis societal interests should not be taken into account (as Judge Sopinka appears to have done in *Rodriguez*)[159] and that such interests were properly to be considered under the s 1 proportionality test.

The court held that the objective of protecting weak people when they were vulnerable was indeed served by the blanket ban on assisted suicide and therefore the limitation could not be said to be arbitrary. The court explained that the overbreadth enquiry was whether the law through attempting to achieve its object, results in limiting the rights of certain people in ways that do not relate to the objective. In this enquiry, the focus is on those whose interests are directly and negatively affected by the law and not on the broader social impacts.[160]

The court concluded that the complete prohibition on assisted dying was overbroad in that it caught people like Ms Taylor who was, 'competent, fully-informed, and free from coercion or duress'. The limitation of rights suffered by persons in her position was not connected to the protection of the vulnerable and accordingly the blanket prohibition 'sweeps conduct into its ambit that is unrelated to the law's objective'.[161]

The court defined the gross disproportionality test as determining, 'if the impact of the restriction on the individual's life, liberty or security of the person is grossly disproportionate to the object of the measure'.[162] The court found it unnecessary to make a ruling in this regard as the law had already been found to be overbroad.

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[158] Supra n4 para 75.
[159] Supra n3.
[160] Supra n4 para 85.
[161] Ibid para 86.
[162] Ibid para 89.

3.2.4.2.3 The limitations analysis

The Supreme Court had found that the limitation of Ms Taylor's s 7 rights was not limited in accordance with the principle of fundamental justice in that it was overbroad. As a result, it became necessary to determine whether such limitation of her rights was saved by s 1. This required Canada to demonstrate that the law had a pressing and substantial object and that the means used to achieve that objective were proportional. Such law would be proportionate if it could be shown that,

> '(1) the means adopted [were] rationally connected to that objective; (2) it … minimally [impaired] … the right in question; and (3) there [was] proportionality between the deleterious and salutary effects of the law'. [163]

The court pointed out that it will not be easy to justify a law under s 1 which has been found to be inherently flawed in that it is not in accordance with the principles of fundamental justice but, that it is not impossible to do so as s 1 takes into account the public good which does not feature in the s 7 analysis. Furthermore, the public good being the protection of the lives of the vulnerable is itself a Charter protected right, the right to life.

The Supreme Court held that the rational connection test requires that it be shown that based on reason and logic there is a rational connection between the blanket ban on physician assisted suicide and the protection of vulnerable people from being induced to take their own lives. It concluded that allowing assisted suicide posed certain risks to the vulnerable and as such, there was a rational connection between the prohibition and its objective.

The court held that the government had a duty to show that there did not exist a less-harmful way to achieve its objective. This was to ensure that the deprivation of rights is limited only to what is reasonably required to achieve the goal.

In light of the drastic effect that the blanket prohibition has on the s 7 rights of persons in Ms Taylor's position, the enquiry was whether there was any alternative manner in which the vulnerable could remain protected which is less restricting of those rights or whether Canada was correct that the risks to the vulnerable cannot be sufficiently limited by the use of any appropriate safeguards. To make this

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[163] Ibid para 94.

determination, the Supreme Court noted that the trial court had heard evidence from scientists, medical practitioners, and extensive evidence from other jurisdictions where physician assisted dying is allowed.[164] The trial judge had expressly rejected the argument that a blanket ban was a necessity. Instead, she concluded that a permissive regime could protect the vulnerable and weak provided a carefully designed system of administered safeguards with careful management mechanisms was introduced and that this would be capable of addressing the inherent risks. Furthermore, there was no evidence to suggest that vulnerable populations such as the elderly, the disabled or those socially vulnerable were at greater risk as a result of accessing physician assisted suicide. Palliative care also improved in jurisdictions with permissive regimes. Finally, she found no compelling evidence that a permissive regime in Canada would result in a 'practical slippery slope'.[165]

The Supreme Court concluded that the absolute prohibition on assisted dying failed the minimal impairment test, and consequently it was not necessary to proceed to the balancing of deleterious effects and salutary benefits nor to consider whether the s 15 rights of Ms Taylor were infringed. The court held that the laws prohibiting physician assisted suicide infringed on Ms Taylor's s 7 rights and were not saved by the limitations clause.[166]

Accordingly, the Supreme Court ordered that the relevant provisions of the Criminal Code are unconstitutional but suspended the order for 12 months for the legislature to pass legislation to fill the resulting lacuna.[167] The Supreme Court extended the declaration of invalidity by 4 months on 15 January 2016, which expired on 6 June 2016. However, the Court also ordered that exemption be granted for those who wish, during the extension period, to seek assistance in ending their life in accordance with the criteria set out in Carter.

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[164] Ibid paras 103-104.
[165] Ibid para 107.
[166] Ibid paras 126-128.
[167] Op cit n4, para 147 reads as follows: 'The appeal is allowed. We would issue the following declaration, which is suspended for 12 months:
Section 241(*b*) and s.14 of the *Criminal Code* unjustifiably infringe s.7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.'

On 17 June 2016, the Medical Assistance in Dying Act (MAID)[168] was passed formally legalising assisted dying through legislation. The act required that natural death must be 'reasonably foreseeable'[169] and that the condition must be 'incurable'.[170] This is a much narrower ambit than the Supreme Court's construction of 'grievous and irremediable' where there is no reference to a time-based criterion within which death is expected. This excludes access to persons who expect to find themselves in 'a grievous and irremediable medical condition … that causes enduring suffering that is intolerable to the individual'[171] but where the illnesses suffered may not foreseeably cause death.[172]

Lemmens, Kim and Kurz suggest that the reason for this narrower criterion is found in the preamble to the Act, which sets out that whilst Canada recognizes the 'autonomy of persons with a grievous and irremediable medical condition that causes them enduring and intolerable suffering and who wish to seek medical assistance in dying',[173] there must also be safeguards to prevent errors and abuse especially of vulnerable persons and that suicide has harmful effects on those left behind.[174]

McMorrow points out that people whose disease is not terminal may suffer for a longer period than those who are terminal:

> 'Foregoing MAID when the end is in sight may be less onerous than when natural death is potentially years and years down the road. From this standpoint, the requirement that "natural death has become reasonably foreseeable" forces those

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[168] The Medical Assistance in Dying (MAID) Act 2016 available at https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent#EH5 (accessed 17 December 2021). MAID was amended by the passing into law of Bill C-7 An Act to amend the Criminal Code (medical assistance in dying) in 2021 available at https://www.parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent (accessed 17 December 2021).
[169] Ibid s 241.2(2)(*d*).
[170] Ibid s 241.2(2)(*a*).
[171] As per the *Carter v Canada* Supreme Court access criteria quoted in n167.
[172] Applicants who launched cases challenging this criterion included Julia Lamb suffering from spinal muscular atrophy that causes intolerable suffering but is not terminal. Jean Truchon suffering from cerebral palsy and had lost the use of all his limbs, and Nicole Gladu suffering from severe post-polio syndrome with a rapid decline in her abilities. All of these applicants considered their conditions to be intolerable but the conditions are not terminal.
[173] Preamble to MAID.
[174] T Lemmens, H Kim & E Kurz 'Why Canada's medical assistance in dying legislation should be *C(h)arter* compliant and what it may help to avoid' (2017) 11(1) *McGill Journal of Law and Health* S66.

> suffering from a painful, debilitating medical condition to accept their lot for an indefinite, potentially long period, no matter how badly they may wish to die.'[175]

In 2019 the Superior Court of Québec handed down judgment in *Truchon v Canada (AG).*[176] The court found the 'reasonably foreseeable' death requirement unconstitutional but suspended the order of invalidity. On 17 March 2021 Bill C-7 became law in Canada thereby removing the reasonably foreseeable requirement. The statute also expressly excludes access to persons suffering from only a mental illness but includes a two-year sunset clause for this provision. The contemporaneous consent requirement[177] has also been amended and accordingly a person may give advanced consent for assistance in dying.[178]

3.3 Conclusion

The objective normative value system brought into being by the South African Constitution requires that any law which limits a right in the Bill of Rights must either pass the limitations clause or be impugned. In Canada, where the blanket prohibition on physician assisted dying faced this challenge, the law criminalising all assistance in dying was found to fail the overbreadth enquiry of its limitations test in that it included people like the applicant who was 'competent, fully-informed, and free from coercion or duress'.[179] The limitation of rights suffered by persons in Ms Taylor's position was not connected to the protection of those who are vulnerable with the effect that the blanket prohibition 'sweeps conduct into its ambit that is unrelated to the law's objective'.[180]

The Canadian 'overbreadth' enquiry is analogous to the requirement in the South African limitation's clause that there be no 'less restrictive means to achieve the purpose'.[181] This is fair to say even though in Canada there is also a 'less restrictive

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[175] T McMorrow 'MAID in Canada: Debating the constitutionality of Canada's new medical assistance in dying law' (2018) 44(1) *Queen's Law Journal* 81.
[176] *Truchon v Canada (AG)* 2019 QCCS 3792.
[177] Section 3(*h*) of MAID op cit n168 provided (before amendment) that 'immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying'.
[178] T McMorrow 'The waxing & waning of informed consent: Medical assistance in dying and the question of advance requests' (2021) 58(2) *Osgoode Hall Law Journal* 287 330.
[179] Supra n4 para 86.
[180] Ibid.
[181] Section 36(1)(*e*) of the Constitution op cit n1.

means test in the s 1 analysis. A well-crafted statute that allows physician assistance in dying for an identified class of persons (with sufficient safeguards) will be a less restrictive means that still protects the weak and vulnerable whilst also allowing assistance in dying for those who wish to escape what they view as an undignified existence.

The Canadian Supreme Court applies its limitations clause as a structured, sequence of enquiries as opposed to the South African Constitutional Court's application of its limitation's clause in a loose value-based approach (as discussed above).[182] Though it can be expected that the methodical nature of the Canadian approach places the blanket ban on assisted suicide under greater scrutiny than the looser South African approach, there remain significant overarching similarities in the way that rights and values are weighed.

Accordingly, due to the similarity of the instruments of the two jurisdictions and their limitations jurisprudence, it may be expected that if an appropriate case came before the South African Constitutional Court that a similar result may be expected.

That court would have to inter alia determine the ethical arguments both for and against physician assisted dying as was done in *Carter* to determine whether a sufficient ethical basis exists in support thereof. The key ethical arguments are discussed in the next chapter.

[182] Under heading 3.1.6.

CHAPTER 4
AN ETHICAL CASE FOR
A RIGHT TO DIE WITH DIGNITY

In this chapter, the most-often cited arguments for and against assisted dying are discussed. These include the slippery slope argument; varying theological, religious and spiritual perspectives and how those are to be handled in a constitutional democracy; bioethical concerns; palliative care implications; the proposition of a conflation between means and ends; the personal autonomy and the transformative power of consent propositions; the beneficial consequence and mercy propositions; and the moral equivalence of suicide with other means of death by choice. It concludes that the arguments in favour of physician assisted suicide and physician administered euthanasia are generally compelling whilst contrary arguments have been largely challenged.

4.1 The slippery slope

The 'slippery slope' argument suggests that if the law were to be amended to allow assisted suicide, initially in very narrowly and clearly defined cases, that it would merely be a matter of time before progressively more circumstances would be identified and included in this exception. Ultimately, this would result in a complete moral breakdown and the abuse and rampant killings of multiple classes of vulnerable persons which according to this view would ultimately lead to a grossly unethical result.[1]

[1] Y Kamisar, 'Against assisted suicide – Even a very limited form' (Summer 1995) 72(4) *University of Detroit Mercy Law Review* 735-770.

4.1.1 Counter-arguments

The Netherlands has the longest experience of an assisted dying law and it would therefore be appropriate to examine whether it has experienced a slippery slope in implementing its law.

De Vito[2] argues that there has been no expansion of the law in the Netherlands to cover additional classes of persons under the euthanasia law as all the classes recognised today were foreseen by the original legislators. Those who claim that the law has expanded to include additional categories claim that these new categories now include those with a lack of terminal illness/dying phase, dementia, psychiatric suffering, completed life, and old age complaints. De Vito examines each of these categories to determine whether they represent an expansion to categories not contemplated in early euthanasia law.

4.1.1.1 Dying phase

De Vito points out that the Dutch legislation on physician assisted dying (PAD) is generally understood as having its basis in the *Postma* case.[3] In this case, five assisted death criteria were identified by the judge who rejected the requirement of a 'dying phase' as necessary to access assisted death. The court held that it is not required that a person be terminal to avoid unbearable and hopeless suffering.[4] This position was confirmed a decade later in *Chabot*[5] wherein it was held that a person who assisted in the death of another did not require that the person assisted was in a dying phase to access the defence of emergency/necessity.[6]

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[2] L De Vito 'Dutch euthanasia law always meant for groups that now receive euthanasia; the euthanasia law options have not been expanded' delivered at #AssistedDying2018 conference, hosted by the World Federation of Right-to-Die Societies, in association with DignitySA on 7-8 September 2018, Cape Town, available at https://www.worldrtd.net/news/article-negate-slippery-slope-argument-published (accessed 14 December 2021).

[3] *Queen v Ms Geertruida Postma* (District court of Leeuwarden) 1973 Nederlandse Jurisprudentie No. 183.

[4] De Vito op cit n2 1.

[5] *Queen v Boudewijn Chabot* (Supreme Court (Penal Section)) 1994 Nederlandse Jurisprudentie No. 656.

[6] The basis of lawfulness in the Netherlands in cases of euthanasia arose as a defence to a charge of homicide being that of 'noodtoestand' or situation of medical emergency/necessity. See J Griffiths, 'Assisted suicide in the Netherlands: The Chabot case' (1995) 58 *Modern Law Review* 232 237 read with 239 at 1(a).

Accordingly, when the assisted dying law was drafted no dying phase requirement was provided and it is clear that assisted death for non-terminal patients was foreseen by the legislator and was not only included later in an expanded view of the area of application.

4.1.1.2 Dementia

With regards to early-onset dementia, De Vito points out that in the 1984 *Schoonheim*[7] case it was recognised that, 'further detachment of the person and the prospect of not dying in a dignified way' was a form of unbearable and hopeless suffering.

As regards advanced dementia, De Vito quotes the statement of the Minister of Justice at the time the legislation was before Parliament in the year 2000 as follows,

> '[i]f an incapacitated patient, for example, a deeply comatose or a deeply demented patient, has formulated an advanced directive, the physician can grant the request for the termination of life'.[8]

From the above, it is clear that assisted dying for early-onset dementia as well as for advanced dementia in cases where advanced directives had been drawn were foreseen by the legislature during debate on the draft legislation.

4.1.1.3 Psychiatric suffering

De Vito demonstrates that the legislature had also considered psychiatric suffering as a legitimate cause of assisted suicide by quoting the parliamentary document's view of what was intended in the *Chabot*[9] decision being that an emergency may exist even in the absence of a somatic cause. This leaves it open for a person with unbearable mental suffering to obtain assistance.[10]

She cautions, however, that not every person with mental suffering qualifies under this principle. As held in the *Brongersma*[11] case in 2002, there must be a 'mental

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[7] *Queen v Schoonheim* (Supreme Court (Penal Section)) 1984 Nederlandse Jurisprudentie No. 407.
[8] De Vito, op cit n2 2, quoting from the Dutch Parliamentary document 26691/22 62.
[9] *Chabot* supra n5.
[10] De Vito op cit n2 4, quoting from the Dutch Parliamentary document 23877/1, 4, relevant because the explanatory memorandum (parliamentary document 26691/3, 10) refers to this document in relation to the unbearable suffering requirement.
[11] *Queen v Brongersma* (Supreme Court (Penal section)) 2003 Nederlandse Jurisprudentie No. 167.

dimension' to the suffering in the form of an identifiable psychiatric disorder. It is insufficient to simply posit psychological suffering with no medically identifiable psychiatric diagnosis.

It follows from the above that assistance for those suffering from unbearable psychiatric illness was contemplated at the time parliament considered the legislation.

4.1.1.4 Completed life

The justification that a person believes that all the important milestones in that person's life have already passed and that there is nothing to look forward to in the future has been put forward as a possible justification to request assisted dying.

De Vito notes that this justification came before the Supreme Court in the *Brongersma*[12] case at the time that parliament was preparing to vote on the assisted dying legislation. Some parties had made it clear that should this ground be understood as falling within the scope of the legislation that they would refuse to support the Bill.

Accordingly, the then Minister of Justice made it clear this would not be the case. To this day completed life grounds are not allowed under the assisted dying law and no slippery slope has been at play to include this class of persons.

4.1.1.5 Old age complaints

A question that arises is whether a multiplicity of complaints of older people that together result in suffering would be a justification for requesting assisted death. De Vito points out that the question of old age complaints was not known before the passing of the legislation and had accordingly not been discussed by the legislature and the principles relating thereto was derived from the thinking of the review committees.[13]

Provided there is a medical dimension to the suffering as would arise from the physical suffering which usually attaches to the ageing body or mental suffering which

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[12] Ibid.

[13] For any termination of life on request or euthanasia in the Netherlands a review committee appointed to the relevant region determines whether the required due care provisions have been sufficiently satisfied. Where it finds non-compliance it refers the physician for prosecution.

has a psychiatric diagnosis, this would fall into the categories recognised for purposes of assisted suicide. As such, this should not be seen as an additional category, but rather as further clarification of what the legislature originally intended. De Vito notes that old age complaints were not considered or discussed by legislators but this does not detract from the requirement that there must be a medical classification.[14]

She concludes that in the Dutch experience there has been no 'slippery slope' of ever-increasing categories of persons to be included in those who may legally obtain assistance in dying. The present categories of justification existed at the time of the passing of the assisted dying legislation and have accordingly not been progressively expanded over time.

4.1.1.6 The evidence

Research reports from the first adopters of lawful assisted suicide and euthanasia practices being the Netherlands[15] and Belgium[16] indicate that the decriminalisation of assisted suicide in limited circumstances has not resulted in an increase of assisted death in the absence of clear consent. There is also no suggestion that there is a reduction in the proper reporting of assisted deaths. There does also not appear to be any evidence to support the predictions that liberalisation would result in wholesale non-compliance with the assisted dying laws. The prediction that decriminalisation would result in rampant abuse of the system and the concomitant killing of the old, weak and vulnerable is therefore not supported by the evidence. Empirical studies conclude that the slippery slope predicted did not materialise.[17]

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[14] De Vito op cit n2 7.
[15] JAC Rietjens, PJ van der Maas & BD Onwutea-Philipsen et al 'Two decades of research on euthanasia from the Netherlands. What have we learnt and what questions remain?' (2009) 6(3) *Journal of Bioethical Inquiry* 271 279 note, '[o]ur studies show no evidence of a slippery slope. The frequency of ending of life without explicit patient request did not increase over the studied years. Also, there is no evidence for a higher frequency of euthanasia among the elderly, people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations'.
[16] JL Bernheim, W Distelmans, & A Mullie et al 'Questions and answers on the Belgian model of integral end-of-life care: Experiment? Prototype?' (2014) 11(4) *Journal of Bioethical Inquiry* 507 508 note, '[n]o substantial evidence of so-called practical "slippery slope" phenomena has been found and Belgians' confidence in their health care system, already high before the euthanasia legislation, further rose to the second-highest in Europe'. (Embedded references omitted)
[17] See n15 and n16.

Despite the above findings, there are critics of these studies from an epistemological point of view that claim that empirical data is irrelevant in the consideration of normative ethics.[18] They argue that one cannot derive general conclusions through inductive reasoning. However, as Bernheim and Raus state at the very least, empirical data informs the debate.[19]

Kuhse notes that the slippery slope argument lacks logical coherence as 'the reasons that justify euthanasia – mercy and respect for autonomy' do not 'logically also justify killings that are neither merciful nor show respect for autonomy'. He then notes the absence of empirical evidence supporting the slippery slope argument and challenges the analogy of the Nazi atrocities by clarifying that those killings had nothing to do with mercy or autonomy but rather racial prejudice and prejudice against the disabled (described in modern parlance as 'ableism'). He concludes that in the Netherlands regarding assisted dying legislation 'there is no evidence that this has sent Dutch society down a slippery slope'.[20]

4.1.1.7 The philosophical counter

Benatar[21] points out that not all slippery slopes are necessarily 'noxious'. He posits as an example the position of a hypothetical anti-apartheid activist living in South Africa in the 1950s. Such an activist would be well aware that at that time it would be an impossible task to suggest the entire dismantling of the apartheid system then in force. The activist may accordingly choose to agitate against petty apartheid at first. Having achieved some success with that project he may thereafter progressively agitate against more elements of the system until ultimately it was destroyed in its entirety. Though one could argue that the minor resistance by the activist to begin with and that develops over time into increased rebellion may be described as a slippery slope, it can by no means be argued that it is a noxious or ethically undesirable one.

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[18] Bernheim & Raus cited in n19 refer to the following article that presents this view: B Jaspers, HC Müller-Busch & F Nauck 'Integral palliative care: a contradiction in terms?' (in German) 2009 (10) *Zeitschrift Palliativmed* 162–6.
[19] JL Bernheim & K Raus 'Euthanasia embedded in palliative care. Responses to essentialistic criticisms of the Belgian model of integral end-of-life care' (2017) 43 *Journal of Medical Ethics* 489.
[20] H Kuhse 'Euthanasia' in P Singer (ed) *A companion to ethics* (1993) 294 301.
[21] D Benatar 'A legal right to die: responding to slippery slope and abuse arguments' (Oct 2011) 18(5) *Current Oncology: A Canadian Cancer Research Journal* 206.

Many people believe that life can be intolerable for persons who are not terminally ill. For these people, a slippery slope is desirable to a particular point, just as the anti-apartheid activist would consider such a slope ethically desirable. Accordingly, not all slippery slopes are inherently noxious slippery slopes with the hidden implication of ever-increasing moral turpitude. There is accordingly nothing to be feared from taking the first steps down a road that may in future require more steps to be taken by society towards a position that may in future be considered altogether ethically acceptable.

4.2 The sanctity of human life

There is a view that arises from a religious and theologically based belief system that is strongly pro-preservation of life in all but a few circumstances that typically include war, self-defence, and punishment. There are also versions of the idea that can be expressed in a secular manner as the 'inviolability of human life'. Keown[22] describes three approaches to valuing human life that he describes as 'vitalism', the 'sanctity/inviolability of life' and the 'Quality of life'.[23]

He describes vitalism as the view that human life is an absolute moral value. This means that either shortening or not doing everything possible to extend it is wrong. The state of the patient is irrelevant, as is the suffering of the patient arising from medical intervention as well as any other cost associated with extending every human life. Human life must be preserved at all costs.[24]

Keown suggests that the sanctity of life view owes much to the advancement of a Judaeo-Christian outlook in the Western world, though similar ideas are found in Eastern thought, all arising from the idea that human life is created in the image of God. A similar secular view is apparent in the idea of the inviolability of human life from the inherent dignity ascribed to the human capacity for rationality and freedom of choice. It does not matter if a particular person is unable to exercise these abilities

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[22] J Keown *Euthanasia, ethics and public policy: An argument against legalisation* 2 ed (2018) 35.
[23] The upper caps 'Q' is intentionally used by Keown to distinguish a small caps use of the words 'quality of life' which is assessing the medical state of a patient before determining whether a proposed medical intervention should proceed from a capital letter 'Quality of life' which determines whether the life of the patient is inherently worthwhile at the outset.
[24]Keown op cit n22 37.

due to age or mental deficiency, but merely that all people merely by being people inherently possess the capacity for rationality. Essentially the idea is that every human has the right not to be killed intentionally because of 'intrinsic dignity or worth because of that radical capacity, inherent in human nature, which normally results in the development of rational abilities, such as understanding and choice'.[25] This is distinct from vitalism as it requires only that no human being be killed intentionally whereas vitalism goes further requiring the preservation of life at any cost.

The view of the 'Quality of life' doctrine looks to assess whether a patient's life is worth living at all. Those whose lives are considered not to be worth living either because of physical or mental ability should not be allowed to continue to live. Some proponents require consent by the patient whose life is considered of too low a quality to continue it, others do not require this. In essence, the question is that, where a person's life is of such low quality, what would be the reason for it to be wrong to end it?[26]

The discussion below on theological beliefs relate primarily to the sanctity of human life approach by organised religion.

4.2.1 Judaism, Christianity and Islam

Koenane[27] references Kuhse[28] as authority for the claim that both early Greek and Roman culture performed euthanasia as an acceptable practice. This changed, however, due to the rising influence of the Jewish and Christian faiths.

Bok argues that it is the emergence of Christianity that altered the common acceptance of suicide throughout antiquity.[29] She suggests that St Augustine considered it the worst possible sin, as it was the only act which the sinner could not

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[25] Ibid 38.
[26] Ibid 42.
[27] M Koenane 'Euthanasia in South Africa: Philosophical and theological considerations' (2017) 38(1) *Verbum et Ecclesia Journal* 7 available at https://doi.org/10.4102/ve.v38i1.1549 (accessed 14 December 2021).
[28] Kuhse op cit n20.
[29] S Bok 'Suicide' in G Dworkin, R Frey & S Bok *Euthanasia and physician-assisted Suicide* (1998) 93 97.

in his life come to repent. She notes that Augustine initiated the idea of punishment in hell after death by suicide which added to the weight of its prohibition.[30]

In both Jewish and Christian faiths, the concept of the sanctity of human life is evident. This idea arises from the sixth commandment in the Torah that: 'Thou shalt not murder'[31] and the fifth commandment in the Bible that: 'You shall not kill',[32] together with the idea that we are made in the image of God and since God has gifted us with life, only God can decide on when we should die.

According to Campbell, Judaism, Christianity, and Islam, despite their differences in approach to end of life choices, move from a similar point of view that includes the values of sovereignty, stewardship, and the self. He explains that the idea of sovereignty refers to the idea that human lives and human bodies are created by God to whom it ultimately returns. This loving God gifted to us our very existence and as such our entire human lives including our births and deaths, are of divine concern. The decisions we make at the end of our lives fall into this arena of concern and since our lives are sacred, the ultimate decisions relating to the time of our death is reserved for God and as such: 'Human beings must not overstep these boundaries, or so to speak "play God" with life and death.'[33]

Baeke et al discuss Jewish perspectives on euthanasia and point out that there are three main branches of the religion: Orthodox, Conservative, and Reformist. All the branches, move from a similar point of departure, placing life and death in 'God's hands'. He references the Hebrew Bible in Genesis: 3:19b and the words: 'For dust you are and to dust you will return' and Ecclesiastes 3:l-2a: 'There is a time for everything and a season for every activity under heaven: there is a time to be born and a time to die.' These point to death as inevitable but the circumstances and timing of death is a mystery and as such 'it is in God's hands'.[34] The corollary of which is that

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[30] Ibid 98.
[31] Deuteronomy 5:16, *The structured Torah (The woven Torah)* arranged by Moshe Kline available at http://www.chaver.com/Torah-New/English/Text/The%20Structured%20Torah%20(JPS%201917).pdf (accessed 14 December 2021).
[32] Exodus 20:13, *The New Jerusalem Bible*: Regular Edition, The Very Reverend Dom (Joseph) Henry Wansbrough, in some other non-Catholic Christian versions of the Bible it is considered the sixth commandment.
[33] S Campbell 'Euthanasia and religion' (2000) 53(1) *The UNESCO Courier Journal* 37.
[34] G Baeke, J Wils & B Broeckaert 'There is a time to be born and a time to die (Ecclesiastes 3:2a): Jewish perspectives on euthanasia' (2011) 50(4) *Journal of Religion and Health (Springer)* 778.

it is not in the hands of human beings, which can be taken to mean that death by suicide is not permitted.

In Jewish law, a *goses*[35] is, however, universally seen as a complete human being, so much so that specific laws prevented such a person from being touched by a caregiver (for fear that this may inadvertently shorten their life) or otherwise interfered with. Failure to adhere to these prohibitions could lead to a death sentence. Baeke et al conclude that a *goses* is considered by Jewish law as a 'living person in every respect and, being even in his last moments of life, he has to be treated according to this living status'.[36]

However, Baeke cautions against considering the Jewish tradition as uniformly against euthanasia, as this would fail to recognise the heterogeneous nature of its followers. It does not have a singular authority and there are accordingly different views on the topic from adherents. However, pro-euthanasia views are exceptional even within more liberal quarters.[37]

Larue argues that Jewish ethics are against active euthanasia.[38] It may be said that organised Judaism, despite its religious diversity has very little pro-euthanasia support from religious leaders. The essence lies in the belief that these issues are issues for God to decide and the very strong sense of the value of life, even those of a *goses*. As such, the conclusion which follows from this point of view is that life at all costs is the overriding imperative and even voluntary consent does not degrade the paramount importance of life.

Despite the few voices in favour of physician assisted death from Jewish religious leaders, some are willing to break with the past. Cohn-Sherbock points out that a key objection to euthanasia is that it interferes with the sovereignty of God relating to human life but that the same could be said of any medical intervention that extends human life. He argues that where strong safeguards are in place for those who voluntarily request a merciful release from life, compassionate reasons to assist

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[35] A person who had a death rattle and was expected to die within three days, see further discussion relating to the law of *goses* in I Jakobovits' *Jewish medical ethics. A comparative and historical study of the Jewish religious attitude to medicine and its practice* (1959) 349.
[36] Baeke op cit n34 783.
[37] Ibid 790.
[38] GA Larue *Euthanasia and Religion: A Survey of the Attitudes of World Religions to the Right-to-Die* (1985) 25.

become apparent. He concludes that there are important reasons for Reform Judaism to expand its views on active euthanasia based on human concern and compassion.[39]

The Roman Catholic Church, the largest Christian faith,[40] has been the most vocal critic of assisted suicide initiatives. Its views are summarised in the *Catechismus Catholicae Ecclesiae* promulgated in the year 1992.[41] Its view is entirely in alignment with the discussion of Christianity in general above and confirmed in December 2017 by Pope Francis in his letter for the attention of the World Regional Meeting of the World Medical Association wherein he supports the withdrawal of over-zealous treatment as morally acceptable but not euthanasia,

> '[i]t is clear that not adopting, or else suspending, disproportionate measures, means avoiding overzealous treatment; from an ethical standpoint, it is completely different from euthanasia, which is always wrong, in that the intent of euthanasia is to end life and cause death'.[42]

Christians and Jews also affirm the idea that human beings are made 'in the image of God'. Though Muslims do not use similar language, they do view human beings as uniquely valuable.[43] Accordingly, suicide is seen as wrongful for three main reasons. First, it goes against human nature and is contrary to personal dignity; secondly, it harms the community; and thirdly, it violates the supremacy of God. In this light, therefore, any suicide assistance is being an accomplice in evil-doing.[44]

Brockopp confirms a similar view from the Islamic perspective and points out that it is Western secular ethicists who derive a right to die from an argument for human dignity whereas Islamic theology understands human dignity to flow from the Muslim's relationship to God. In this approach, human life acquires its value and dignity from God. Death is therefore a mere moment in a larger set of events. [45]

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[39] D Cohn-Sherbok 'Judaism and euthanasia' (2011) 52(3) *Modern Believing* 27 32.
[40] *Annuario Pontificio* 2018 (Pontifical Yearbook 2018 Catholic Church Directory); also see reference to *The World's Religions in Figures* at n46.
[41] Available at http://www.vatican.va/archive/ENG0015/__P7Z.HTM (accessed 14 December 2021).
[42].http://w2.vatican.va/content/francesco/en/messages/pont-messages/2017/documents/papa-francesco_20171107_messaggio-monspaglia.html (accessed 14 December 2021) para 4.
[43] Campbell op cit n33 38.
[44] Ibid.
[45] JE Brockopp. 'The "good death" in Islamic theology and law' in JE Brockopp (ed) *Islamic ethics of life: abortion, war and euthanasia* (2003) 179.

4.2.2 Buddhism and Hinduism

The number of Buddhist adherents may be significantly larger than previously thought due to China not recording census figures by religion. [46] Damien Keown and John Keown have claimed that Buddhist views on euthanasia bear a striking resemblance to those of Christianity by exhibiting an idea similar to that of the sanctity of life.[47] They reference the precepts of 'The Monastic Rule' (*Vinaya*) which sets out the canons prescribed by the Buddha according to which Buddhist monks are required to conduct themselves. These canons are set out as case law where Buddha considers the facts of a case and hands down judgment. The relevant precept (the third pārājika) militates against the destruction of human life and prescribes the penalty for contravention as lifelong ex-communication.[48] The motivation for this precept was a case where some monks had developed feelings of disgust towards their bodies and had as a result either stabbed themselves to death with knives or had requested another to stab them. Both suicide and requesting another to wield the knife were forbidden.

In another case,[49] a monk suggested to another monk who was suffering terribly that being dead was preferable to the pain being suffered. This was suggested out of compassion for the suffering monk. The judgment was however that the compassionate monk had contravened the precept by making death the desired aim. It may be concluded that neither a compassionate intention nor beneficence are justifiable reasons for assisting in causing death.

The brothers Keown make the following observations in respect of Christianity and Buddhism. First, the beliefs of both religious schools are remarkably similar in their shared view of intentional killing for whatever higher purpose; secondly, the rejection of intentional killing arises from both preferring to view life as a basic rather than an instrumental good; thirdly, despite the opposition to intentional killing, they

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[46] TM Johnson & BJ Grim *The World's Religions in Figures: An Introduction to International Religious Demography* (2013) 34-37; P Harvey *An Introduction to Buddhism: Teachings, History and Practices* 2ed (2013). Also see claims of under-calculation of Buddhist adherents in non-scholarly article: https://www.lankaweb.com/news/items/2014/11/01/worlds-buddhist-population-pre-eminence-of-the-mahayana-tradition/ (accessed 14 December 2021).

[47] D Keown & J Keown 'Killing, karma and caring: Euthanasia in Buddhism and Christianity' (1995) 21 *Journal of Medical Ethics* 265.

[48] Ibid 268: 'If any monk should intentionally deprive a human being of life or look for a knifewielder he commits the offence of defeat (pārājika) and is no longer in communion.' (Vinaya iii.7 1).

[49] Ibid 267.

do not go as far as to see life as to be preserved at any cost; fourthly, the consensus between these worldviews runs contrary to the present view that consensus is impossible between them; and fifthly, it appears possible to find core values across the world's religions.[50]

According to Perret, this is a significant overstatement of the similarities. He points out that the idea of the sanctity of life is not easy to define and challenges the five conclusions arrived at by the Keowns described above. Perret bases his challenge on the Keowns' formulation of the idea of 'the sanctity of life' which they describe as including:

> '(1) That as life is a gift from God, it is to be cherished. (2) All human beings are to be valued, irrespective of age, sex, race, religion, social status or their potential for achievement. (3) The deliberate taking of human life is prohibited except in self-defence or the legitimate defence of others. (4) Human life is a basic good as opposed to an instrumental good, a good in itself rather than as a means to an end.'[51]

He argues that these formulations are not logically equivalent and it is not clear what the relationship is between the different formulations. In the first formulation, the Keowns acknowledge that Buddhism's purported belief in the sanctity of life 'is grounded not in its divine origin but in its spiritual destiny, namely the state of final perfection known as nirvana'.[52] Accordingly, this is a wholly dissimilar view as to the origins of the sanctity of life to those arising from a Judeo-Christian perspective.

By analysing the other three formulations, Perrett frames the view that these suffer from several complications from a Buddhist perspective. First, there is a paucity of Buddhist texts on issues relating to bioethics. Secondly, the many schools of Buddhism do not have a singular central authority and there is no clear consensus on the underlying ethics of the different schools in general and in particular on their ethics relating to euthanasia. Thirdly, modern sanctioned Buddhist practice in many areas do not coincide with canonical texts and so the texts alone rather than the modern practices are not sufficiently indicative of Buddhist thinking. Fourthly, the texts referred to are a collection of judgments and do not always have a clear ratio as to the

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[50] Ibid 268.
[51] RW Perrett 'Buddhism, Euthanasia and the Sanctity of life' (1996) 22(5) *Journal of Medical Ethics* 309 310.
[52] Ibid.

basis on which they were decided. Fifthly, the texts referred to relate to the strict rules of monastic life and not to the laity for whom we may reasonably infer the ethical standard expected may well be lower.[53]

From the above, it may well be reasonable to conclude that a notion of the 'sanctity of life' in Buddhism may well be different to the Judaeo-Christian conception thereof or at the very least not as clearly formulated.

Buddhist and Hindu views on the sanctity of human life arise from the two values of liberation and non-violence or *ahimsa*. Liberation is to be understood as the idea that human beings are trapped in an ever-recurring cycle of birth, death and rebirth in the suffering state of life on Earth called *samsara* with the ultimate aim being the transcendence of this cycle by accumulating merit and good karma. Suicide does therefore not liberate a person from suffering as the bad karma derived therefrom would merely place such a person in worse suffering in their future lives. Also, the same fate would apply to any person who may have assisted in such suicide as the assistant would have acted contrary to the value of non-violence.[54]

However, when the motive for suicide is spiritual advancement, a very different paradigm is applied. Both Hindus and Buddhists believe that the state of mind of a person just before death has a significant effect on the future lives of such a person. A more favourable rebirth is attained when the dying person is lucid and has full self-control. Accordingly, if it is expected that as death approaches such person would be less conscious and therefore suffer from a diminishing awareness, or an increase in pain, it may well be justified to die earlier by suicide. Of course, the means of suicide must not cause unconsciousness or a reduction in the ability of the dying person to comprehend the approaching moment of death.[55]

Hinduism is the oldest major religion still widely in existence.[56] The discussion above relates to aspects that are common to Hinduism and Buddhism, however, it should be understood that Hinduism is also the most diverse religion. Despite the Upanishads, the Vedas and the Bhagavad Gita scriptures, which are common to all practising Hindus, there is no founder nor a present singular leader. In practice,

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[53] Ibid.
[54] Campbell op cit n33 39.
[55] Ibid.
[56] See TM Johnson & BJ Grim op cit n46 23-24.

therefore, there is no common doctrine and with millions of Gods to worship Hinduism is in effect a collection of myriads of micro-religions.[57] It is also not appropriate to determine a singular Hindu view on euthanasia from its scriptures as typically a practising Hindu in determining an appropriate religious stance would first consider his conscience, then respected religious role models, and thereafter appropriate *dharma* literature which is written by experts, and only lastly the ancient scriptures.[58]

Hinduism espouses respect for all life and with it an attitude against unnecessary killing. It is a common view that people are expected to wait for death. Suffering is seen as arising from karma and the result of previous negative behaviour (in this life or previous lives). The proper attitude is accordingly to face the suffering with equanimity as the path to ultimate liberation (*moksa)*. In general, Hinduism is against suicide which it generally views as a logical result of being against violence.[59] There are several exceptions to this general rule, which include suicide by a 'willed death' where a person who is not terminal but old and weak refuses to eat or drink. Also excepted is a woman who believes she will become an ideal wife by throwing herself on her deceased husband's funeral pyre (*satī*). A further exception is a person in enough grief to prefer dying. Finally, there is an exception for penance, such that the ruler is relieved from being forced to apply the death penalty.[60]

4.2.3 The counter-argument

The counter-argument follows from the simple proposition that all people should be entitled to adopt whatever religious or theological perspective they prefer as is guaranteed in the Constitution.[61] This means that a person against euthanasia should be entitled to refuse that option. However, it also implies that those who would choose

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[57] Ibid.
[58] F Anthony & C Sterkens 'Religion and the right to (dispose of) life: A study of the attitude of Christian, Muslim and Hindu students in India concerning death penalty, euthanasia and abortion' in H Ziebertz & F Zaccaria (eds) *Euthanasia, abortion, death penalty and religion – The right to life and its limitations* (2019) 24.
[59] It is worth considering whether it is fair to categorise the relief of suffering through death on the request of a patient by painless medication as an incidence of 'violence'.
[60] Op cit n58 25.
[61] Section 15(1) of the Constitution of South Africa 1996 provides: 'Everyone has the right to freedom of conscience, religion, thought, belief and opinion.'

to take advantage of lawful euthanasia should be entitled to make that choice instead. As stated by Smith J in the *Carter v Canada* trial court,

> [t]he sanctity of life is a principle that is not absolute in our society (it is subject to exceptions such as self-defence) and, while it is central to the value system of a number of religions, that does not settle its place in a secular society'.[62]

This should leave it open in a secular society for a person to choose to demand their right to dignity and autonomy and to hold such considerations more highly than the sanctity of their own life. This is not to say that all people who choose to die with dignity necessarily disagree with the idea of the sanctity of human life entirely. It may well be that such a person believes in the sanctity of human life when such human life is a dignified one but also believes that an undignified life not worth living is not to be regarded as a life worthy of sanctity. Also, those who offer the sanctity of human life argument generally accept exceptions that relegate this sanctity that include: war, self-defence and punishment. There is no reason in principle that a further exception for a competent person whose suffering and imminent death lacks dignity should not be included in a list of exceptions. Of course in a society that respects all views, an individual is entitled to not believe in the sanctity of life at all if they so choose and whilst the law may demand that no other person may be murdered by them, it should not limit their right to choose to die with dignity themselves.

The Supreme Court in *Carter*[63]*,* referencing the case of *A.C. v Manitoba (Director of Child and Family Services),*[64] noted that though we may 'instinctively recoil' from someone making a choice that results in their death because we believe in the sanctity of human life, we must also understand that someone who chooses death to escape intolerable suffering does so because of a deep and fundamental belief as to how they wish to live or die. Such a decision emerges from that person's deep sense of dignity and integrity and is a conscious choice that the manner of their death be consistent with the values they have lived by throughout their life and through their life experiences. By limiting such autonomy, we impinge on their liberty and security of their person rights.[65] Similarly in a constitutional analysis of a blanket ban on

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[62] *Carter v Canada (AG)* [2012] BCSC 886 [trial court] para 315.
[63] *Carter v Canada* 2015 SCC 5 [Supreme Court Appeal].
[64] *AC v Mantioba (Director of Child and Family Services)* 2009 SCC 30.
[65] Supra n63 para 68.

euthanasia under the South African Bill of Rights, the prescripts of religion or theology will be met with the same response.

In the course of a debate, at the #AssistedDying 2018 conference,[66] on whether assisted dying is a human right, Phillip Rosenthal, representing Christian View Network suggested two reasons why South Africa could not claim to be a secular state. First, almost 80 per cent of South Africans identified as Christian,[67] and secondly, at the end of the Preamble to our Constitution, an appeal is made to a deity.[68] I disagree with this view. There is no State Church in South Africa and freedom of religion, belief and opinion are explicitly protected in the Constitution.[69] This protection includes the right to be an atheist. Furthermore, ss 1 and 2 of the 1996 Constitution are explicit in their formulation of the Constitution as the supreme law.

The recognition in the Constitution of a deity in no way suggests that any specific religious or theological framework should be imposed on our legal system. Joan Church points out that freedom of religion has two key meanings; first, that it is a liberty right or the right to exercise one's religion without any interference by another including the government; and secondly, an equality right which means freedom from practices that favour one religion over another or over non-religious views.[70]

The meaning ascribed to the term 'secular' has shifted since the enactment of the South African Constitution 1996. Benson points out that the Supreme Court of Canada in 2002 in *Chamberlain v Surrey School District No. 36,*[71] per Justice Gonthier, explicitly held that all people had 'belief' or 'faith' which may be religious faith or non-religious faith such as agnosticism or atheism. It would therefore be wrong to understand the word 'secular' to apply to the arena which is devoid of faith and doing so elevates those with non-religious beliefs above those with religious beliefs in

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[66] Hosted by the World Federation of Right-to-Die Societies, in association with DignitySA on 7-8 September 2018, held in Cape Town.

[67] http://www.statssa.gov.za/census/census_2001/primary_tables/RSAPrimary.pdf (accessed 14 December 2021) 28. The 2001 census reflected 79.8% as Christian. (Religious adherence statistics was not collected in the 2011 census).

[68] 'May God protect our people.
Nkosi Sikelel' iAfrika. Morena boloka setjhaba sa heso.
God seën Suid-Afrika. God bless South Africa.
Mudzimu fhatutshedza Afurika. Hosi katekisa Afrika'.

[69] See n61.

[70] J Church 'Religion and the constitution' in WA Joubert (ed) *The law of South Africa* 3ed (2021) 34 para 252.

[71] [2002] 4 S.C.R. 710 para 137.

the public sphere. That in turn is not fair in a liberal society upon religious believers where only non-religious believers are to be heard in the public square. A more accurate meaning of 'secular' must be inclusive of all 'beliefs' or 'faiths', religious or otherwise.[72]

Benson argues that a similar view is evolving in South Africa, as appears from the Constitutional Court case of *Fourie*[73] in which Sachs J held that the,

> 'objective of the Constitution is to allow different concepts about the nature of human existence to inhabit the same public realm, and to do so in a manner that is not mutually destructive and that at the same time enables government to function in a way that shows equal concern and respect for all'.[74]

According to this meaning, the word 'secular', includes recognition of and respect for all beliefs, be they religious or otherwise and where nobody is compelled to act against their beliefs. This in turn means that the fact that some (even many) South Africans hold views against the legalisation of physician assisted dying should not be a bar to accommodating contrary views, irrespective of the number or volume of those who disagree.

4.3 Human error and the role of doctors (Bioethics)

The human error argument is usually posited against capital punishment but has a bearing on euthanasia. In particular, the argument is that the decision to terminate life is always subject to discretion, medical and judicial, and accordingly open to human error. In the case of physician assisted death two key questions arise. First, is the request of a patient a true and considered independent act of autonomy or could it be influenced by other factors resulting in an error by the physician[75] in granting the request? Secondly, would it be contradictory to the role of medical practitioners, whose apparent function would shift from being protectors of life to being agents of death and thereby directly affect the moral integrity of the health professions?

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[72] I Benson 'Taking pluralism and liberalism seriously: The need to re-understand faith, beliefs, religion, and diversity in the public sphere' (2010) 23(1/2) *Journal for the Study of Religion* 17 23.
[73] *Minister of Home Affairs and Another v Fourie and Another* 2006 (1) SA 524 (CC).
[74] Ibid para 95.
[75] Cohn-Sherbok op cit n39 32 where it is suggested that doctors can make errors of diagnosis or be unaware that new treatments are imminent.

Sprung et al consider certain questions of ethics related to patient choices and psychological states. They are of the view that a physician is a moral agent and that in the case of a conflict between patient and physician, the patient's wish does not automatically trump that of the physician.[76] They are further of the view that there are challenges to the argument that the autonomy of the patient should reign supreme. These include the possibility that a request for physician assisted death arises from a form of clinical depression, and that almost half of the terminally ill patients who at some time seriously considered assisted death changed their minds with better symptom control and psychological assistance.[77]

They suggest that 'attention and cognition impairments' can affect the ability of even competent patients resulting in distorted assessments and decisions. They also argue that physician assisted death requests are often initiated not from the pain and suffering of the patient but from psychological issues such as being joyless, hopeless, fear of death, isolation, a sense of being a burden, and financial fears. They conclude that all requestors of physician assisted death should have psychological support and be further assisted with palliative care and that no far-reaching changes be made to the law to allow for physician assisted death.[78]

According to the American Medical Association (AMA):

> 'It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.'[79]

It is clear from this statement that the AMA does not support physician assisted dying.

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[76] CL Sprung et al 'Physician-assisted suicide and euthanasia: Emerging issues from a global perspective' (2018) 33(4) *Journal of Palliative Care (SAGE)* 197 197.
[77] Ibid 199.
[78] Ibid.
[79] American Medical Association *Physician-Assisted Suicide Code of Medical Ethics Opinion 5.7* available at https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide (accessed 15 December 2021).

4.3.1 The counter-argument

Safeguards can ensure that requestors of physician assisted death are performing a truly considered and independent act of autonomy. These should include proper psychological assessments and support. There is no reason to suggest that mental health practitioners are not able to properly assess a patient's state of mind and to determine whether their clinical depression, other mental diseases, or undue influence, is affecting the proper decision-making ability of a patient. This issue does not have relevance in certain jurisdictions such as the Netherlands that allows for mental illness to be the basis of the request as long as such illness has a medical dimension.[80]

It is important to appreciate the inherently complex nature of decisions made by human beings, in particular, those of a far-reaching nature and gravity such as a request for physician assisted death. Such a decision may well include diverse factors simultaneously ranging from high-minded issues such as dignity, agency, liberty, independence and altruism, to simple daily factors such as a sense of burdening others, financial considerations or plain boredom. An analysis of the 'real' or 'essential' reason or reasons for a physician assisted death request is neither necessary nor appropriate. All that should be required is a truly considered and independent act of autonomy that is independent of clinical depression or any other mental illness that affects decision-making ability (except where the mental illness itself is the very basis of the request).

The role of the physician was touched on by the trial court in *Carter v Canada*.[81] The evidence before the court suggested that it is incumbent on a doctor not to abandon the patient in dire circumstances, as a matter of medical ethics. Prof Battin, a philosopher and professor of bioethics, testified that a patient should not be deprived of liberty or be compelled to suffer and that non-abandonment was a core value of practice for physicians in that they are under an ethical duty to respond to the autonomous requests of their patients, particularly when those requests relate to the extreme suffering by those who are dying.[82]

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[80] *Queen v Brongersma* supra n11.
[81] *Carter v Canada* Trial Court supra n62.
[82] Ibid para 239.

The relationship between a doctor and patient can be expected to be very much improved when the patient is secure in the knowledge that they need not fear abandonment by their physician. Merely because a legal option exists for physician assisted death in certain limited circumstances does not imply that doctors will shift their primary focus away from their care for and preservation of the life of their patients. Only until and unless it no longer appears in the interests of the patient not to remain alive at all costs (and on the patient's request) will they consider physician assisted dying options. There appears to be no evidence in the literature that suggests that the respect for the medical profession declines, nor that suspicions of patients rose in respect of their doctors in jurisdictions where physician assisted death is lawful.[83]

The issue of moral equivalence discussed under heading 4.9 below is also relevant to medical ethics as it suggests that the current practice of withholding or withdrawing treatment on request of a patient that has the foreseeable consequence of the death of the patient, is morally equivalent to actively assisting the patient to die.

4.4 Focus away from and lack of knowledge of palliative care

There is an argument that increased access to physician assisted death would result in a focus away from developing advances in palliative care methods and that patients would increasingly choose assisted dying as a result of being unaware that such care may lead to a pain-free extension of their lives.

This position is strongly argued by Sprung et al who claim that the majority of terminal patients can be made physically comfortable by palliative care and accordingly no state should consider the legalisation of physician assisted death until it has ensured access to all for such care together with the medications required. They claim that where such pain relief treatment is offered together with treatments for depression, the desire for people to access physician assisted death declines as patient's experience a sense of the return of their autonomy and increased quality of life.[84]

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[83] JL Bernheim & K Raus op cit n19 508.
[84] Sprung op cit n76 199.

4.4.1 The counter-argument

The suggestion above is based on the view that palliative care is the panacea to all end of life questions and that palliative care development would be inhibited by legalising physician assisted death. Implicit in this argument is the suggestion that palliative care and physician assisted dying are two mutually exclusive paradigms.

Certainly, wherever proper and effective palliative care can be made available to a patient before any request for physician assistance, this is desirable. However, there are many patients for whom certain levels of sedation are not acceptable. This is true in particular of palliative sedation where a patient would prefer not to be kept in an unending mental haze, alive only in body but barely so in mind. Some people may consider this state 'worse than death'.[85] This argument was noted by the trial court in *Carter*:

> 'Some patients may find death while under palliative sedation repugnant or unacceptable, and may find other forms of palliative care unacceptable. Patients should not be required to submit to treatment against their wishes.'[86]

The key counter-argument, however, is that palliative care and physician assisted dying are not necessarily opposing paradigms. In the Belgian experience, physician assisted dying is seen as potentially a part of the continuum of palliative care. Bernheim et al describe with reference to their diagram below, the Belgian model:

> 'Integral palliative care as conventional palliative care that has embraced and embedded euthanasia (Federatie Palliatieve Zorg Vlaanderen 2003; Vanden Berghe et al. 2013) is illustrated in Fig. 2. The Venn diagram shows the qualitative relationships between types of care: Integral palliative care is conventional palliative care (as practised in countries without legal euthanasia) offering also the option of euthanasia.'[87]

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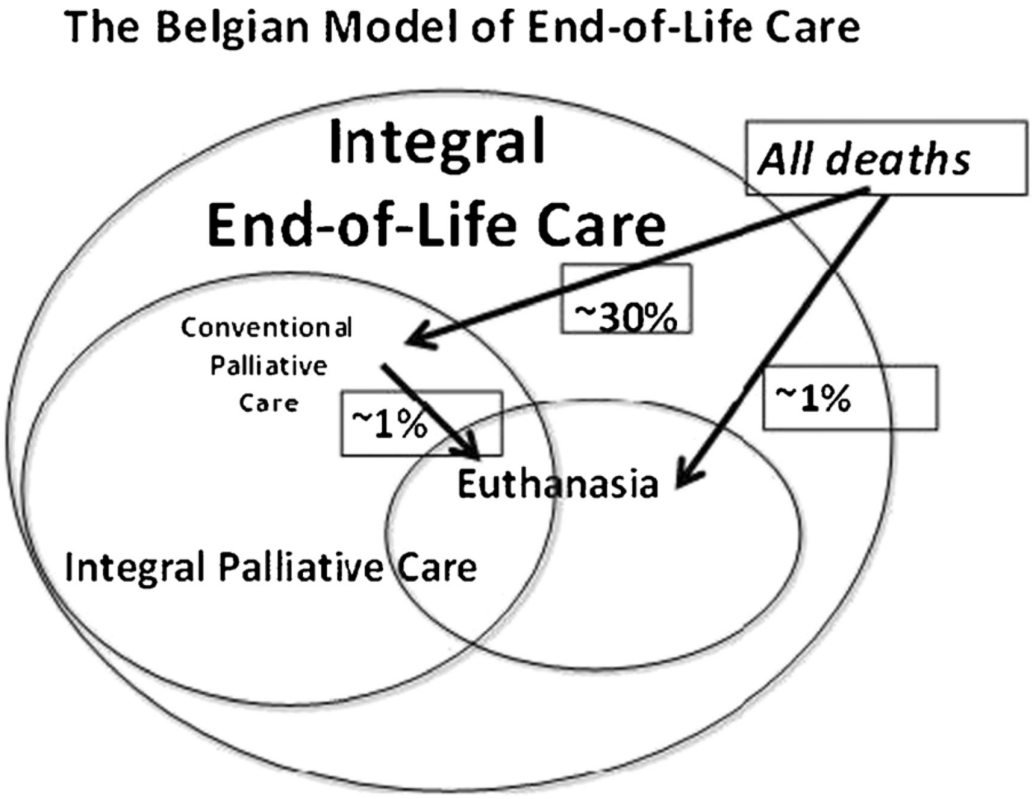
[85] D Benatar 'Assisted suicide, voluntary euthanasia and the right to life' in J Yorke (ed) *The Right to Life and the Value of Life* (2010) 291 295.
[86] *Carter v Canada* supra n62 para 315.
[87] JL Bernheim et al op cit n16 515.

The diagram below by Bernheim et al models the Belgian Model of End-of-Life Care:[88]



From the Belgian perspective, palliative care and physician assisted death are not opposing approaches but integrated into a continuum of patient assistance.

There appears to be no evidence in the literature that suggests that in jurisdictions in which physician assisted death is lawful, there is a concomitant decrease in the advances in palliative medical technology.

4.5 Conflation between the means and the ends

It has been argued that the suffering of the requestor of physician assisted death is the problem and that it is the suffering that should be 'killed' and not the sufferer. As Sprung et al frame this argument, the euthanasia issue is not related to whether we die but rather how we die. They argue that proponents of euthanasia see hastening the death of a person who is suffering and who is going to die anyway as acceptable

[88] Ibid fig 2.

because they see such intentional death as similar to any other treatment. Those against euthanasia do not regard this issue in the same way; they believe that killing the patient is not a proper means of relieving suffering. Instead, they believe in killing the pain and suffering, as opposed to the patient who experiences the pain and the suffering.[89]

4.5.1 The counter-argument

The arguments in favour of euthanasia below together form the counter-argument to the proposition that the pain and suffering should be the sole focus. Sufferers should have the right to exercise their agency, autonomy and liberty and to decide whether they find life in their present condition acceptable or whether they would prefer to die. In most jurisdictions, including South Africa and Canada, neither suicide nor attempted suicide is unlawful. As such, a person already has the legal right to attempt suicide without assistance. The only question, therefore, is whether there is a good reason for a person who wishes freely to die to be assisted by a medical professional to do so. From this point of view any conflation as described above falls away as the physician is not the central moral agent but acting on the free and autonomous will of the requestor and as such the moral dilemma posed is the concern of the requestor and not the physician.

4.6. Personal autonomy is sacrosanct

Paterson argues from a natural law point of view that,

> 'the state sanctioning of such practices would openly propagate and encourage the "deep incivility" of "officially devaluing" societal respect and protection for the radical worth and dignity of all innocent persons. The state, by virtue of its ordination to serve and uphold the common good of society, cannot permit appeals to "consent" or to bold "quality of life assessment" to empower a culture that licenses the intentional procurement of death without also undermining part of its very reason for being—to promote and protect conditions that facilitate and do not undermine plans and projects that are compatible with the respect for the ultimate purposes of human well-being'.[90]

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[89] Sprung et al op cit n76 200.
[90] C Paterson *Assisted Suicide and Euthanasia a Natural Law Ethics Approach* (2008) 182.

Boer suggests that euthanasia law in the Netherlands was originally based on the idea of an 'emergency'. This emergency situation was understood to be similar to that studied in a class on ethics such as whether it is acceptable to shoot a truck driver who has smashed his vehicle into a wall to save him from the inevitable pain of burning to death. He suggests that this reliance on an emergency situation has shifted over time to an emphasis on personal autonomy instead, whether the person requesting euthanasia was in an emergency situation or not. Autonomy has overshadowed the necessary emergency which was the original basis for the Dutch court rulings and the initial 'exceptional cases' approach of the protestant churches.[91] He warns countries considering liberalising their euthanasia laws to also consider how this may develop in their jurisdictions.[92]

4.6.1 The counter-argument

With respect to the view of Paterson, the discussion in chapter 3[93] on how the values of human dignity, equality and freedom underpin the South African constitutional framework and how dignity arises from the idea that human beings are morally autonomous is relevant. As Bognetti remarks,

> '[m]ost appropriately, the father of the modern concept of human dignity is considered to be *Kant*, with his theory that man is a morally autonomous being, who as such deserves respect and must never be treated, in general and especially by the law, as only a means to contingent ends but always (also) as an end unto himself'.[94]

The discussion in chapter 3 relating to the ethics findings in the *Carter* trial court is also relevant as it was held therein that the distinction between the existing end of life practices such as the doctrine of double effect and physician assisted death vanishes where the patient's decision to commit suicide is rational, autonomous, in the best interest of the patient and the request for assistance is properly informed.[95]

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[91] 'Gereformeerde Kerken in Nederland', and 'Nederlandse Hervormde Kerk'.
[92] TA Boer 'Euthanasia, ethics and theology: A Dutch perspective' (2014) 6(2) *Revista Ecumenica Sibiu* 197 211.
[93] Under heading 3.1.3.
[94] G Bognetti 'The concept of human dignity in European and U.S. constitutionalism' in G Nolte (ed) *European and US Constitutionalism* (Science and Technique of Democracy No. 37) Council of Europe (2005) 75 79.
[95] Supra n62 paras 336-339; see discussion under heading 3.2.4.1.4.

Mill suggests that the very idea of freedom demands that human beings are the guardian of their health:

> 'The only freedom which deserves the name, is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily, or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest.'[96]

Dworkin agrees succinctly, '[m]aking someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny'.[97]

In South Africa, the 1996 Constitution is underpinned by the triumvirate of values being liberty, equality and freedom. The South African state should therefore not have the power to prevent an autonomous person from freely choosing what should happen to their own body or mind. There is no 'harm to others' basis to protect society from a free-thinking individual choosing to die nor in having a willing physician to assist. Autonomy is sacrosanct and the constitutions of both South Africa and Canada recognise these liberty interests. As has already occurred in Canada, the proper plaintiff should similarly succeed in a South African court and successfully assert a right to physician assisted death on this basis.

The view of Boer is similar to the slippery slope argument discussed above.[98] Accordingly, similar counter-arguments made there also apply to this notion which includes that there is no evidence of a slippery slope to date in the Netherlands or Belgium (or indeed anywhere else) and that not all slippery slopes are noxious and legal developments may ultimately be desirable. There is a case for the centrality of personal autonomy in ethics to be made to the effect that it is not the physician's function to determine how real or acute the physical or mental cause of the patient's request is but rather how serious the request is from the patient's point of view.

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[96] JS Mill *On liberty* 1859 16.
[97] R Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia* (1993) 217.
[98] Discussion above under heading 4.1.

4.7 The transformative power of consent

Alexander describes the transformative power of consent as a normative power that alters the normative situation similarly to how the promises we make bind us. As such, consent is central to morality and law as it transforms what would be a crime into something acceptable. He offers the following transformations that consent provides: a trespass becomes a dinner party, an assault becomes a boxing match, theft becomes a gift, and rape becomes consensual sex.[99]

Hurd agrees that it is consent that has the power to transform that which is immoral into that which is morally acceptable or even desirable; similarly, it is consent that should transform that which is unlawful into that which is lawful. It follows that independent and informed consent should be allowed to transform the assistance to suicide from murder or homicide to an act that is not wrongful. This is common in our understanding of the law on a myriad of matters, as Hurd elaborates, our promises create obligations on us and our consent creates rights for others. Our consent and promises in large part define the ambit of acceptable limits and by so doing the rights and liberties of other people.[100]

Hurd goes on to connect the power of consent to liberty. He proposes that consent determines the obligations and permissions we give to others. When we consent to someone touching us, we transform the obligation on them ordinarily in place not to touch us. It is the ability to create and withdraw rights and duties that generates our power to be autonomous givers and takers of rights this being the very essence of liberty.[101]

If we refuse to recognise the moral nature of the consent of a person to commit suicide through the assistance of a physician, we fail to respect the right to liberty of that independent autonomous person. As pointed out above, neither suicide nor attempted suicide is a crime and as such, there is no logical reason why the consent of a requestor to be assisted in suicide should not transform the act of assistance by a physician into one which is neither wrongful nor unlawful. In essence, a person who has the right to life may waive such right under certain circumstances and as such,

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[99] L Alexander 'The ontology of consent' (2014) 55(1) *Analytic Philosophy* 102 102.
[100] HM Hurd 'The moral magic of consent' (1996) 2(2) *Legal Theory,* HeinOnline 121 121.
[101] Ibid 124.

there is no duty to live. Once the right to life has been properly (and after certain safeguards have been met) waived, no wrong is done.

In chapter 2 the limits of consent were discussed including *R v McCoy*[102] and *Castell v De Greef.*[103] *McCoy*[104] held that consent must be given freely and voluntarily and is invalid if the act consented to is unlawful.[105] If the common law, by recognising the shifting legal convictions of the community determines that there is no *wrongfulness* attached to a physician who assists a patient to die which patient has given free and voluntary consent to the physician to assist him in suicide, then such assistance would be lawful.

In *Castell v De Greef*[106] the defence of volenti non fit injuria (to one consenting no wrong is done) was raised. The enquiry required establishing whether proper consent had been given by the patient to the surgeon and whether such consent was 'properly informed consent'.[107] The judgment confirmed that any patient was entitled to refuse to have an operation performed which entitlement arose from their fundamental right to self-determination. The court held that this remained the case even if in the view of the medical profession such decision by the patient was grossly unreasonable as such right to refuse arose from the patient's right to bodily integrity and autonomous moral agency.[108] It is hard to distinguish a right to refuse to have any operation performed from the absence of a right to freely and voluntarily choose a physician assisted death that arises from the same right of the patient to bodily integrity and autonomous moral agency.

4.8 Beneficial consequence and mercy

It can be argued that it is ethically beneficial to assist a terminally ill person by relieving their interminable suffering. Goligher et al suggest that, though the value of life is great, it is not infinite and though death may not be a pleasant experience, it may be the only way to prevent suffering. The positive value of living is sometimes

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[102] *R v Mcoy* 1953 (2) SA 4 (SR).
[103] *Castell v De Greef* 1994 (4) SA 408 (C).
[104] *McCoy* supra n102.
[105] Ibid 7.
[106] *Castell v De Greef* supra n103.
[107] Ibid 420H read with 423C-D.
[108] Ibid 420I/J and 421C-E.

outweighed by the burden of being alive whilst suffering, and the value inherent in honouring the patient's considered wish to die.[109]

Hester proposes that there are metaphysical benefits to dying on one's own terms. That after a patient has made a sincere and thorough reflection on their lives and their choices, as a community we will find such a decision has moral legitimacy. By assisting such a person, we give meaning to their final moments and thereby help 'empower the patient as the narrator of her own complete life story'.[110]

The death of a patient on their own terms is a significant beneficial consequence. By allowing a patient to make significance and meaning of the moment of death, we also allow the patient to take control of the end of the story of their life.

4.9 Moral equivalence

The withholding or withdrawal of medical treatment is often referred to as 'passive euthanasia' in contrast to 'active euthanasia' in which the physician takes an active part in causing the death of the patient. Withholding treatment relates to the situation where life-sustaining treatment may be available but the patient refuses it. Withdrawal relates to the situation where life-sustaining treatment has begun and where the patient subsequently wishes such treatment to cease.

The right of a patient to refuse medical treatment is settled in South African Law. Ackermann J in *Castell*[111] held that a patient has the right to refuse any medical treatment and that this entitlement arises from the right to bodily integrity and autonomous moral agency. It would be irrelevant whether the entire medical profession disagreed or thought such refusal grossly unreasonable.

The question then follows whether there is any difference between accepting a patient's request to have life-sustaining treatment withheld or withdrawn and accepting a patient's request to be assisted with suicide.

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[109] EC Goligher, EW Ely, DP Sulmasy et al 'Physician-assisted suicide and euthanasia in the ICU' (2017) 45(2) *Critical Care Medicine* 149 150.
[110] MH Hester *End-of-life Care and Pragmatic Decision Making – A Bioethical Perspective* (2010) 91.
[111] *Castell v De Greef* supra n103 420I/J and 421C-E.

It may be argued that a physician has the same duty of care to a patient from injury arising from the commission of an act as by omitting to act in the context of a physician-and-patient relationship.

Dubose describes the development of the ambit of the practice referred to as 'passive euthanasia'. He suggests that initially it was meant only to prevent extremely heroic treatments to prolong life at all costs. The justification of this was that such treatments should be withheld to prevent prolonging the lives of terminally ill patients who experienced pain and suffering. Soon the practice was expanded and the term developed to include withdrawal of medical treatment which had already begun to prevent pain and suffering. More recently withdrawals included medically supplied nutrition and hydration, which raises the question of whether there is any ethical distinction between such practices and physician assisted death.[112]

Sumner proposes that the basis upon which to consider whether suicide is ethical is to determine that it is in the interests of the well-being of the patient and has reverence for the autonomy of the patient. It follows that if these conditions co-exist then no ethical distinctions arise as to how the patient dies by suicide, that is that it would be ethical if the patient takes his own life, or dies as a result of refusing treatment, or is assisted to commit suicide by another, or if another performs active euthanasia. He concludes that the 'extensionist' argument is valid as there are no 'ethical bright lines' between the justifiability of suicide; assisted suicide and euthanasia; if treatment refusal is justifiable then so is euthanasia.[113]

The trial court in *Carter* came to the same conclusion that withdrawing a ventilator or failing to hydrate or nourish a patient who is sedated results in death in the same way from an ethical point of view as the administration of lethal medication. In all of the above cases, death is the result. In the same way, failing to give life-sustaining treatment is passively causing death and if such practices are ethically acceptable then so should the practice of physician assisted death also be ethically acceptable.[114]

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[112] ER Dubose 'Historical perspectives: physician aid-in-dying (active voluntary euthanasia)' in GE McCuen (ed) *Doctor-assisted suicide and the euthanasia movement* (1999) 8 14.
[113] LW Sumner *Assisted death: A study in ethics and law* (2011) 91-99.
[114] *Carter v Canada* Trial Court supra n62 at paras 321-322 read together with paras 335-339 and para 358, the judge could also not find an ethical distinction between suicide and assisted suicide in that if

There are two inescapable conclusions. First, that if suicide is ethically defensible and legal as it is in South Africa then no bright-line ethical distinction exists between suicide, physician assisted suicide and physician administered euthanasia. Secondly, that where treatment is withheld or withdrawn on the instruction of the patient that there is also no ascertainable ethical distinction between this practice and physician assisted death as in both cases it can be foreseen that the result is that the patient's death is being hastened.

4.10 Conclusion

The main arguments against physician assisted death have been debunked as follows.

Slippery slopes have not materialised in jurisdictions that were early adopters of physician assisted dying. The belief by many that life is to be preserved at all costs does not mean that in a constitutional democracy (with embedded human rights) a person who disagrees with that view may be prevented by law from accessing assisted death. Safeguards can be effectively employed to ensure that requests for assisted death are the result of a truly considered, informed, and independent act of autonomy. Physicians and mental health practitioners can refuse inappropriate requests that arise from situations where mental illness or undue influence affects the decision-making capacity of a person requesting physician assisted death. There is no reason to suggest that physicians will shift their focus from care and preservation of life to being proponents of death. Instead, physicians may be expected to only employ a legal option for physician assisted death when it is no longer in the patient's interest to preserve life at all costs and at the patient's explicit request. There is no evidence that the medical profession is held in lower regard in jurisdictions where physician assisted death is lawful. Legalising physician assisted death should not be seen as shifting the focus away from palliative care but rather as part of a continuum of palliative care that may end in assisted death. The conflation between means and ends focuses incorrectly on only the pain and discomfort of the patient and neglects the right of patients to exercise their agency, autonomy and liberty and determine for themselves the

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suicide is ethically permissible then a physician assisting a patient to commit suicide is assisting in something which was itself ethically permissible.

conditions under which they find living unacceptable and when they would prefer assistance in dying.

The main arguments in favour of assisted dying are compelling as follows.

An autonomous person is entitled to freely choose what should happen to his own body or mind and not be prevented in doing so in a constitutional democracy (with embedded human rights) as long as no harm is caused to others. It is the very essence of liberty to transform that which is wrong to that which is right by an ability to consent and in a constitutional democracy (with embedded human rights) a person should have the right to consent to physician assisted death through an autonomous request. It is ethically beneficial to assist a terminally ill person by relieving their interminable suffering and in doing so we allow a patient to make significance and meaning of the moment of death and to take control of the end of the story of their life. If suicide is ethically defensible under certain circumstances, then there is no bright-line ethical distinction between suicide, physician assisted suicide and physician administered euthanasia.

The question at the heart of this issue is: what is to be done in cases where the patient has decided that they are 'better off dead'? Who but the patient is better placed to make that decision? We should honour the request of autonomous individuals to decide to die over living in interminable pain and suffering and to be assisted by a physician to do so. To abandon a terminally ill and suffering individual to suffer a slow and painful death is ethically wrong and our law should recognise this by removing the blanket prohibition of assistance to suicide in these limited cases.

We must however be certain that sufficient safeguards are put in place to ensure that requestors are qualifying persons who make autonomous, free and informed decisions and to protect others including the weak and the vulnerable. In the next chapter, the safeguards employed in permissive jurisdictions are disaggregated.

CHAPTER 5
DISAGGREGATION OF SAFEGUARDS ACROSS JURISDICTIONS

5. Introduction

This chapter considers jurisdictions with permissive legal frameworks relating to physician assisted dying that include physician assisted suicide and physician administered euthanasia. These are to be distinguished from 'passive euthanasia' which is legal in many more jurisdictions than dealt with here and which involves the withholding or withdrawal of treatment by the physician but in which the physician does not take an active part in causing the death of the patient. As discussed previously there is debate as to whether there is an ethical distinction between the two practices.[1] The safeguards that apply in each of the following jurisdictions (in which formal legalisation took place in the year bracketed) are considered: Switzerland (1942), the Northern Territory of Australia (1995-1997), Oregon USA (1997), the Netherlands (2002), Belgium (2002), Washington State USA (2008), Luxembourg (2009), Montana USA (2009), Vermont USA (2013), California USA (2015), Colombia (2015), Canada (2016), Colorado USA (2016), the State of Victoria in Australia (2017), the District of Columbia USA (2017), Hawaii USA (2018), the State of Western Australia (2019), Maine USA (2019), New Jersey USA (2019), Germany (2020), and New Zealand (2020).

This disaggregation of the safeguards across jurisdictions will give insight into which safeguards are appropriate in a draft South African Bill discussed in the next chapter. The jurisdictions in which physician assisted suicide and/or physician

[1] See the discussion under heading 4.9.

administered euthanasia have been legalised have done so by either passing formal regulatory legislation, court order, referendum, amending the penal code, or a combination of these. Irrespective of the method of legalisation, safeguards are universally included in the relevant law with the only exceptions being Montana in the United States of America and Germany where there is little regulation as the change in law was ordered by a court with no subsequent regulating statute passed. For comparison between safeguards applicable across jurisdictions, it is convenient to divide the safeguard mechanisms into three levels.

The first level lies in the exact words of the pertaining law which determines whether only physician assisted suicide is legalised or if physician administered euthanasia is legalised in addition.[2] It will become evident from the discussion below that a court-initiated change in the law can affect the outcome of this level even where legislation subsequently follows.

The second level is the addition of other qualifying criteria. These include the age of the patient, the nature of the medical diagnosis necessary (together with the objective prognosis thereof), a subjective state of suffering requirement of the patient, as well as the required level of the voluntariness of the decision to consent that may include psychiatric and legal checks on the patient.

The third level is the addition of procedural safeguards as a monitoring tool and to ensure compliance with the procedures that may include waiting periods after requests and the number and form of requests, the engagement of additional independent physicians in the vetting process, and reporting tools and procedures.

These three levels may also be described as what is permitted (physician assisted suicide and/or physician administered suicide), who is eligible to be assisted, and how the entire procedure is governed. Together they form the basis of each system designed to prevent the deaths of people who are not the intended beneficiaries of the law, to prevent abuse, and to ensure that all the necessary compliances are met.

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[2] The only exception being Belgium which has legalised only physician administered euthanasia (discussed below).

5.1 Level 1 safeguards

5.1.1 Physician assisted suicide (PAS)/physician administered euthanasia (PAE)

5.1.1.1 Jurisdictions that allow PAS and PAE

5.1.1.1.1 The Netherlands

In the Netherlands, the origins of the legalisation of physician assisted death can be traced back to the *Postma*[3] case and developed in a series of cases including *Wertheim*[4], *Schoonheim*[5] and *Chabot*[6] amongst others. These cases developed the common law relating to physician assisted death and ultimately resulted in the passing of a statute to regulate the practice.[7] The exemption available applies only to a physician who complies with the 'due care criteria' laid down in the Act.[8] Article 20 of the Act amends the penal code to exempt a physician who 'terminates another person's life at that person's express and earnest request' provided that the physician fulfils the due care criteria and notifies the municipal pathologist. Since art.1(*b*) defines 'assisted suicide' as 'intentionally assisting in a suicide of another person or

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[3] *Queen v Ms Geertruida Postma* (District court of Leeuwarden) 1973 Nederlandse Jurisprudentie No.183.
[4] *Queen v Ms Wertheim Rechtbank Rotterdam* (The District Court of Rotterdam) 1982 Nederlandse Jurisprudentie No.63.
[5] *Queen v Schoonheim* (Supreme Court (Penal Section)) 1984 Nederlandse Jurisprudentie No.407.
[6] *Queen v Boudewijn Chabot* (Supreme Court (Penal Section)) 1994 Nederlandse Jurisprudentie No.656; see also J Griffiths 'Assisted suicide in the Netherlands: The Chabot case' (1995) 58 *Modern Law Review* 232.
[7] The Netherlands: Termination of Life on Request and Assisted Suicide (Review Procedures) Act entered into force on 1 April 2002 available at https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/brochures/brochures/euthanasiecode/2018/euthanasia-code-2018/EuthanasieCode_2018_ENGELS_def.pdf (accessed 17 December 2021, text of Act from page 57 of downloaded pdf onwards).
[8] Ibid art.2, see art.2(1) quoted in n171.

procuring for that other person the means', both physician assisted suicide and physician administered euthanasia are decriminalised.

5.1.1.1.2 Luxembourg

In Luxembourg, legislation[9] allows physicians to grant assistance or perform euthanasia if such a request by the patient is both a voluntary and an express request. The Act defines 'suicide counselling' as 'a doctor [who] intentionally helps another person to commit suicide or provides another person with the means to this end, at the express and voluntary request of that person'.[10] The Act defines 'euthanasia' as 'an act performed by a physician that intentionally terminates a person's life at the express and voluntary request of the person'.[11] By these definitions, both physician assisted suicide and physician administered euthanasia are provided for when performed by a physician. The Penal Code of Luxembourg was amended to create an exception to the crime of murder by poisoning for physicians complying with the Act.[12]

5.1.1.1.3 Colombia

In Colombia, the lawful recognition of physician assisted dying arose from a Constitutional Court order.[13] The penal code of Colombia[14] makes provision in art.103 for the crime of 'homicide' a period of imprisonment from thirteen to twenty-five years, with the aggravating circumstances provided for in art.10 extending such a sentence to a maximum of forty years. A separate crime of 'homicide for mercy' is criminalised in art.106[15] of the Code and by contrast, carries a relatively short period

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[9] Luxembourg: Act of 16 March 2009 on Euthanasia and Assisted Suicide available at https://legilux.public.lu/eli/etat/leg/loi/2009/03/16/n2/jo (accessed 17 December 2021).
[10] Ibid art.1.
[11] Ibid.
[12] The crime of murder by poisoning is contained in art.397 of the Penal Code that provides: 'Poisoning is murder committed by means of substances which can cause death more or less promptly, however such substances have been used or administered. He will be punished with life imprisonment.' Article 397-1 was inserted by the 2009 Act op cit n9 and provides the requirements for a physician to lawfully assist in dying.
[13] *Carlos Gaviria Diaz. Judgment C-239*, it demands for unconstitutionality. Constitutional Court. Colombia 1997.
[14] Colombia: Código Penal, Ley No. 599, 24 July 2000, available at https://www.refworld.org/docid/3dbd1fd94.html (in the Spanish, accessed 17 December 2021).
[15] Translated from the Spanish: 'Article 106. Homicide for mercy. He who kills another out of mercy, to end intense suffering from bodily injury or serious and incurable illness, will incur imprisonment of one (1) to three (3) years.'

of imprisonment of one to three years provided such homicide is 'to end intense suffering from bodily injury or serious and incurable illness'.

The Colombian Constitution[16] confers powers on its Constitutional Court that includes 'the task of reviewing, analyzing and interpreting the norms contained and established' in Colombia.[17] It is empowered to make findings employing a constitutional mechanism that allows a Colombian citizen to challenge laws on the basis that they violate the constitution, even where such laws do not affect the challenger directly. In 1997 a Colombian citizen came before the court claiming that the reduced sentences provided for in art.106[18] in cases of homicide for mercy were unconstitutional.[19] He made various claims in his application including that the state fails in its duty to protect and guarantee the lives of its people by its failure to punish those who take life in such cases.[20] Further that the state fails when it 'leaves the decision of the doctor or individual to end the lives of those whom it considers an obstacle, a nuisance or whose health represents a high cost'.[21] He also claimed that the lightness of the sentences in cases of homicide for mercy amounted to an 'authorization to kill'.[22]

The court disagreed and found instead that the supreme value of dignity informed the proper approach.[23] This supreme value when expressed by an autonomous person and with their proper consent in turn relies on the constitutional principle of 'solidarity' and accordingly separates such an act from one which requires stringent criminal sanction. This consent must, however, come from a person who is reliably informed of his therapeutic options, his illness, and his prognosis and who has the necessary intellectual capacity to appreciate these facts.[24]

The court expressly recognised that where a third party was required to ensure the autonomy of a person who has decided to end his life, the actions of such a third

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[16] The Colombian Constitution 1991, available at https://constituteproject.org/constitution/Colombia_2015.pdf?lang=en (accessed 17 December 2021).
[17] LLL Benavides 'The right to die with dignity in Colombia' (2018) 6 *Forensic Research & Criminology International Journal* 426 427.
[18] In 1997 when the matter was heard this provision was numbered art.326 Cod. Pen.
[19] Supra n13.
[20] Ibid at I(*B*).
[21] Ibid.
[22] Ibid.
[23] Ibid at II(*C*)(1).
[24] Ibid.

party was not criminalised. The court placed three minimum requirements to access physician assisted death: first, that there be clear scientific verification that the disease is terminal and causes great suffering; secondly, that the only authorised 'active' person must be a qualified medical doctor; and thirdly, that there must be unequivocal and free consent that a person has based on reliable information relating to his illness, therapeutic options, and prognosis.[25] The court delivered only the above minimum requirements and requested that Congress pass laws to regulate physician assisted death with additional safeguards. Congress failed to enact any relevant law in the ensuing 18 years.

In 2014 the Constitutional Court[26] dealt with a physician assisted death request by a plaintiff who was dying of cancer. The plaintiff died before the judgment but the court recognised that as a result of the failure to pass regulating procedures the right to die with dignity was not readily accessible. The court accordingly ordered the Ministry of Health and Social Protection to develop procedures to regulate the right to physician assisted death. In 2015, this Ministry issued a resolution[27] and a protocol.[28] These two documents read together with the two Constitutional Court Judgments[29] decriminalises both physician assisted suicide and physician administered euthanasia where the necessary safeguards have been observed.

5.1.1.1.4 Canada

In Canada, the recognition of physician assisted death arose from the Supreme Court of Canada judgment in *Carter v Canada.*[30] This case is discussed in more detail in chapter 3. The court concluded that s 241(*b*) and s 14 of the Canadian Criminal Code infringed on the plaintiff's right to life, liberty, and security of the person and that this infringement was not saved by the limitations clause in s 1 of the Canadian Charter of

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[25] E Palomino 'How to die in Colombia: A constitutional dilemma' (2017) 10(2) *Asia Pacific Journal of Health Law & Ethics* 51 56.
[26] *Luis Ernesto Vargas Silva. Judgment T-970,* action of guardianship. Constitutional Court. Colombia 2014.
[27] Resolution 1216 of 2015 available at https://www.icbf.gov.co/cargues/avance/docs/resolucion_minsaludps_1216_2015.htm (accessed 17 December 2021).
[28] Protocol for the Application of the Euthanasia Procedure in Colombia available at https://encolombia.com/medicina/materialdeconsulta/aplicacion-eutanasia/eutanasia-colombia/ (accessed 17 December 2021).
[29] Judgments supra n13 and n26.
[30] *Carter v Canada* 2015 SCC 5.

Rights and Freedoms.[31] It accordingly found these sections void in so far as they prohibited physician assisted death in the case of,

> 'a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable," it should be added, does not require the patient to undertake treatments that are not acceptable to the individual'.[32]

The court suspended the invalidity order for 12 months which was later extended by a further 4 months to allow parliament to pass legislation to regulate the practice and on 7 June 2016 the Medical Assistance in Dying (MAID) Act was passed by parliament.[33]

The Act amends the Canadian Criminal Code by the rewording of s 14 and the insertion of s 227 which exempts a medical or nurse practitioner from the culpable homicide provisions when providing 'medical assistance' in dying in terms of the Act. Medical assistance is now defined in s 241.1 of the Act as,

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

Accordingly, both physician assisted suicide and physician administered euthanasia are decriminalised.

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[31] Canadian Charter of Rights and Freedoms, Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), c 11 ['the Canadian Charter'].
[32] *Carter v Canada* supra n30 paras 126-128.
[33] The Medical Assistance in Dying (MAID) Act 2016 available at https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent#EH5 (accessed 17 December 2021). MAID was amended by the passing into law of Bill C-7 An Act to amend the Criminal Code (medical assistance in dying) in 2021 available at https://www.parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent (accessed 17 December 2021).

5.1.1.1.5 Australia

Northern Territory, State of Victoria, State of Western Australia

The first jurisdiction in the world to legalise euthanasia directly through legislation was the Northern Territory of Australia in 1995;[34] however, the legislation was voided by the Federal Government of Australia in 1997. No physician assisted dying law was in effect anywhere in Australia until 20 years later when in 2017 the State of Victoria passed such a law[35] followed by the State of Western Australia in 2019.[36] Willmot et al suggest that the shift towards physician assisted dying legislation through the intervening years owes to a convergence of factors that make this issue increasingly difficult for politicians to ignore:

> 'high and sustained public support for reform in Australia; an ageing and increasingly informed population seeking choices for their end-of-life experience; the changing legal landscape internationally; and the media's interest in the topic particularly for social media, and its agitation for change'.[37]

The Northern Territory

The parliament of this jurisdiction was the first to pass assisted dying legislation in 1995.[38] The Northern Territory does not have the status of an Australian state and as such is subject to s 122 of the Commonwealth Constitution.[39] The Rights of the Terminally Ill Act 1995 was effectively abolished by the passing of the Euthanasia

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[34] The Northern Territory of Australia: Rights of the Terminally Ill Act 1995 available at https://legislation.nt.gov.au/en/Legislation/RIGHTS-OF-THE-TERMINALLY-ILL-ACT-1995 (accessed 17 December 2021).

[35] State of Victoria, Australia: Voluntary Assisted Dying Act (VAD) 61 of 2017 *available at* https://content.legislation.vic.gov.au/sites/default/files/8caaf3b4-28f6-3ad1-acf3-e3c46177594e_17-61aa003%20authorised.pdf (accessed 17 December 2021).

[36] State of Western Australia: Voluntary Assisted Dying Act. 27 of 2019 available at https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42491.pdf/$FILE/Voluntary%20Assisted%20Dying%20Act%202019%20-%20%5B00-00-00%5D.pdf?OpenElement (accessed 17 December 2021).

[37] L Willmott, B White & C Stackpoole et al '(Failed) voluntary euthanasia law reform in Australia: Two decades of trends, models and politics' (2016) 39(1) *University of New South Wales Law Journal* 42.

[38] The Northern Territory of Australia: Rights of the Terminally Ill Act 1995 op cit n34.

[39] Section 122 of the Commonwealth of Australia Constitution Act 1900 (Imp) 63 & 64 Vict, c 12, s 9 available at https://www.legislation.gov.au/Details/C2013Q00005 (accessed 17 December 2021) provides, '(t)he Parliament may make laws for the government of any territory surrendered by Any State to and accepted by the Commonwealth, or of any territory placed by the Queen under the authority of and accepted by the Commonwealth, or otherwise acquired by the Commonwealth, and may allow the representation of such territory in either House of the Parliament to the extent and on terms which it thinks fit'.

Laws Act 1997 by the Federal Government of Australia by amending the Northern Territory (Self-Government) Act 1978 to the effect that the Northern Territory does not have jurisdiction in respect of euthanasia laws.[40]

In the short period in which it was in effect s 4[41] of the Rights of the Terminally Ill Act read together with the definition of 'assist'[42] meant that only a physician could be called upon to assist and that such assistance included both physician assisted suicide and physician administered euthanasia.

According to a report commissioned by the parliament of the Northern Territory, there was significant opposition to the Act within the Aboriginal community which represents a quarter of the territory's population many of whom described this practice as 'not the Aboriginal way'.[43]

State of Victoria

The State of Victoria passed a Voluntary Assisted Dying Act (VAD) that came into effect in 2019.[44] The State of Victoria is a state and not a territory and as such does not face the jurisdictional issues which led to the nullification of the Northern Territory law. The Victorian Act exhibits a comprehensive set of safeguards with 68 safeguards having been identified by the State Government.[45] This law has been criticised for making access to assisted dying restrictive, bureaucratic, and the process lengthy.

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[40] Section 1 of Schedule 1 of the Euthanasia Law Act 1997 inserts s 50A into the Northern Territory (Self-Government) Act 1978 which provides:
'(1) Subject to this section the power of the Legislative Assembly conferred by section 6 in relation to the making of laws does not extend to the making of laws which permit or have the effect of permitting (whether subject to conditions or not) the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life.'

[41] Section 4 provided that: 'A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life.'

[42] Section 3 provided that: 'In this Act, unless the contrary intention appears:
assist, in relation to the death or proposed death of a patient, includes the prescribing of a substance, the preparation of a substance and the giving of a substance to the patient for self administration, and the administration of a substance to the patient.'

[43] JI Fleming 'Death, dying, and euthanasia: Australia versus the Northern Territory' (2000) 15(3) *Issues in Law and Medicine Journal* 291 303.

[44] State of Victoria, Australia: Voluntary Assisted Dying Act op cit n35.

[45] Victoria State Government, Health and Human Services *Ministerial Advisory Panel on Voluntary Assisted Dying (Final Report)* (21 July 2017) 221-228 available at https://www2.health.vic.gov.au/about/publications/researchandreports/ministerial-advisory-panel-on-voluntary-assisted-dying-final-report (accessed 17 December 2021).

The Act authorises a co-ordinating medical practitioner to apply for a self-administration permit to prescribe and supply the voluntary assisted dying substance specified in the permit to cause the death of the person, provided such person 'is physically able to self-administer and digest the poison or controlled substance or the drug of dependence proposed'.[46] The Act accordingly authorises physician assisted suicide. The Act also authorises a co-ordinating medical practitioner to apply for a practitioner administration permit if the person 'is physically incapable of the self-administration or digestion of an appropriate poison or controlled substance or drug of dependence'.[47] Accordingly, as an exception, where a person is physically incapable of self-administration, physician administered euthanasia is authorised.

State of Western Australia

The State of Western Australia passed a physician assisted dying Act in 2019.[48] The Voluntary Assisted Dying Act (VAD) of Western Australia is based on the State of Victoria Act[49] with similar eligibility criteria and request processes. However, some differences lessen the administrative burdens imposed by the Victoria statute, thereby improving access to assisted dying in Western Australia.

A key difference is that the Western Australia Act provides that a patient may 'in consultation with and on the advice of the coordinating practitioner' choose either to self-administer or to have the co-ordinating practitioner administer the voluntary assisted dying substance. The acceptable reasons that may be given for a 'practitioner administration decision' are that a 'self-administration decision' is in the circumstances,

> 'inappropriate having regard to 1 or more of the following —
>
> (a) the ability of the patient to self-administer the substance;
>
> (b) the patient's concerns about self-administering the substance;
>
> (c) the method for administering the substance that is suitable for the patient'.[50]

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[46] Section 45 read with s 47(1) of the Victoria Act op cit n35.
[47] Ibid s 46 read with s 48(3).
[48] State of Western Australia: Voluntary Assisted Dying Act op cit n36.
[49] Op cit n35.
[50] Section 56 of the State of Western Australia: Voluntary Assisted Dying Act op cit n36.

This is in sharp contrast to the Victoria State statute that only authorises practitioner administration where the patient is physically incapable of the self-administration or digestion of the substance.[51] Accordingly, physician assisted suicide is authorised and physician administered euthanasia is authorised under significantly less stringent requirements in Western Australia than in Victoria.

5.1.1.1.6 New Zealand

Simultaneously with the general elections held on 17 October 2020, New Zealand voted in a referendum on whether a physician assisted dying Act[52] should come into force. The referendum was passed with 65.1% support and the Act came into force in November 2021. The safeguards included are similar to those now found in other modern statutes.

The Act provides for 'assisted dying' which is defined as,

> '(*a*) the administration by an attending medical practitioner or an attending nurse practitioner of medication to the person to relieve the person's suffering by hastening death; or
> (*b*) the self-administration by the person of medication to relieve their suffering by hastening death'.[53]

The eligible person may choose the method of administration from the following,

> '(i) ingestion, triggered by the person:
> (ii) intravenous delivery, triggered by the person:
> (iii) ingestion through a tube, triggered by the attending medical practitioner or an attending nurse practitioner:
> (iv) injection administered by the attending medical practitioner or an attending nurse practitioner'.[54]

Accordingly, the Act authorises both physician assisted suicide and physician administered euthanasia and the choice of which option is to be applied is left to the eligible patient.

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[51] Section 46 read with s 48(3) of the Voluntary Assisted Dying Act (Victoria) op cit n35.
[52] New Zealand: End of Life Choice Act of 2019 available at https://www.legislation.govt.nz/bill/member/2017/0269/latest/DLM7285905.html (accessed 17 December 2021).
[53] Ibid s 4.
[54] Ibid s 19(2)(*a*).

5.1.1.2 Jurisdictions that allow only PAS

Jurisdictions that only allow physician assisted suicide are Switzerland and jurisdictions in the United States being Oregon, Washington State, Montana, Vermont, California, Colorado, the District of Columbia, Hawaii, Maine, and New Jersey.

5.1.1.2.1 Switzerland

The first Swiss Criminal Code[55] came into force in 1942.[56] Article 115 of the Code,[57] by only criminalising assistance in suicide where there are 'selfish motives'[58] effectively did not criminalise assistance to a person committing suicide where the motive of the person assisting is altruistic or non-selfish and by so doing Switzerland became the first jurisdiction to formally legalise assisted suicide indirectly. At the time of drafting, the legislature was primarily concerned with what it considered to be valid (non-selfish) reasons for suicide such as for honour or failed romance and not with regulating assisted dying as a medical matter.[59] Subsequent revisions of the code have retained the article intact.

Article 115 does not require that the person assisting be a physician. The only prerequisite is that the patient must be 'decisionally competent' as without this capacity the death cannot legally be considered a suicide.[60]

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[55] Swiss Criminal Code of 21 december 1937 (status as of 20 July 2020) available at https://www.droit-bilingue.ch/rs/lex/1937/00/19370083-unique-en-rm.html (accessed 17 December 2021).
[56] C Bartsch, K Landolt & Anita Ristic et al 'Assisted suicide in Switzerland' (2019) 116 *Deutsches Ärzteblatt International* 545 545.
[57] 'Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.'
[58] See O Guillod & A Schmidt 'Assisted suicide under Swiss law' (2005) 12(1) *European Journal of Health Law* 30, where the authors describe when a selfish ground may be said to exist: '[W]here the person acts in order to satisfy his or her personal interests, whether financial, professional or affective. For instance, the person acts for the purpose of inheriting from the person who commits suicide or of marrying afterwards his or her spouse. A selfish ground would also be recognized if the person acted to avenge him or herself, to relieve him or herself of a maintenance order or simply to get rid of a hated person.'
[59] N Steck, M Egger & M Zwahlen 'Assisted and unassisted suicide in men and women: Longitudinal study of the Swiss population' (2016) 208(5) *British Journal of Psychiatry* 484 484.
[60] C Grosse & A Grosse 'Assisted suicide: Models of legal regulation in selected European countries and the case law of the European Court of Human Rights' (2015) 55(4) *Medicine, Science and the Law* 246 251.

Article 114[61] of the Code criminalises euthanasia despite such crime being considered a lesser crime than murder without consent and in doing so prohibits administered euthanasia whether the person administering is a physician or not.

The right to assisted suicide is also accorded to non-residents which gave rise to a practice referred to as 'suicide tourism'[62] where citizens of other countries travel to Switzerland to be assisted to die.

Despite not being formal law, in 2006 the Federal Court of Switzerland made the guidelines set out by the Swiss Academy of Medical Sciences mandatory for doctors throughout the federation.[63] This order standardised the documentation required from the assister and created an obligation that any potential mental disorders of a patient be ruled out.[64] The guidelines also require that the doctor ensures certain preconditions: first, that the patient's illness makes it likely that death is close; secondly, that all other options in which the patient could be supported were discussed and implemented; thirdly, that the patient is capable of discernment and the request has been well considered, and is not the result of pressure and may be regarded as final, all of which is to be corroborated by an independent party; and fourthly, the final act of suicide must be performed by the patient.[65]

5.1.1.2.2. Germany

The German Criminal Code[66] has historically dealt with, in order of severity, the crimes of murder under specific aggravating circumstances,[67] murder,[68] less serious

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[61] 'Any person who for commendable motives, and in particular out of compassion for the victim, causes the death of a person at that person's own genuine and insistent request is liable to a custodial sentence not exceeding three years or to a monetary penalty.'

[62] EJ Emanuel, BD Onwuteaka-Philipsen, JW Urwin et al 'Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe' (2016) 316(1) *Journal of the American Medical Association* 79 82.

[63] *Schweizerisches Bundesgericht: Entscheide 2A.48/2006* and *2A.66/2006* available at https://www.bger.ch/ext/eurospider/live/de/php/aza/http/index.php?highlight_docid=aza%3A%2F%2F03-11-2006-2A-48-2006&lang=de&type=show_document&zoom=YES& (accessed 17 December 2021).

[64] C Bartsch, K Landolt & A Ristic et al op cit n56 546.

[65] C Grosse & A Grosse op cit n60 251.

[66] German Criminal Code (Strafgesetzbuch – StGB) Criminal Code in the version published on 13 November 1998 (Federal Law Gazette I, p. 3322), as last amended by Article 2 of the Act of 19 June 2019 (Federal Law Gazette I, p. 844) available at https://www.gesetze-im-internet.de/englisch_stgb/index.html (accessed 17 December 2021).

[67] Ibid s 211.

[68] Ibid s 212.

cases of murder,[69] and killing upon request.[70] Depending on the facts in a specific case, the crimes of failure to render assistance and obstruction of persons rendering assistance may also be applicable.[71]

Since the first codification of the German Criminal Code in 1871, there was no law addressing the issue of assisted suicide with the result being a de facto legalisation thereof through the assumption that if suicide itself was not a crime, neither could aiding nor abetting it be a crime.[72]

However, on 5 November 2015, the Bundestag approved the first legal provision relating to assisted suicide which came to be referred to as the 'businesslike support of suicide' provision as this is what the provision intended to avoid.[73] The Bill clarified that for an act of assisted suicide to contravene this provision it would be sufficient for such assistance to be the purpose of a person's employment or if it were done repeatedly irrespective of whether a selfish motive is absent such as a doctor who repeatedly offers this service. This directly hindered assistance organisations and professional assistants due to the uncertainty as to how this provision would criminalise their activities.[74]

Several legal challenges followed and on 2 March 2017, the Federal Administrative Court held that in certain circumstances it would be illegal to provide a sufferer with the necessary medications to end life.[75]

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[69] Ibid s 213.
[70] Ibid s 216 which reads:
'Killing upon request
(1) Whoever is induced to kill at the express and earnest request of the person killed incurs a penalty of imprisonment for a term of between six months and five years.
(2) The attempt is punishable.'
[71] Ibid s 323*c*.
[72] M Freire de Andrade Neves 'States of uncertainty: plural laws and affective governance in the context of assisted suicide in Germany' (2018) 50(3) *The Journal of Legal Pluralism and Unofficial Law* 317 320.
[73] Section 217 of the German Criminal Code op cit n66 which read:
'Facilitating suicide as recurring pursuit
(1) Whoever, with the intention of assisting another person to commit suicide, provides, procures or arranges the opportunity for that person to do so and whose actions are intended as a recurring pursuit incurs a penalty of imprisonment for a term not exceeding three years or a fine.
(2) A participant whose actions are not intended as a recurring pursuit and who is either a relative of or is close to the person referred to in subsection (1) is exempt from punishment.'
[74] Freire de Andrade Neves op cit n72 at 321-322.
[75] The German Reference Centre for Ethics in the Life Sciences (DRZE) 'In Focus Euthanasia Legal Regulations' (2020) available at http://www.drze.de/in-focus/euthanasia/legal-regulations (accessed 17 December 2021).

On 26 February 2020, the German Federal Constitutional Court declared s 217 unconstitutional.[76] The court held that art.2 of the Basic Law requires that 'any legislative restriction of assisted suicide must ensure that sufficient scope remains in practice for the individual to exercise their constitutionally protected right to depart this life based on their free decision and with the assistance of others'.[77]

To date, no legislation has been passed to regulate the practice. Accordingly, since the Federal Constitutional Court order, physician assisted suicide is lawful with minimal regulation.

[76] *BVerfG, Judgment of the Second Senate* of 26 February 2020 - 2 BvR 2347/15 -, paras. 1-343, http://www.bverfg.de/e/rs20200226_2bvr234715en.html (accessed 17 December 2021).
[77] Ibid para 341 (English translation).

5.1.1.2.3 The United States of America

Oregon, Washington State, Vermont, California, Colorado, the District of Columbia, Hawaii, Maine, and New Jersey.

The Oregon State Legislature passed the Oregon Death with Dignity Act[78] in 1997. It provides that a terminally ill patient ordinarily resident in Oregon may self-administer lethal medications that have been prescribed by a physician for the express purpose of dying with dignity. The Act authorises a physician to either prescribe lethal medications or if the physician is registered in Oregon as a dispensing physician and has a current Drug Enforcement Administration certificate, such physician may also dispense the medications directly to the patient.[79] However, only the prescribing and/or dispensing of the medication is authorised. The physician may not administer it to the patient. As such, only physician assisted suicide is authorised and not physician administered euthanasia.

The states of Washington,[80] Vermont,[81] California,[82] Colorado,[83] Hawaii,[84] Maine,[85] New Jersey,[86] and the District of Columbia[87] passed physician assisted dying laws based on the Oregon model with relatively minor adjustments.

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[78] The Oregon Death with Dignity Act 1997, available at https://deathwithdignity.org/wp-content/uploads/2015/10/1994-OR-Death-with-Dignity-Act.pdf (accessed 17 December 2021).
[79] Ibid s 3.01(1)(*k*) read together with s 3.01(1)(*l*).
[80] Section 4(1)(*k*) read together with s 4(1)(*l*); and s 1(12) read with s 2(1) of the Washington Death with Dignity Act 2009 available at https://app.leg.wa.gov/rcw/default.aspx?cite=70.245 (accessed 17 December 2021). This legislation was initiated consequent to Initiative 1000 of 2008. Article II, s 1(a) of the Washington State Constitution makes provision for an 'Initiative' process by which a resident may propose a new law which if not enacted by its legislature may be voted into law by a majority at a ballot.
[81] Section 5283(*a*)(13)(*A*) read together with s 5283(*a*) of the Patient Choice and Control at End of Life Act 39 of 2013 available at https://deathwithdignity.org/states/vermont/ (accessed 17 December 2021).
[82] Section 443.5(*b*) read together with s 443.2 of The End of Life Option Act, 2015 available at https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=1.&title=&part=1.85.&chapter=&article= (accessed 17 December 2021).
[83] Section 103 and s 106 of the End-of-Life Options Act 2016 available at https://deathwithdignity.org/states/colorado/ (accessed 17 December 2021).
[84] Section 2 and s 4(12) of the Our Care Our Choice Act, 2018 available at https://www.findlaw.com/state/hawaii-law/hawaii-euthanasia-laws.html (accessed 17 December 2021).
[85] Section 4 and s 6(*M*) of the Death with Dignity Act 2019 available at https://legislature.maine.gov/legis/statutes/22/title22sec2140.html (accessed 17 December 2021).
[86] Section 4 and s 6(9) of the Medical Aid in Dying for the Terminally Ill Act 2019 available at https://www.njconsumeraffairs.gov/Statutes/Medical-Aid-in-Dying-for-the-Terminally-Ill-Act.pdf (accessed 17 December 2021).
[87] Section 4(*a*)(1) and s 6(*b*)(1) and s 6(*b*)(2) of the Death with Dignity Act 2016 available at https://deathwithdignity.org/wp-content/uploads/2015/11/DC-Death-with-Dignity-Act.pdf (accessed 17 December 2021).

Montana (2009)

In *Baxter v Montana,*[88] the Supreme Court of the State of Montana heard an appeal from the District Court judgment which had held that Robert Baxter,

> 'a competent, terminally ill patient has a right to die with dignity under art.II, s 4 and 10 of the Montana Constitution, which includes protection of the patient's physician from prosecution under the homicide statutes'.[89]

Mr Baxter suffered from a terminal form of cancer. He was treated by chemotherapy which was expected to become progressively less effective over time and the symptoms he suffered were many and varied and both uncomfortable and painful. Worst of all, it was expected that the symptoms he suffered would worsen as the efficacy of the chemotherapy weakened.[90]

The Appeal Court diverged from the constitutional argument accepted by the court a quo and instead applied the judicial principle that it should where possible, decide a case without reaching issues of constitutionality.[91] The court acknowledged that suicide is not a crime in Montana and as such the only possible accused in a physician assisted suicide scenario would be the physician who had assisted the patient. The court then considered the 'consent defence'[92] provision provided for in the Montana Code that provides for conditions under which the consent of the victim to otherwise criminal conduct may be invoked.[93]

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[88] *Baxter v Montana*, 2009 MT 449 available at https://law.justia.com/cases/montana/supreme-court/2009/50c59956-3100-468d-b397-4ab38f6eda4d.html (accessed 17 December 2021).
[89] Ibid para 1.
[90] Ibid para 5.
[91] Ibid para 10.
[92] Section 45-2-211 of the Montana Code.
[93] Section 45-2-211. 'Consent as defense
(1) The consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense.
(2) Consent is ineffective if:
(*a*) it is given by a person who is legally incompetent to authorize the conduct charged to constitute the offense;
(*b*) it is given by a person who by reason of youth, mental disease or disorder, or intoxication is unable to make a reasonable judgment as to the nature or harmfulness of the conduct charged to constitute the offense;
(*c*) it is induced by force, duress, or deception;
(*d*) it is against public policy to permit the conduct or the resulting harm, even though consented to; or
(*e*) for offenses under 45-5-502, 45-5-503, 45-5-508, 45-5-601, 45-5-602, 45-5-603, or Title 45, chapter 5, part 7, it is given by a person who the offender knew or reasonably should have known was a victim of human trafficking, as defined in 45-5-701, or was subjected to force, fraud, or coercion, either of which caused the person to be in the situation where the offense occurred.'

The court noted that the first three exceptions to which consent would be ineffective numbered '(2)(*a*) to (2)(*c*)' to the defence were factual considerations that would need to be considered in the circumstances of each case. On the fourth exception numbered '(2)(*d*)', the court found that there was only one relevant reported case in Montana. The court had in that case considered which actions should be against public policy and had found that these occurred in situations in which 'violent, public altercations breach public peace and endanger others in the vicinity'.[94] After surveying decisions of courts in other states, the court concluded that the violence which fell under the exception was characterised by 'aggressive and combative acts that breach public peace and physically endanger others'.[95] The court then distinguished such aggressive acts on the one hand from the peaceful act of 'a physician handing medicine to a terminally ill patient, and the patient's subsequent peaceful and private act of taking the medicine'.[96] The physician performs no violent act and the patient decides to take and then takes the medicine himself whilst the relationship between the patient and his physician is at all times private, civil and compassionate.

The court then turned its attention to the law criminalising deliberate homicide, provided for in s 45-5-102 of the Montana Code.[97] It concluded that the words used in the provision imply that killing 'another' is an offence and that killing oneself is not. Since in the case of physician assisted suicide the patient takes the lethal medicine, this is a case of suicide and the patient has caused his death. Accordingly, the physician who hands the patient the means to commit suicide is not acting against public policy as expressed in this provision.[98]

The Montana Rights of the Terminally Ill Act incorporated into the Montana Code[99] then came under scrutiny. The court pointed out that s 50-9-204 of the Code 'expressly immunizes physicians from criminal and civil liability for following a patient's directions to withhold or withdraw life-sustaining treatment'.[100] The court noted that the provisions went further to criminalise the failure by a physician to act

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[94] *Baxter v Montana* supra n88 9 referring to the case *State v Mackrill* 2008 MT 297.
[95] Ibid para 18.
[96] Ibid para 21.
[97] Which provides as follows: 'A person commits the offense of deliberate homicide if:
(a) the person purposely or knowingly causes the death of another human being …'.
[98] *Baxter v Montana* supra n88 para 26.
[99] Section 50-9 of the Montana Code.
[100] *Baxter v Montana* supra n88 para 27.

on the patient's wishes.[101] The court also noted that there is no indication in the Act that any additional means of giving effect to a decision by a patient to effect the patient's death was prohibited or against public policy, provided this was done without any direct physician assistance (as would be the case when a physician prescribes medication).[102] Finally, the court noted that these provisions authorise the withdrawal of life-sustaining conditions through a 'direct act' by the physician. The court reasoned that 'the lesser physician involvement' of making lethal medication available which is then taken after 'a terminally ill patient's intervening choice and subsequent[ly] self-administered' cannot be regarded as against public policy.[103]

The court concluded that physician assisted suicide is accordingly not against public policy in either the case law or statutes of Montana and that accordingly, the consent defence is available to a physician who makes available the means of suicide. It follows that a physician who complies with the Montana Code, is protected by it when providing the means of suicide to the patient, provided the patient takes such means independently.[104]

The Act read together with the *Baxter*[105] judgment sets out a defence to a charge of a physician to provide lethal medications to the patient. However, the physician may not administer it, and as such only physician assisted suicide is authorised and not physician administered euthanasia.

Only the jurisdictions of Montana and Germany have no other safeguards due to a lack of legislation, As Svenson notes:

> 'To this point, then: because Montana's PAID [physician assistance in dying] operates without any safety net — not to mention nets like those in Oregon and Washington, statutory rules and regulations that could be put into service as bulwarks against Montana wrongdoings will be reckoned with ''later than sooner.'' Terminal illness?

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[101] Section 50-9-206 provides: 'Penalties. (1) A health care provider who wilfully fails to transfer the care of a patient in accordance with 50-9-203 is guilty of a misdemeanour punishable by a fine not to exceed $500 or imprisonment in the county jail for a term not to exceed 1 year, or both.
(2) A physician or advanced practice registered nurse who wilfully fails to record the determination of terminal condition or the terms of a declaration in accordance with 50-9-201 is guilty of a misdemeanour punishable by a fine not to exceed $500 or imprisonment in the county jail for a term not to exceed 1 year, or both.'
[102] *Baxter v Montana* supra n88 para 28.
[103] Ibid para 32.
[104] Ibid para 50.
[105] *Baxter v Montana* supra n88.

> Competency determinations? Waiting periods? The voluntary nature of consent? Residency and age requirements? Record keeping?'[106]

The state of the Montana law on physician assisted suicide shows what can result if a court makes a legal determination of a complex matter without resort to the legislative authority. It would have been preferable for the court to have ordered that a statute be passed by the State of Montana and if the Montana legislature fails to do so by a specified date that a court-designed set of basic safeguards would come into effect. Both Oregon and Washington had similar legal frameworks enacted that were available for the court to reference. Unfortunately, the result is that in Montana physician assisted suicide is largely unregulated.

5.1.1.3 Jurisdiction that allows only PAE

5.1.1.3.1 Belgium

The debate in Belgium in 2002 was whether it should follow suit with similar legislation to that of the Netherlands[107] and in May of that year, it passed The Belgian Act on Euthanasia.[108] It allows physicians to perform active euthanasia if requested by a competent patient, provided the patient was not influenced by others in the making of that decision. The Act defines 'euthanasia' as 'intentionally terminating life by someone other than the person concerned, at the latter's request'.[109] By this definition, only administered euthanasia is allowed. Furthermore, only a physician may administer euthanasia.[110] This Act is in stark contrast to that of the Netherlands which allows physician assisted suicide in addition to physician administered euthanasia. The reason for the Belgian law's departure from that of the Netherlands may be mainly explained by two factors. First, that the Belgian's did not have the case law which preceded the Netherlands legislation; and secondly, that in Belgium despite euthanasia

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[106] AG Svenson 'Montana's courting of physician aid in dying could Des Moines follow suit?' (2010) 29(2) *Politics and the Life Sciences* 2 12.
[107] R Cohen-Almagor 'Belgian euthanasia law: a critical analysis' (2009) 35 *Journal of Medical Ethics* 436 436.
[108] The Belgian Act on Euthanasia May, 28th 2002 available at http://eol.law.dal.ca/wp-content/uploads/2015/06/Euthanasia-Act.pdf (accessed 17 December 2021).
[109] Ibid s 2.
[110] Ibid s 3(1) and s 3(2).

being technically illegal it was in practice tolerated with prosecutions being rare.[111] As such, the Belgian Act was merely formalising the existing practices. Despite the Belgian Act not formally legalising physician assisted suicide, such cases appear to be condoned in practice and treated in the same manner as euthanasia cases by the Belgian 'Federal Control and Evaluation Commission: Euthanasia' which monitors dying law compliance.[112]

5.1.1.4 Summary

Only Switzerland and the permissive jurisdictions in the United States of America restrict their application to physician assisted suicide that by definition requires the active participation by the patient in the suicide. Such participation increases the probability that the decision to die was voluntary and ensures that the physician is not the sole cause of the death of the patient. The jurisdictions that allow both physician assisted suicide and physician administered euthanasia are the Netherlands, Luxembourg, Colombia, Canada, and in Australia the State of Victoria and the State of Western Australia (and for a short period the Northern Territory of Australia), and New Zealand. Belgium is the only jurisdiction to formally allow only physician administered euthanasia and not physician assisted suicide despite the latter reportedly being tolerated in practice.

In the Netherlands and Canada, where both physician assisted suicide and physician administered euthanasia are legalised, physician administered euthanasia has become the dominant mode by far.[113] Preston suggests that the reason for physician administered euthanasia being the method of choice is that in this mode the patient is the passive recipient of medications similar to medical care interventions with which patients are accustomed, as opposed to being required to actively ingest lethal substances which are psychologically more closely associated with the act of

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[111] R Cohen-Almagor op cit n107 436.
[112] L Van den Block, R Deschepper & J Bilsen et al 'Euthanasia and other end of life decisions and care provided in final three months of life: nationwide retrospective study in Belgium' (2009) 339(b2772) *British Medical Journal* available at https://www.bmj.com/content/bmj/339/bmj.b2772.full.pdf (accessed 17 December 2021) 2.
[113] R Preston 'Death on demand? An analysis of physician-administered euthanasia in The Netherlands' (2018) 125(1) *British Medical Bulletin* 145 154.

suicide.[114] There are two additional reasons at play, being that in some jurisdictions such as Belgium and the Netherlands it is the practice to administer lethal drugs as well as a preference towards more precise medical control through intravenous injections as opposed to orally ingested drugs.

Ryan and Kaye agree that there are advantages to physician administered suicide, as opposed to physician assisted suicide, from the Australian perspective. For example, in that in that country the lack of an ethical distinction between physician assisted suicide and physician administered euthanasia has long been debated and the advantage of physician administered euthanasia is that intravenous drugs are more easily administered and absorbed and results in more rapid death from exactly titrated doses. It also prevents the exclusion of patients from physician assisted dying because they are physically unable to administer drugs to themselves.[115]

As is apparent from the discussion below, where a specific jurisdiction does not pass legislation after a physician assisted dying judgment, the law set out by the court tends to be vague, wide and unregulated, yet even where legislation is passed after a court judgment such legislation often follows the general ambit as set out by the court order merely codifying it and limiting further debate.

5.2 Level 2 safeguards

5.2.1 Age

5.2.1.1 Age of majority set at 18 years subminimum

All the following jurisdictions have the age of majority, being 18 years, as the subminimum age to access physician assisted dying: Luxembourg,[116] Canada,[117] the Northern Territory of Australia (1995-1997),[118] the State of Victoria in Australia,[119]

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[114] Ibid.
[115] CJ Ryan & M Kaye 'Euthanasia in Australia' (1996) 334(5) *The New England Journal of Medicine* 326 327.
[116] Article 4 para 1 of the Luxembourg Act op cit n9.
[117] Section 241.2(1)(*b*) of the Canada Act op cit n33.
[118] Section 7(1)(*a*) of the Northern Territory of Australia Act op cit n34.
[119] Section 9(1)(*a*) of the State of Victoria Act op cit n35.

the State of Western Australia,[120] New Zealand,[121] Oregon,[122] Washington State,[123] Vermont,[124] California,[125] Colorado,[126] the District of Columbia,[127] Hawaii,[128] Maine,[129] and New Jersey.[130]

5.2.1.2 Deviations from 18 years subminimum

The following jurisdictions depart from this age requirement: Switzerland, the Netherlands, Belgium, Montana, Colombia, and Germany.

The Swiss Criminal Code only criminalises assistance in suicide for selfish motives as discussed above.[131] Accordingly, there are no level 2 safeguards including no subminimum age.

In the Netherlands, a minor patient between 16 and 18 years of age who 'may be deemed to have a reasonable understanding of his interests' must have the parents or guardian 'involved in the decision process'.[132] Minors between the ages of 12 and 16 who 'may be deemed to have a reasonable understanding of his interests' must have the parents or guardian agree to the decision.[133] The age of 12 is therefore subminimum for the application of the Netherlands Act. The Act is silent on the issue of the active ending of the life of severely impaired new born babies. However, a protocol was developed at the University Medical Centre of Groningen that is known as the Groningen protocol.[134] This protocol lays down the criteria for such termination.[135]

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[120] Section 16(1)(*a*) of the State of Western Australia Act op cit n36.
[121] Section 5(1)(*a*) of the New Zealand Act op cit n52.
[122] Section 1.01(1) read together with s 2.01(1) of the Oregon Act op cit n78.
[123] Section 70.245.10(1) read together with s 70.245.20(1) of the Washington State Act op cit n80.
[124] Section 5281(*a*)(8) read together with s 5283(*a*) of the Vermont Act op cit n81.
[125] Section 443.1(*a*) read together with s 443.2(*a*) of the California Act op cit n82.
[126] Section 102(1) read with s 103(1) of the Colorado Act op cit n83.
[127] Section 2(13) read with s 6(*b*) of the District of Columbia Act op cit n87.
[128] Section 1 read with s 2 of the Hawaii Act op cit n84.
[129] Section 2(A) read with s 4 of the Maine Act op cit n85.
[130] Section 3 read with s 4 of the New Jersey Act op cit n86.
[131] See n57 and the discussion under heading 5.1.1.2.1.
[132] Article 2.3 of the Netherlands Act op cit n7.
[133] Ibid art.2.4.
[134] E Verhagen & P Sauer 'The Groningen Protocol — Euthanasia in severely ill Newborns' (2005) 352(10) *The New England Journal of Medicine* 959, available at https://www.nejm.org/doi/full/10.1056/NEJMp058026 (Accessed 17 Deember 2021).
[135] Ibid at Table 2:
'Requirements that must be fulfilled:
The diagnosis and prognosis must be certain
Hopeless and unbearable suffering must be present

Case law and the recognition of the protocol by the Dutch public prosecutor has meant that in practice if the protocol is followed, these terminations are not prosecuted.

In Belgium, between promulgation in 2002 of the physician assisted dying Act[136] and until 2014 the age requirement of the patient was that they must have 'attained the age of majority or [be] an emancipated minor'.[137] According to the Belgian Civil Code, the age of majority in Belgium is 18 years.[138] On 13 February 2014, the Act was amended by the Belgian Act amending the Act of 28 May 2002 on Euthanasia[139] to include in the age requirement 'or a minor with the capacity of discernment' (translated).[140] An additional qualifier was added to the effect that 'death in the short term' be expected as a prerequisite.[141] Imminent death is not a prerequisite for adult patients. Two additional safeguards also apply to this category of patient. First, a psychiatrist or a psychologist must examine the patient and certify that the minor has the necessary discernment; and secondly, the legal representatives of the minor must confirm their agreement.[142]

In the State of Montana, the consent defence[143] arising from the Montana Code has limited exceptions[144] including that the victim 'by reason of youth, mental disease or disorder, or intoxication is unable to make a reasonable judgment'. Although the word 'youth' is not defined in terms of a specific number of years it does require that the victim must be old enough to form the required reasonable judgment.

In Colombia, the Constitutional Court[145] confirmed in 2017 that minors may also access the right to euthanasia and ordered that the Ministry of Health and Social

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The diagnosis, prognosis, and unbearable suffering must be confirmed by at least one independent doctor
Both parents must give informed consent
The procedure must be performed in accordance with the accepted medical standard.'

[136] The Belgian Act op cit n108.

[137] Ibid s 3(1).

[138] Article 388 as translated from the French reads as follows: 'A minor is an individual of either sex who has not yet the age of eighteen years completed.'

[139] K Raus 'The extension of Belgium's euthanasia law to include competent minors' (2016) 13(2) *Journal of Bioethical Inquiry* 305 306.

[140] Ibid.

[141] Ibid 307.

[142] Section 3(2)(7) of the Belgian Act amending the Act of 28 May 2002 on Euthanasia.

[143] Discussed above under heading 5.1.1.2.3 (sub-heading 'Montana (2009)').

[144] See text of the exceptions in the Code at n93.

[145] *Gloria Stella Ortiz Delgado. Judgment T-544,* action of guardianship. Constitutional Court. Colombia 2017, available in Spanish at https://www.corteconstitucional.gov.co/relatoria/2017/t-544-17.htm (accessed 15 December 2021). For further discussion on the judgment see Benavides op cit n17 428.

Protection regulate this legal development. The Ministry of Health and Social Protection enacted a resolution to provide for the euthanasia of certain minors. The resolution provides that mentally competent minors between the age of 14 and 18 may request euthanasia and do not require parental consent.[146] Mentally competent minors between the ages of 12 and 14 years may request euthanasia but require parental consent.[147] Mentally competent minors between the ages of 6 and 12 years require parental consent to request euthanasia and also must,

> '(i) reach neurocognitive development and exceptional psychological [capacity] allowing them to make a free, voluntary decision, informed and unequivocal in the medical field and
>
> (ii) the concept of death reaches the level expected for a child over 12 years …'.[148]

In Germany, the judgment of the German Federal Constitutional Court[149] discussed above[150] did not make any reference in its order to a subminimum age, however, the person must have the required level of voluntariness for consent which includes the necessary level of decision-making capacity to form the intention to express personal autonomy by committing suicide.[151] It follows that a person must have attained a sufficiently mature age to reach the necessary level of decision-making required.

5.2.1.3. Summary

Few jurisdictions deviate from the norm of only allowing adults to undergo physician assisted dying. However, there is a compelling argument that younger persons may also possess the necessary competence to voluntarily make requests to die with dignity. A protocol that requires psychiatric testing to confirm such competence together with the guardian's consent appears to strike the correct balance.

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[146] Article 8 read together with art.10.2 of Ministry of Health and Social Protection Resolution 825 of 2018.
[147] Ibid art.9 read together with art.10.1.
[148] Ibid art.3.6 (translated from the Spanish).
[149] Supra n76.
[150] Discussed under heading 5.1.1.2.2.
[151] German Federal Constitutional Court decision supra n76 para 275 (translated from the German).

5.2.2 Objective and/or subjective test

These tests measure the position that the patient finds themselves in so that it may be determined whether they are sufficiently ill and/or suffering mentally such that they qualify to be assisted in dying. An objective test relates to the objective medical opinion of a physician as to the physical condition and diagnosis of the patient and their prognosis whereas a subjective test relates to the patient's internal mental state of suffering and what the patient deems as intolerable mentally and/or physically.

5.2.2.1 Both objective and subjective tests

All the following jurisdictions have both objective diagnosis/prognosis requirements as well as subjective mental state requirements to access physician assisted dying. Though the wording in the legislation differs between jurisdictions the net effect is similar in that they all require both objective medical opinions by physicians and subjective mental states of suffering by the patient. These jurisdictions are the Northern Territory of Australia (1995-1997),[152] the State of Victoria in Australia,[153] the State of Western Australia,[154] New Zealand,[155] Belgium,[156] Luxembourg,[157] Colombia,[158] and Canada.[159]

The objective tests typically relate to medically confirmable opinions by expert physicians that include two elements; first, the current medical state of the patient (diagnosis) and secondly the expected medical outcome (prognosis) for the patient. The current state of the patient is described using terms such as that the patient is 'suffering from an illness', is 'diagnosed with a disease, illness or medical condition',

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[152] Section 7(1)(*b*) and s 7(1)(*d*) of the Northern territory of Australia Act op cit n34. See n40 The Rights of the Terminally Ill Act 1995 was effectively abolished by the passing of the Euthanasia Laws Act 1997 by the Federal Government of Australia effectively reverting to the legal position that physician assisted dying was unlawful in this jurisdiction.
[153] Section 9(1)(*d*) and s 9(4) and s 9(1)(*d*)(iv) of the State of Victoria Act op cit n35.
[154] Section 16(1)(*c*)(i)-(ii) and s 16(1)(*c*)(iii) of the State of Western Australia Act op cit n36.
[155] Section 5(1) of the New Zealand Act op cit n52.
[156] Section 3(1) of the Belgian Act op cit n108.
[157] Article 1 para 3 of the Luxembourg Act op cit n9.
[158] See Article 2 of the Resolution 1216 op cit n27 and under heading 'Recommendation Definition of Terminal Patient Susceptible to the Application of Euthanasia in Colombia' of the Protocol op cit n28 and discussion under heading 5.1.1.1.3.
[159] Section 241.2(1)(*c*) and s 241.2(2) of the Canadian Act op cit n33, note that the requirement that 'their natural death has become reasonably foreseeable' was repealed by Bill C-7 as discussed under heading 3.2.4.2.3.

or has ‘a serious and incurable disorder’, or is in a ‘dead end medical situation’ or ‘suffers from a grievous and irremediable medical condition’.

The expected outcome for the patient incorporates descriptions such as that the prognosis ‘is terminal’ or ‘will result in the death of the patient’ or is ‘incurable; is advanced, progressive and will cause death’. Some jurisdictions add a lifespan element including descriptions such as a ‘fatal prognosis in the short term’ or the likely ‘end [of] the person’s life within 6 months’ or the illness is expected to cause death ‘within weeks or months, not exceeding 6 months’.

The subjective test relates to the patient’s internal mental state of suffering and what the patient deems as intolerable. Such internal mental states include terms such as that the illness must be ‘causing the patient severe pain or suffering’ or ‘experiences unbearable suffering’ or is ‘enduring physical or psychological suffering’. The limits of what is subjectively tolerable by the patient may be described as ‘intolerable to them and that cannot be relieved under conditions that they consider acceptable’.

5.2.2.2 Only objective tests

All of the following nine jurisdictions of the United States of America only have objective diagnosis/prognosis requirements to access physician assisted dying: Oregon,[160] Washington State,[161] Vermont,[162] California,[163] Colorado,[164] the District of Columbia,[165] Hawaii,[166] Maine,[167] and New Jersey.[168] These requirements are very similar in all these states despite subtle differences in the language used that does not appear to make material distinctions in the law between jurisdictions. Montana is the

[160] Section 2.01(1) read together with s 1.01(12) of the Oregon Act op cit n78.
[161] Section 70.245.20(1) read together with s 70.245.10(13) of the Washington State Act op cit n80.
[162] Section 5281(*a*)(10) read together with s 5283(*a*) of the Vermont Act op cit n81.
[163] Section 443.1(*q*) read together with s 443.2(*a*) of the California Act op cit n82.
[164] Section 25-48-102(16) read together with with s 25-48-103(*a*) of the Colorado Act op cit n83.
[165] Section 2(16) read together with s 4(*a*)(1)(*A*) of the District of Columbia Act op cit n87.
[166] Section 1 read together with s 2 of the Hawaii Act op cit n84.
[167] Section 2(*M*) read together with s 4 of the Maine Act op cit n85.
[168] Section 3 read with s 4 of the New Jersey Act op cit n86.

only permissive state in the United States of America that does not follow this model and is dealt with under another heading.[169]

The wording of the legislation relating to the objective test typically provides that the required medical diagnosis/prognosis is that the patient is suffering from a 'terminal disease' (the diagnosis) which means an 'incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months' (the prognosis).[170] There is no subjective state of suffering test.

5.2.2.3 Only subjective tests

The Netherlands has a subjective mental state of the patient as a requirement of 'due care' to access physician assisted dying. However, the provisions couch the requirement in a manner such that it is the physician who must hold the conviction that the patient experiences the subjective mental states. The 'due care' requirements[171] (amongst others) are therefore that the physician, 'holds the conviction that the patient's suffering was lasting and unbearable'[172] and the subjective state of suffering is that the physician and the patient hold 'the conviction that there was no other reasonable solution for the situation he was in'.[173] This necessitates that the physician must also have informed the patient about the situation he was in and about his prospects which do imply that medically objective information must be conveyed to the patient regarding his physical or mental health (with which a second physician must concur). However, as Preston notes, the Act does not 'require that the patient should have been diagnosed as having a terminal illness. The two principal

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[169] See heading 5.2.2.4.
[170] This is the wording from the Oregon Act op cit n78 see sections referred to in n160.
[171] 'The requirements of due care, referred to in Article 293 second paragraph Penal Code mean that the physician:
a. holds the conviction that the request by the patient was voluntary and well-considered,
b. holds the conviction that the patient's suffering was lasting and unbearable,
c. has informed the patient about the situation he was in and about his prospects,
d. and the patient hold the conviction that there was no other reasonable solution for the situation he was in,
e. 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.'
[172] Chapter II art.2(1)(*b*) of The Netherlands Act op cit n7.
[173] Ibid chapter II art.2(1)(*d*).

criteria are a voluntary and well-considered request and lasting and unbearable suffering'.[174]

5.2.2.4 Neither objective nor subjective tests

The criteria to access physician assisted dying in Switzerland, Montana, and Germany do not include the objective diagnosis/prognosis of the patient nor tests for the subjective mental state of suffering of the patient.

In Switzerland, the Swiss Criminal Code only criminalises assistance in suicide for selfish motives as discussed above without a medical diagnosis/prognosis or mental state of suffering conditionality.[175]

A similar position pertains in the State of Montana where the consent defence[176] arising from the Montana Code does not include a specific diagnosis/prognosis nor a subjective mental state of suffering.

In Germany, the judgment of the German Federal Constitutional Court[177] discussed above[178] did not make any reference in its order to an objective diagnosis/prognosis nor any subjective mental state requirements provided the reason for wishing to commit suicide is a self-determined death as an expression of personal autonomy.[179] However, the court does find that certain circumstances may arise where the duty of the state to protect life must take precedence over the individual's freedom where 'the individual is exposed to influences that endanger their self-determination over their own life'.[180] Similarly, no specific subjective state is required as the assistance is to someone wishing to commit suicide and,

> 'an individual's decision to end their own life, based on their personal understanding of what constitutes a meaningful existence, must be recognised as an act of autonomous self-determination'.[181]

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[174] R Preston op cit n113 146.
[175] See n57 and the discussion under heading 5.1.1.2.1.
[176] Discussed above under heading 5.1.1.2.3.
[177] Supra n76.
[178] Discussed under heading 5.1.1.2.2.
[179] German Federal Constitutional Court decision op cit n76 para 275 (translated from the German).
[180] Ibid.
[181] Ibid.

5.2.2.5 Summary

Most countries with physician assisted dying Acts in place have both objective diagnosis/prognosis tests and mental state of suffering subjective tests. In the United States of America, all its jurisdictions (other than Montana) have an objective diagnosis/prognosis test only. Only the Netherlands has a subjective state of suffering test only but no objective medical diagnosis/prognosis test (with the caveat that the physician must engage in a medical consultation which implies that objective medical advice is offered). The three jurisdictions with neither an objective diagnosis/prognosis test nor a subjective state of mental suffering test have no physician assisted dying Act in place.

5.2.3 Voluntariness

Voluntariness relates to the nature of a patient's request for physician assisted dying in order to ensure that the decision to request is freely and rationally made on an informed basis without undue influence. Voluntariness requirements ensure that patients who are weak, vulnerable, incapable, uncertain or uninformed are not coerced into requesting assisted dying.

Ethically and legally, voluntariness is at the core of distinguishing physician assisted dying from homicide. Accordingly, jurisdictions that allow physician assisted dying have laws which universally incorporate voluntariness requirements relating to a patient request for physician assisted dying, to ensure that the request arises from the voluntary decision of the patient. These requirements in Switzerland, the Netherlands, Belgium, Luxembourg, Colombia, Canada, Germany, New Zealand, the Northern Territory of Australia (1995-1997), the State of Victoria in Australia, the State of Western Australia, Oregon, Washington State, Vermont, California, Colorado, the District of Columbia, Hawaii, Maine, New Jersey, and Montana are considered.

Five key elements for determining whether voluntariness can be established may be distilled from jurisdictions with assisted dying law with all jurisdictions incorporating some or all of these approaches. The key elements are: first, establishing capacity and competence to make the request; secondly, that the request is voluntary and considered; thirdly, that the request is an informed one; fourthly, that the request is unequivocal; and fifthly, that the request is autonomously made.

5.2.3.1 Capacity and competence to make the request

This element of voluntariness requires that the patient making an assisted dying request exhibit the necessary legal capacity and competence to make such a request. Jurisdictions other than the Netherlands, Switzerland and Germany that explicitly contain this element are Belgium,[182] Luxembourg,[183] Colombia,[184] Canada,[185] New Zealand,[186] Northern Territory of Australia (1995-1997),[187] the State of Victoria (in Australia),[188] the State of Western Australia,[189] and all the permissive jurisdictions in the United States of America.[190]

There is no explicit reference to capacity or competence to make an assisted dying request in the Netherlands. However, key requirements in that jurisdiction include that the voluntariness of a request must be assessed by a physician who must be certain that the request of the patient is voluntary and well-considered.[191] It may be argued that for a patient to pass these requirements the patient must also exhibit capacity and competence as an incapable incompetent patient cannot make a voluntary and well-considered request.

In Switzerland, where only assistance in suicide for 'selfish motives' is criminalised, when an assisted suicide is reported, a police investigation is initiated and if it is found that the deceased was not competent to make an autonomous choice a prosecution will proceed.[192] Competence is therefore tied to the autonomy of the decision in Switzerland.[193]

A similar position may be inferred in Germany where the judgment of the German Federal Constitutional Court[194] discussed above[195] did not make any reference in its

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[182] Section 3(1) of the Belgian Act op cit n108.
[183] Article 2(2) of the Luxembourg Act op cit n9.
[184] See Protocol op cit n28 at 21 and discussion under heading 5.1.1.1.3.
[185] Section 241.2(1)(*b*) of the Canadian Act op cit n33.
[186] Section 4 read with s 5(1)(*f*) read with s 6 of the New Zealand Act op cit n52.
[187] Section 7(1)(*k*) of the Northern Territory of Australia Act op cit n34.
[188] Section 9(1)(*c*) of the State of Victoria Act op cit n35.
[189] Section 16(1)(*d*) of the State of Western Australia Act op cit n36.
[190] Including Montana in that a physician who claims the consent defence can only do so if the consenting person is 'legally competent' (discussed below).
[191] Chapter II art.2(1)(*a*) of the Netherlands Act op cit n7.
[192] SA Hurst & A Mauron 'Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. (Education and debate)' (2003) 326(7383) *British Medical Journal* 271 271.
[193] See discussion under heading 5.2.3.5.
[194] Supra n76.
[195] Discussed under heading 5.1.1.2.2.

order specifically to competency requirements but to the reason for wishing to commit suicide through a self-determined death as an expression of personal autonomy.[196] However, the court found that certain circumstances may arise where the duty of the state to protect life must take precedence over the individual's freedom where 'the individual is exposed to influences that endanger their self-determination over their own life'.[197] Assistance may be granted to someone wishing to end their life and is 'based on their personal understanding of what constitutes a meaningful existence, [and] must be recognised as an act of autonomous self-determination'.[198] It may be argued that an incompetent person cannot perform an autonomous act of self-determination and accordingly competence is tied to and a necessary condition for autonomous action.

In the jurisdictions that explicitly include this element, other than the terms 'capacity' and 'competence' alternative terms are used such as 'capable' or 'mentally qualified' or of 'sound mind'. Both the State of Victoria[199] and the State of Western Australia[200] use the term 'decision-making capacity in relation to voluntary assisted dying' and define this phrase extensively with the definition in the State of Western Australia being more succinct than its Victorian counterpart. These definitions include that the patient has the capacity to understand the information and advice offered and the matters involved in assisted dying and the effect of such a decision as well as the ability to weigh up these factors in the making of the decision.

In the United States of America, the jurisdictions where assisted dying is legalised (other than Montana which is discussed separately hereunder) are Oregon,[201] Washington State, [202] Vermont,[203] California,[204] Colorado,[205] the District of Columbia,[206] Hawaii,[207] Maine,[208] and New Jersey.[209] In each of these jurisdictions,

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[196] German Federal Constitutional Court decision op cit n76 para 275 (translated from the German).
[197] Ibid.
[198] Ibid.
[199] Op cit n188.
[200] Op cit n189.
[201] Section 2.01(1) read together with s 1.01(3) of the Oregon Act op cit n78.
[202] Section 70.245.20(1) read together with s 70.245.10(3) of the Washington State Act op cit n80.
[203] Section 5281(*a*)(2) read together with s 5283(*a*)(5)(*B*) of the Vermont Act op cit n81.
[204] Section 443.1(*e*) read together with s 443.2(*a*) of the California Act op cit n82.
[205] Section 25-48-103(*b*) of the Colorado Act op cit n83.
[206] Section 4(*b*)(2)(*A*) of the District of Columbia Act op cit n87.
[207] Section 2 of the Hawaii Act op cit n84.
[208] Section 4 of the Maine Act op cit n85.
[209] Section 4(*b*) of the New Jersey Act op cit n86.

one of the three terms 'capable', 'competence' or 'mental capacity' is used. Irrespective of which term is used the definition in the applicable Act is materially the same as that in Oregon where the term used is 'capable' and is defined as,

> 'that in the opinion of a court or the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient can make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available'.[210]

In the State of Montana, the consent defence[211] provided for in the Montana Code only has limited exceptions[212] including that the safeguards relating to voluntariness are that the person must be 'legally competent' and be able to make a 'reasonable judgment' and it must not be 'induced by force, duress, or deception' in deciding to access physician assisted dying. Accordingly, Montana also includes competence as a voluntariness requirement.

5.2.3.2 Voluntary and well-considered request

This element of voluntariness requires that the patient making an assisted dying request only does so after a voluntary and considered application of their mind. The following jurisdictions explicitly contain this element: the Netherlands,[213] Belgium,[214] Luxembourg,[215] New Zealand,[216] the Northern Territory of Australia (1995-1997),[217] the State of Victoria (in Australia),[218] and the State of Western Australia.[219]

In the jurisdictions that explicitly include this element, other than the term 'well-considered' alternative terms such as 'reflected', 'due consideration' and 'use or weigh' are used.

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[210] Op cit n201.
[211] Discussed above under heading 5.1.1.2.3.
[212] See text of the exceptions in the Code at n93.
[213] Chapter II art.2(1)(*a*) of the Netherlands Act op cit n7.
[214] Section 3(1) of the Belgian Act op cit n108.
[215] Article 2(2). of the Luxembourg Act op cit n9.
[216] Section 4 read with s 5(1)(*f*) read with s 6 of the New Zealand Act op cit n52.
[217] Section 7(1)(*k*) of the Northern Territory of Australia Act op cit n34.
[218] Section 9(1)(*c*) read with s (4)(1)(*c*) of the State of Victoria Act op cit n35.
[219] Section 16(1)(*d*) read with s 6(2) of the State of Western Australia Act op cit n36.

5.2.3.3 Informed request

This element of voluntariness requires that the patient making an assisted dying request does so only after having access to sufficient information. Such information may include being fully informed of their present medical condition and health progression, their treatment and palliative options and their prognosis as well as the effect of their decision to proceed with a request for assisted dying. The following jurisdictions explicitly contain this element: the Netherlands,[220] Belgium,[221] Colombia, [222] Canada,[223] New Zealand,[224] the State of Victoria,[225] and the State of Western Australia.[226]

5.2.3.4 Unequivocal request

This element of voluntariness requires that the patient making an assisted dying request does so unequivocally. Two jurisdictions explicitly containing this element are Colombia[227] and Luxembourg.[228] Whilst Colombia uses the term 'unequivocally', Luxembourg uses the term 'express'. In the context used here, the two terms are materially similar in meaning.

5.2.3.5 Autonomous request

This element of voluntariness requires that the patient making an assisted dying request does so as an autonomous expression of their free will without undue influence. Two jurisdictions explicitly containing this element are Switzerland and Germany. In Switzerland, where only assistance in suicide for 'selfish motives' is criminalised, when an assisted suicide is reported, a police investigation is initiated and if it is found that the deceased was not competent to make an autonomous choice

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[220] Chapter II art.2(1)(*c*) of the Netherlands Act op cit n7.
[221] Section 2(1) of the Belgian Act op cit n108.
[222] Article 15 of Resolution 1216 op cit n27 and the Protocol op cit n28 at 21, see discussion under heading 5.1.1.1.3.
[223] Section 241.2(1)(*e*) of the Canadian Act op cit n33.
[224] Section 4 read with s 5(1)(*f*) read with s 6 of the New Zealand Act op cit n52.
[225] Section 4(1)(*a*)-(*b*) of the State of Victoria Act op cit n35.
[226] Section 6(2)(*a*)-(*c*) of the State of Western Australia Act op cit n36.
[227] Article 15 of the Resolution 1216 op cit n27, see discussion under heading 5.1.1.1.3.
[228] Article 1 of the Luxembourg Act op cit n9.

a prosecution will proceed.[229] Autonomy is therefore tied to the competence of the decision.[230] In Germany, the judgment of the German Federal Constitutional Court[231] requires that sufficient scope be given to a person requesting physician assisted suicide where such patient's request is 'based on their free decision'.[232] According to the court, the very basis of the right in Germany is based on individual autonomy in that 'an individual's decision to end their own life, based on their personal understanding of what constitutes a meaningful existence, must be recognised as an act of autonomous self-determination'.[233]

5.2.3.6 Summary

The requirements for ensuring voluntariness range from merely requiring the legal capacity of the patient on the one end of the spectrum such as in Switzerland to the comprehensive checks applicable in Victoria. Most jurisdictions require 'capacity' and/or 'competence' as an elementary requirement with the remainder using terms such as 'voluntary', 'freely', 'duly considered', 'repeated', 'unequivocal' and 'autonomous'. In the United States of America, typically 'capable' or 'competent' is used interchangeably together with a similar definition. Ensuring that voluntariness is verified is a key safeguard in physician assisted dying legislation as it is central to the principle of autonomy which is in turn at the root of the idea of voluntary euthanasia.

5.2.4 Psychological tests and referrals

Mandatory psychological tests to exclude depression or other recognised psychological conditions before accessing physician assisted dying is not as a matter of course required under the physician assisted dying laws of the following jurisdictions: Switzerland, the Netherlands, Belgium (except for minors and those 'not expecting to die in the near future'),[234] Luxembourg, Colombia,[235] Canada, and

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[229] SA Hurst & A Mauron op cit n192 271 271.
[230] See discussion under heading 5.2.3.1.
[231] Supra n76.
[232] Ibid para 341 (English translation from the German).
[233] Ibid para 275 (English translation from the German).
[234] See s 3(3) of the Belgian Act op cit n108 and the discussion under heading 5.2.1.2.
[235] There is no mandatory psychiatric test but there is a psychiatrist on the committee that hears the euthanasia application, see discussion under heading 5.1.1.1.3.

Germany. However, in Canada since 2021 mental illness is specifically excluded from falling into the definition of the qualifying criteria for assistance in that it is not considered 'an illness, disease or disability' in cases where the sole underlying medical condition is a mental disorder.[236] This exclusion is subject to a two-year sunset clause by which time it is expected that the law will be further clarified. However, people with clinical depression may access assistance in dying provided they qualify based on another health condition.

In Switzerland in 2006 the Swiss Federal Supreme Court in the case of *Schweizerisches Bundesgericht: Entscheide*[237] laid out guidelines regarding assisted suicide for psychiatric patients and those with other mental illnesses. The applicant submitted that he had the right to self-determination under art.8 of the European Convention on Human Rights. However, no physician would prescribe the necessary medications to end his life as he fell outside of the requirement of mental competence. The court held that the applicant and those suffering from 'incurable, permanent, severe psychological disorders' did have the right to be assisted in suicide. The court reasoned that a distinction must be drawn between those who are temporarily impaired as 'an expression of treatable psychological disturbances' and those who have a severe and long-term mental illness where the decision is 'rational' and 'well-considered'.[238]

Mandatory psychological tests to access physician assisted dying are required for all requestors in Hawaii[239] where the attending provider 'shall' refer the patient to counselling that confirms the patient 'does not appear to be suffering from undertreatment or nontreatment of depression or other conditions' which may affect the ability of the patient to make an informed decision. A similar position pertained in the Northern Territory of Australia[240] whilst the physician assisted dying law was in effect there which Act required that a qualified psychiatrist must examine the patient and confirm that the patient is not suffering from treatable clinical depression in respect of the illness.[241]

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[236] Section 241.2(2.1) of MAID as amended by Bill C-7 op cit n33.
[237] Supra n63.
[238] JM Appel 'A suicide right for the mentally ill? A Swiss case opens a new debate' (2007) 37(3) *Hastings Center Report* 21-23, available at http://www.jstor.com/stable/4625742 (accessed 17 December 2021).
[239] Section 4(5) and s 6 read together with s 1 of the Hawaii Act op cit n84.
[240] Section 7(1)(*c*)(ii) read together with s 7(1)(*c*)(iv) of the Northern Territory Act op cit n34.
[241] Ibid.

In the State of Victoria in Australia,[242] the State of Western Australia,[243] and New Zealand[244] the physician assisted dying law requires psychiatric or psychological counselling only where the physician is uncertain as to the patient's decision-making capacity concerning voluntary assisted dying.

A similar position pertains in the permissive jurisdictions of the United States of America being Oregon,[245] Washington State,[246] Vermont,[247] California,[248] Colorado,[249] the District of Columbia,[250] Maine, [251] and New Jersey.[252] In Oregon, the physician assisted dying law requires psychiatric or psychological counselling only if,

> 'in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counselling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counselling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment'.[253]

Though the wording of legislation varies in the remaining jurisdictions of the United States of America, the effect is the same as that in Oregon which is that referral to counselling is only required where the physician is in doubt as to the psychiatric or psychological condition of the patient.

In Montana, the consent defence[254] arising from the Montana Code has limited exceptions[255] including that the patient does not have a 'mental disease or disorder, or intoxication' such that there is an inability to make the required reasonable judgment and to refer the patient to counselling should there be any doubt. Accordingly, the result is similar to that of the other permissive United States of America jurisdictions

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[242] Section 18(1) and s 27(1) of the State of Victoria Act op cit n35.
[243] Section 16(1) read together with s 26(1) of the State of Western Australia Act op cit n36.
[244] New Zealnd Act op cit n52 s13(1)(c).
[245] Section 3.03 read together with s 1.01(5) and s 3.01(1)(*e*) of the Oregon Act op cit n78.
[246] Section 6 read together with s 70.245.10(5) and s 70.245.40(1)(*e*) of the Washington State Act op cit n80.
[247] Section 5281(*a*)(5) read together with s 5283(*a*)(14)(*F*) of the Vermont Act op cit n 81.
[248] Section 443.5(*a*)(1)(*A*)(ii) and s 443.6(*d*) of the California Act op cit n82.
[249] Section 25-48-108(2) of the Colorado Act op cit n83.
[250] Section 5(*a*) of the District of Columbia Act op cit n87.
[251] Section 8 of the Maine Act op cit n85.
[252] Section 8(*a*) of the New Jersey Act op cit n86.
[253] Op cit n245.
[254] Discussed above under heading 5.1.1.2.3.
[255] See text of the exceptions in the Montana Code at n93.

in that referrals are necessary in cases of doubt but in Montana, this requirement arises from the exceptions to the consent defence.

5.2.4.1 Summary

Only Hawaii requires and the Northern Territory of Australia required psychiatric or psychological counselling in all cases to access physician assisted dying. The United States of America jurisdictions all require counselling only where the physicians are concerned about the possibility of mental illness (including Montana). This is similar to the position in the Australian jurisdictions and New Zealand. The other jurisdictions do not explicitly require counselling but these would be necessary under their capacity, competence or capability requirements of voluntariness. The correct balance appears to be that referrals not be required in all cases (except in the case of minors) but where there is doubt by a physician as to competence, such referrals are appropriate to ensure that the assisted dying request is truly voluntary and not the result of an underlying mental condition.

5.3 Level 3 safeguards

5.3.1 Additional physician(s)

In the physician assisted dying law of Switzerland, Germany, Montana and Colombia there is no reference to additional physicians being required to access physician assisted dying. An additional physician is required to access physician assisted dying in the Netherlands,[256] Belgium,[257] Luxembourg,[258] Canada,[259] New Zealand,[260] the Northern Territory of Australia (1995-1997),[261] the State of Victoria in Australia,[262]

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[256] Article 2(1)(*e*) of the Netherlands Act op cit n7.
[257] Section 3(2)(3)of the Belgian Act op cit n108.
[258] Article 2 para 2(3) of the Luxembourg Act op cit n9.
[259] Section 241.2(3)(*e*) of the Canadian Act op cit n33.
[260] Section 14 of the New Zealand Act op cit n52 requires that the attending practitioner engage the SCENZ group to provide the details of an independent medical practitioner to give a second opinion. Section 4 of the Act defines 'SCENZ' as a contraction for the Support and Consultation for End of Life in New Zealand and establishes it in s 25 of the Act.
[261] Section 7(1)(*c*)(iii) of the Northern Territory of Australia Act op cit n34; also see see discussion on mandatory appointment of a qualified psychiatrist in the Northern Territory (1995-1997) under heading 5.2.4.
[262] Section 34 of the State of Victoria Act op cit n35.

the State of Western Australia,[263] Oregon,[264] Washington State,[265] Vermont,[266] California,[267] Colorado,[268] the District of Columbia,[269] Hawaii,[270] Maine, [271] and New Jersey.[272]

5.3.1.1 Summary

The vast majority of jurisdictions require the involvement of a second physician. In those jurisdictions that do not require a second physician, the position of Germany and Montana are that they presently only have court judgments legalising physician assisted dying and no formal legislation which explains this lacuna. Colombia has a physician assisted dying process that engages an interdisciplinary group including medical professionals and accordingly additional opinions are incorporated into the physician assisted dying consideration process.[273] Switzerland has a long history of physician assisted dying before modern safeguards were developed. A second physician requirement is the modern approach.

5.3.2 Number of requests and delaying periods

In the physician assisted dying law of Switzerland, Germany and Montana there is no reference to a required number of requests or mandatory delaying periods.

In Colombia, there are no explicit number of requests or delaying periods but these are implied as the physician assisted dying process is guided by a Scientific-Interdisciplinary Committee. Once the physician has established the patient's capacity and confirms that the illness is terminal, the physician immediately summonses the Scientific-Interdisciplinary Committee for the right to die with dignity at the appropriate health facility. These committees consist of a doctor with a speciality in

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[263] Sections 30-37 of the State of Western Australia Act op cit n36.
[264] Section 3.02 read together with s 1.01(4) of the Oregon Act op cit n78.
[265] Section 70.245.50 read together with s 70.245.10(4) of the Washington State Act op cit n80.
[266] Section 5283(*a*)(7) read together with s 5283(*a*)(14) of the Vermont Act op cit n81.
[267] Section 443.5(*a*)(3) read with s 443.1(*f*) of the California Act op cit n82.
[268] Section 25-48-106(*d*) read with s 25-48-102(3) and s 25-48-102(9) of the Colorado Act op cit n83.
[269] Section 2(3) read with s 4(*b*) of the District of Columbia Act op cit n87.
[270] Section 1 read with s 2 and s 4(4) of the Hawaii Act op cit n84.
[271] Section 2(*D*) read with s 4 of the Maine Act op cit n85.
[272] Section 3 read with s 7 of the New Jersey Act op cit n86.
[273] See discussion on Colombia under heading 5.3.2.

the pathology that the person suffers, a lawyer, and a psychiatrist or clinical psychologist.[274] If the Committee finds the application passes the criteria laid down, the applicant is asked whether he wishes to confirm his request and if so the procedure must be carried out within 15 days of such confirmation.[275]

All the remaining jurisdictions have explicit requirements relating to the number of requests and/or mandatory delaying periods. These jurisdictions include the Netherlands,[276] Belgium,[277] Luxembourg,[278] Canada,[279] New Zealand,[280] the Northern Territory of Australia (1995-1997),[281] the State of Victoria in Australia,[282] the State of Western Australia,[283] and all the permissive states in the United States of America (except Montana).

In all jurisdictions, there is the requirement that a request is in writing and although there is some variation between jurisdictions typically two oral requests are also required. Some jurisdictions also place delay periods between the requests and minimum periods to pass after a final request before the assistance may be granted.

A similar position pertains in the permissive jurisdictions of the United States of America (except Montana) being Oregon,[284] Washington State,[285] Vermont,[286] California,[287] Colorado,[288] the District of Columbia,[289] Hawaii,[290] Maine,[291] and New Jersey. [292]

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[274] Article 6 of the Resolution op cit n27 and see discussion under heading 5.1.1.1.3.
[275] Ibid art.7.
[276] Section 2(1) of the Netherlands Act op cit n7.
[277] Section 3(1) and s 2(3) and s 3(4) and s 3(3)(2) of the Belgian Act op cit n108.
[278] Article 2 para 2(2) and art.2 para 2 of the Luxembourg Act op cit n9.
[279] Section 241.2(3)(*b*)(*i*) and s 241.2(3) of the Canadian Act op cit n33.
[280] Sections 10-12 and s 14(3) of the New Zealand Act op cit n52.
[281] Section 7(1)(i) and s 7(1)(*n*) and s 10(1) of the Northern Territory of Australia Act op cit n34.
[282] Section 11(1) and (2) and s 8(1) and s 13 and s 34 and ss 37-38 of the State of Victoria Act op cit n35; the Act which runs to 123 pages sets down a technical and extensive procedure to access voluntary assisted dying that has been criticised for hampering access.
[283] Section 18 and s 20 and s 42 and s 48 of the State of Western Australia Act op cit n36.
[284] Section 3.06 and s 3.08(1) read with s 3.08(2) of the Oregon Act op cit n78.
[285] Section 70.245.090 and s 70.245.110 of the Washington State Act op cit n80.
[286] Section 5283(*a*)(4) and s 5283(*a*)(2) and s 5283(*a*)(12) of the Vermont Act op cit n81.
[287] Section 443.3(*a*) and s 443.5(*a*)(12) and s 443.11(*c*)(1) of the California Act op cit n82.
[288] Section 104 read together with s 112 of the Colorado Act op cit n83.
[289] Section 3(*a*)(1) and s 3(*a*)(2) and s 3(*b*)(1) of the District of Columbia Act op cit n87.
[290] Section 9 and s 11 of the Hawaii Act op cit n84.
[291] Section 11 and s 13 of the Maine Act op cit n85.
[292] Sections 10(1)-10(5) of the New Jersey Act op cit n86.

In Oregon, the patient shall make at least two oral requests and one written request. After a first oral request by the patient, a second oral request is required after a minimum period of 15 days has passed, except where,

> 'the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request under this section, the qualified patient may reiterate the oral request to his or her attending physician at any time after making the initial oral request'.[293]

At least 48 hours must pass between the second oral request and the writing of the prescription unless,

> 'the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die before the expiration of at least one of the waiting periods'.[294]

In this case, the prescription 'may be written at any time following the later of the qualified patient's written request or second oral request'.

Though the wording of legislation varies in the remaining jurisdictions of the United States of America, the 15 day period (except for Hawaii where it is a 20 day period) between the first and second oral request (though some jurisdictions waive this requirement where the patient is expected to die shortly) and the 48 hour delay period between the final request and the writing of the prescription as well as the requirement of a written request is applicable in these jurisdictions (except Montana).

5.3.2.1 Summary

Repeated requests and delaying periods are near-universal across jurisdictions except for Germany, Switzerland and Montana. Germany and Montana only have court decisions authorising physician assisted dying and accordingly display a lack of safeguards and Switzerland's physician assisted dying laws predate modern safeguards. The common construction is two oral requests a minimum period apart

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[293] Section 3.06 of the Oregon Act op cit n78.
[294] Ibid s 3.08(1) read with s 3.08(2).

and one written and independently witnessed request with a maximum period between the last request and the assistance.

5.3.3 Reporting mechanisms and compliance

In the physician assisted dying law of Montana and Germany, there is no reference to reporting mechanisms or compliance as the law in these jurisdictions arise from court judgments with no legislative regulatory framework in place to date.

In Colombia, the reporting mechanisms and compliances arise out of the process being conducted under the purview of the Scientific-Interdisciplinary Committee that determines in each case which compliances and evidence are required before physician assisted dying may be engaged.[295]

In Switzerland, there are federal reporting requirements other than the reporting of unnatural death by assisted suicide as discussed above.[296] There is however no central federal registry of deaths by assisted suicide and the Swiss Federal Statistics Office has only reported these as a separate category of deaths since 2011.[297] Certain requirements apply at a cantonal level as a result of cantonal sovereignty. For example, in Zurich, this includes documentation by forensic medicine doctors at Zurich's Institute of Forensic Medicine, while in some other cantons such documentation is provided by the district medical officer or cantonal medical officer.[298] Such cantonal responsibilities of the physician may include confirmation of the patient's identity, ensuring a legal inspection of the corpse to consider the unequivocally independent ingestion of the lethal substance, and ensuring that the documents submitted by the organisation that provided assisted suicide are complete and correct. The Senior Public Prosecutor's Office of the Canton of Zurich has now established certain documents as standard requirements since 2009.[299] In 2004, the Swiss Academy of Medical Sciences

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[295] See discussion under heading 5.3.2.
[296] See discussion under heading 5.1.1.2.1.
[297] C Bartsch, K Landolt, A Ristic et al op cit n56 545.
[298] Ibid at 546 notes to Figure 1.
[299] Ibid. These include, 'confirmation of the diagnosis by a physician, soundness of judgment confirmed by a physician, a prescription for the lethal medication, minutes documenting the process of the assisted suicide, a suicide declaration signed by hand, a membership pass, a specification of costs from the organisation which supplied the assistance, [and] confirmation that the client was of sound judgment regarding their wish to die by suicide'. (punctuation and capitalisation adapted)

adopted guidelines (these have been updated with the latest version issued in 2018)[300] for physicians engaged in physician assisted suicide which according to the Supreme Court do not have the formal quality of the law but are regarded as a code of conduct.[301]

All the jurisdictions other than those already referred to set out reporting mechanisms and procedures before and/or after assistance in dying including the Netherlands,[302] Belgium,[303] Luxembourg,[304] Canada,[305] New Zealand,[306] the Northern Territory of Australia (1995-1997),[307] the State of Victoria (in Australia),[308] the State of Western Australia,[309] and all the permissive jurisdictions in the United States of America (except Montana).

Reporting tools are typically reports by the attending physician detailing how all requirements of the law have been observed together with confirmation by a second physician, notes as to consultations with the patient, and the patient's written request. These are reported to a designated institution that ensures compliance and reports cases of concern for investigation and prepares statistical reports for the public as well as advising the legislature on the performance of and compliance with the assisted dying law.

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[300] Swiss Academy of Medical Sciences (SAMS) *Management of Dying and death* (2018) available at https://www.samw.ch/en/Publications/Medical-ethical-Guidelines.html (accessed 17 December 2021).
[301] C Grosse & A Grosse 'Assisted suicide: Models of legal regulation in selected European countries and the case law of the European Court of Human Rights' (2015) 55(4) *Medicine, Science and the Law* 246 251.
[302] Article 21 of the Netherlands Act op cit n7; reports to one of the five Regional Review Committees see H Weyers 'The legalization of euthanasia in the Netherlands: Revolutionary normality' in SJ Youngner & GK Kimsma (eds) *Physician-assisted death in perspective: Assessing the Dutch experience* (2012) 55.
[303] Section 6(2) of the Belgian Act op cit n108, reports to the Federal Control and Evaluation Commission.
[304] Article 5 of the Luxembourg Act op cit n9, reports to the National Commission for Monitoring and Evaluation.
[305] Section 241.31(3) and s 9.1 and s 10 of the Canadian Act op cit n33, reports to the Ministry of Health.
[306] Section 21 and ss 26-29 of the New Zealand Act op cit n52, reports to a Registrar that forwards the report to an End of Life Review Committee (established by the Minister of Health) which refers problematic cases back to the Registrar for investigation.
[307] Section 12 and s 14 of the Northern Territory of Australia Act op cit n34, reports to the Coroner.
[308] Sections 47-52 and s 103 and s 93 and s 117 of the Victoria Act op cit n35, reports to the Dying Review Board; see discussion of the Dying Review Board process in Victoria under heading 5.3.2; also see BP White, L Del Villar, E Close & L Willmott 'Does the voluntary assisted dying act 2017 (Vic) reflect its stated policy goals?' (2020) 43(2) *University of New South Wales Law Journal* 417 449.
[309] Section 51 and ss 150-155 and ss 118-119 and s 84 of the State of Western Australia Act op cit n36, reports to the Dying Review Board.

A similar position pertains in the permissive jurisdictions of the United States of America (except Montana) being Oregon,[310] Washington State,[311] Vermont,[312] California,[313] Colorado,[314] the District of Columbia,[315] Hawaii,[316] Maine,[317] and New Jersey.[318]

In Oregon, the attending physician is required to keep the following patient records: all of the oral and written requests, the diagnosis and prognosis, confirmation of the patient's capability, confirmation that the patient voluntarily took an informed decision, the consulting physician's diagnosis and prognosis, the consulting physician's confirmation of all of the medical opinions of the attending physician, any reports related to counselling (if applicable), confirmation that the death of the patient is imminent, evidence that the attending physician made an offer for the patient to rescind the request upon the second oral request, and confirmation by the attending physician of the required processes being met as well as the prescribed medication.[319] The Oregon Department of Human Services does an annual review of a sample of records that are to be maintained under the Act and any healthcare provider which has dispensed medication in terms of the Act must file a copy with the department which may make rules requiring the collection of information regarding compliance with the Act.[320] The information collected is not a public record but the department is required to make public a statistical record of information collected.[321]

Though the wording of legislation varies in the remaining permissive jurisdictions of the United States of America, the effect is the same as that in Oregon which is that

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[310] Section 3.09 and ss 3.11(1) - 3.11(3) of the Oregon Act op cit n78.
[311] Section 70.245.120 of the Washington State Act op cit n80, the additional words 'any medically confirmed certification of the imminence of the patient's death' contained in the Oregon Act does not appear in the Washington State Act.
[312] Section 5283(*a*)(14) and s 5283(*a*)(15) of the Vermont Act op cit n81, also see Vermont Department of Health (Prepared by: David C. Englander, Esq.) *Report Concerning Patient Choice at the End of Life in Accordance with Act 27 of 2015* (15 January 2018) available at https://legislature.vermont.gov/assets/Legislative-Reports/2020-Patient-Choice-Legislative-Report-2.0.pdf (accessed 17 December 2021).
[313] Section 443.8 and s 443.9 and ss 443.19(*a*)-s 443.19(*b*) of the California Act op cit n82.
[314] Section 111 and s 111(2) of the Colorado Act op cit n83.
[315] Section 7 and s 8 of the District of Columbia Act op cit n87.
[316] Section 12 and s 14 of the Hawaii Act op cit n84.
[317] Section 14 and s 17(*B*) and s 17(*D*) of the Maine Act op cit n85.
[318] Section 10(6)(*d*) and s 13(*a*)(2) and s 13(*c*) of the New Jersey Act op cit n86.
[319] Section 3.09 of the Oregon Act op cit n78.
[320] Ibid ss 3.11(1) and (2).
[321] Ibid ss 3.11 (2) and (3).

the medical record of the patient must be kept and a copy delivered to that jurisdiction's Department of Health which may make rules relating to any relevant information it requires, reviews the records for compliance and makes a statistical record available to the public and for consideration by the legislature (except in Montana).

5.3.3.1 Summary

Only Germany and Montana have no reporting mechanisms or compliances which is the result of the physician assisted dying law in these jurisdictions arising from court judgments with no legislative framework in place. All other jurisdictions require reporting and conduct oversight to monitor and ensure compliance and to take the necessary action in the case of non-compliance. The collection of reporting materials makes oversight institutions able to review the assisted dying practices and to develop the statistical reports for use by the legislature and the awareness of the public.

5.4 Conclusion

Safeguards are universally applied in jurisdictions that have modern legislation specifically designed to regulate physician assisted dying. Where legalisation of physician assisted dying is indirect and not through specifically crafted legislation such as in Switzerland, or through court orders with no subsequent regulating legislation such as in Germany and Montana, the result is that there are minimal safeguards.

The disaggregation of safeguards globally shows that a system of safeguards for assisted dying that is appropriate to a modern state based on human rights should include: access to both physician assisted dying and physician administered euthanasia, minimum age restrictions, both objective diagnosis/prognosis and subjective state of suffering requirements, comprehensive requirements to ensure voluntariness, psychological tests in cases where a physician suspects treatable mental illness exists such that these patients are excluded from undergoing assistance in dying in that they are treatable, the opinion of at least two independent physicians to ensure the reliability of medical conclusions and to avoid misuse of legislation, appropriate delay periods to ensure that the decision is not rushed and is instead carefully

considered, and reporting mechanisms to ensure proper oversight and review by the legislature and for public information purposes.

Sufficient safeguards are an essential precondition for assisted dying law to prevent abuse and protect the weak and vulnerable whilst at the same time ensuring access to the right to die is practically accessible for those who truly wish to die with dignity.

In the next chapter, a draft assisted dying Bill is proposed for South Africa.

CHAPTER 6
TOWARDS A DRAFT BILL

This chapter discusses and presents a proposed draft Bill for the legalisation of physician assisted dying in South Africa.

The proposed Bill is based on insights gained from the statutes discussed in the previous chapter. Key elements are incorporated from the broad consultation which the South African Law Commission undertook in 1998,[1] especially those elements related to eligibility criteria as this project represents the most recent engagement with a wide range of stakeholders. Elements are included from the learnt experience in jurisdictions that were early adopters of physician assisted dying as well as the more recent statutes. Careful consideration has been given to South Africa as a developing country with one of the highest Gini coefficients. This has an impact on the state resources available to regulate and monitor the practice as well as access to assistance from poorer communities. For this reason, only a framework for monitoring and regulation is provided that allows parliament to determine the degree of, and accordingly cost of, the implementation of safeguard measures. The three levels of safeguards defined in the introduction to chapter 5 are applied to the discussion below.

6.1 Level 1 Safeguards

In the proposed Bill (which is included at the end of this chapter and the sections of which are referenced in the footnotes), the right to die with dignity is defined as the right of a patient to request the services of a willing independent medical practitioner

[1] South African Law Commission Report (Project 86) *Euthanasia and the Artificial Preservation of Life* (1998) available at https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf (accessed 18 December 2021) referred to as 'Project 86'.

who agrees to end their suffering either by the prescribing of a lethal agent (that the patient will self-administer) or the administration of the lethal agent.[2]

As such both physician assisted suicide and physician administered euthanasia is decriminalised. This proposal is based on three primary reasons. First, the prevalence of the modern view that there is no ethical distinction between assistance and active engagement by a physician. Accordingly, the two acts are viewed as ethically similar and as such should be treated as legally similar. Secondly, intravenous medication is more precise, more quickly absorbed and gives the physician more control of the dying process. It is also more akin to medical treatment than to suicide which makes it more appealing to the surviving family and community thereby acting against potential stigma. Thirdly, access to physician assisted death is not excluded for those patients unable to physically perform the necessary physical actions themselves. It also eliminates the reason for someone accessing physician assisted suicide earlier than they might otherwise out of fear that they may at a later stage not have the prerequisite physical ability.

There is no residency requirement for a patient which is based on the view that the right to die with dignity is founded from the Bill of Rights which rights apply 'to all people in our country'.[3] This may result in some measure of 'suicide tourism' in South Africa which, as discussed above, has been experienced in Switzerland. South Africa has a very well developed private medical system and there should be no objection to foreigners taking advantage of a permissive law in South Africa provided that all the safeguards are properly applied and the costs are borne by the patient. Should a large influx of foreigners wish to take advantage of the public health system, this could place an undue burden on public doctors and hospitals. In my opinion, foreigners wishing to take advantage of permissive dying laws in South Africa would be more likely to engage the private health system. However, should the public health system become overburdened with assisted suicide requests a limitation on the right in the public system for foreigners would pass constitutional muster.

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[2] Section 1 read with s 2 and s 3.
[3] Section 7(1) of the Constitution of the Republic of South Africa 1996.

6.2 Level 2 Safeguards

The proposed Bill applies to adults who are older than 18 years and competent with 'competent' being defined as 'capable of understanding and appreciating the nature and consequence of accessing the right to die with dignity including its finality'.[4] It also applies to minors from the age of 14 who are certified as similarly competent by a child psychiatrist or child psychologist and with the legal assistance of all surviving guardians. Where there are no surviving guardians the High Court acts as the upper guardian.[5] Though few jurisdictions allow access to physician assisted dying for minors, this proposal is based on the view that age is not the only factor that affects maturity and that different minors possess differing levels of comprehension. A professional psychological assessment of an individual minor can assess the level of understanding and determine if the required 'competence' has been attained, to ensure that a proper mature and voluntary decision is being made. A further requirement that guardians must consent ensures that the adults closest to the minor agree that the decision is rational to adults in the circumstances the minor faces.

The required prognosis proposed is that the patient is suffering from an unbearable and grievous medical condition that is either terminal or intractable.[6] Project 86[7] described the necessary prognosis of a qualified patient as suffering from a 'terminal or intractable and unbearable illness'.[8] Unfortunately, this definition is ambiguous as it may be read as:

(a) [terminal] or [intractable and unbearable]; or

(b) [terminal or intractable] and [unbearable].

The proposed formulation clarifies this ambiguity and can only be read as:

> suffering from an [unbearable and grievous medical condition] that is either [terminal] or [intractable].

This proposed condition is further defined so that a patient in order to claim that an 'unbearable and grievous medical condition' is being suffered must exhibit a serious

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[4] Section 1.
[5] Section 1 read with s 2.
[6] Section 2(1)(*b*).
[7] Project 86 op cit n1 at page x.
[8] Ibid at page xvii (5.1(*a*)).

illness, disease or disability that must be causing them enduring physical or psychological suffering and that this suffering is unbearable to them and cannot be relieved to an acceptable level under conditions measured by them to be acceptable. In addition, the patient's natural death must either be such that in reasonable medical judgement the medical condition, will inevitably cause the untimely death of the patient concerned or the situation of the patient is intractable.[9]

This definition includes patients suffering from an unbearable and grievous medical condition which are either terminal patients, or those with intractable medical conditions which may not be terminal such as neurological diseases, rheumatic, and connective tissue diseases such as rheumatoid arthritis and osteoporosis as well as serious disabilities.

The patient must also be 'competent' as discussed above and the request of the patient is based on a free and considered decision not made as a result of undue pressure after the patient has been adequately informed regarding the medical condition from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available including palliative care.[10]

A psychiatric or psychological referral is not a requirement except for qualifying minors as discussed above. However, if either independent medical practitioner doubts the mental competence of the patient the first independent medical practitioner must engage a consulting psychologist or psychiatrist to examine the patient and determine whether the patient is sufficiently competent to make an assisted dying request.[11]

The above proposals are in alignment with international best practice as most jurisdictions that allow physician assisted dying have both an objective prognosis requirement as well as a subjective mental state requirement and require professional competency referrals only in cases of doubt as to treatable mental illness.

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[9] Section 3.
[10] Section 2(1)(*c*)-(*d*).
[11] Section 4(1)(*c*).

6.3 Level 3 Safeguards

The patient must make at least two requests which are at least seven days apart and no more than seventy-two hours before the medical assistance requested may occur. The patient must also sign a written clear and unambiguous certificate of request before both doctors and two independent witnesses, as well as an interpreter in the case of a medical doctor not sharing or understanding the first language of the patient.[12] An interpreter requirement is needed in South Africa where there are many languages and dialects spoken, with eleven official languages. If the patient is physically unable to sign the certificate of request the patient may request an adult person of their choice provided such person qualifies in terms of the same criteria set for independent witnesses in terms of the proposed Bill, to sign on their behalf and in their presence.[13] The independent medical practitioner then is required to ensure that the patient is eligible to be assisted to die in accordance with the right to die with dignity and that there is compliance with all the safeguards set out.[14] The independent medical practitioner must then refer the patient to a consulting independent medical practitioner who must provide a written opinion that all eligibility criteria have been met.[15]

The two medical practitioners must be 'independent medical practitioners' which is defined in the proposed Bill and which includes independence based on their professional relationship, being unable to receive any financial or material benefit from the death of the patient (other than their reasonable fees), not being employed in the same medical practice and no other relationship which would affect their objectivity. In the case that any of the independent medical practitioners are employed by the state, they shall make all decisions independent of any hospital or other policy imposed by the state as employer. This is to prevent any hospital or state policy from determining whether a person qualifies for assisted dying. Immediately before offering the certificate of request to the patient for signature and again just before providing

[12] Section 4(1)(*d*) – (*h*).
[13] Section 4(1)(*e*).
[14] Section 4.
[15] Section 4(1)(*b*).

the medical assistance, the independent medical practitioner must offer the patient the opportunity to withdraw the request.[16]

The disturbing appearance of medical and non-medical interventions designed to facilitate suicide such as the '3-D printed pod'[17] where no physician assistance is required and which may make suicide appear trendy and of superficial importance harms the state interest in protecting life. Such interventions are against the boni mores of the community and are accordingly prohibited.[18]

The Minister responsible for Health must pass regulations for the provision and collection of information from independent medical practitioners, pharmacists and other relevant parties to monitor the right to die with dignity. The Minister must also designate the recipient of such information and the use, analysis and disclosure thereof including for annual monitoring by parliament.[19] These provisions are intentionally non-prescriptive to accommodate a budget that is considered reasonable to implement the proposed Bill within a state health budget with many competing demands. However, as this legislation seeks to regulate a constitutional right, the state must fund its proper functioning. The Bill leaves it to the Minister responsible for Health to determine how to handle monitoring information and an annual review.

The above proposal follows international best practice by requiring multiple requests including a witnessed written request with delay periods to ensure that a decision is enduring and well-considered and the involvement of a second independent physician ensures that more than one medical opinion is required as to whether physician assisted dying is appropriate in each case. For budgetary reasons, the collection of information, monitoring and review mechanisms are left in the hands of the executive.

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[16] Section 4(1)(*e*)(iii) and s 4(1)(*h*)(i).
[17] Christine Hauser 'A 3-D Printed Pod Inflames the Assisted Suicide Debate' *The New York Times* 16 December 2021 available at https://nl.nytimes.com/f/newsletter/2gwt7UnJs1MK2l_gkP81pQ~~/AAAAAQA~/RgRjnqyWP0T7aHR0cHM6Ly93d3cubnl0aW1lcy5jb20vMjAyMS8xMi8xNi93b3JsZC9ldXJvcGUvc3VpY2lkZS1wb2RzLXN3aXR6ZXJsYW5kLmh0bWw_Y2FtcGFpZ25faWQ9NTEmZW1jPWVkaXRfbWJlXzIwMjExMjE3Jmluc3RhbmNlX2lkPTQ4MDUyJm5sPW1vcm5pbmctYnJpZWZpbmclM0EtZXVyb3BlLWVkaXRpb24mcmVnaV9pZD0xMDgyMDU5NzYmc2VnbWVudF9pZD03NzI0MyZ0ZT0xJnVzZXJfaWQ9YWM1OTZiZTM0YWZkMWJlZGIwMjZmMzU3OWFjMzBkNjdXA255dEIKYbuWJ7xhYVkAy1IXaGFsdG9uQGNoZWFkbGVsYXcuY28uemFYBAAAAAA~ (accessed 18 December 2021).
[18] Section 4(2).
[19] Section 8.

6.4 Additional provisions of interest

6.4.1 Prescribed medical benefit (PMB)

No provision has been included in the proposed statute for inclusion of all the costs associated with accessing the right to die with dignity as a prescribed medical benefit (PMB) in all health insurances operating in South Africa as this is only possible through the amendment of various other pieces of existing legislation. However, it is proposed that the legislature consider such PMB inclusion, with a minimum period of insurance membership before a first request not exceeding three years.

6.4.2 Medical practitioner conscientious objection

Provision is made for any medical practitioner to object to assisting under the proposed Act, but such practitioner must do so personally within forty-eight hours of a request together with the delivery of the contact details in writing of a medical practitioner who is not a conscientious objector. Provision is also made for the Minister responsible for Health to ensure that there is reasonable access to medical practitioners who are not conscientious objectors in the public health system. The purpose of these provisions is to balance the right to conscientious objection to physician assisted dying by a physician with the right of a patient to access assistance.[20]

6.4.3 Medical practitioner exemption

Where a medical practitioner complies with all the prescripts of the proposed statute, such medical practitioner enjoys exemption from any civil, criminal, or disciplinary liability. The corollary is also true being that where a medical practitioner does not comply with all prescripts in the proposed statute, they are subject to the usual civil, criminal, and disciplinary sanction for such acts. There is no exemption from prosecution for a person that assists who is not a medical practitioner.[21]

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[20] Section 5.
[21] Section 6.

6.4.4 Effect of accessing the right to die with dignity on contract, will, or agreement

It is necessary to ensure that the decision whether to choose access to the right to die with dignity is not influenced by the fear of the potential legal consequences of that decision on the material benefits of surviving beneficiaries. Accordingly, the proposed Bill provides that a provision in a contract, will, or other agreement if it be conditional upon withdrawing, making or rescinding such decision is void ab initio. Similarly, a provision in a contract, will, or other agreement if it affects any benefit or obligation accrued under the agreement for withdrawing, making or rescinding such decision is void ab initio.

Any contract, including but not limited to a sale agreement, accident insurance agreement, health insurance agreement, annuity policy, or any rate charged under any agreement shall not be contingent upon making or rescinding the request for assisted dying. Neither shall any such instrument be conditional upon an agreement relating to assisted dying. Finally, provision is made that assisted dying is not suicide for legal purposes and a qualified patient dying by accessing the right to die with dignity shall not affect life, health, or accident insurance or an annuity policy.[22]

[22] Section 7.

REPUBLIC OF SOUTH AFRICA

THE RIGHT TO DIE WITH DIGNITY BILL (RDD Bill)

(The English text is the official text of the Bill)

(MINISTER OF HEALTH)

[B XX—20XX]

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BILL

To determine the circumstances in which and conditions under which a patient with an unbearable and grievous medical condition that is either terminal or intractable may request the assistance of a physician to access the right to die with dignity, and to provide for matters connected therewith.

PREAMBLE

Recognising the values of human dignity, the achievement of equality, and freedom upon which our Constitution is based;

Recognising that enshrined in our Constitution is the right to dignity; right to life; right to equality; right to freedom of religion, belief and opinion; 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; and right to bodily and psychological integrity, which includes the right to security in and control over their body;

Recognising the finality and irreversibility of ending a life requires that sufficient safeguards are in place to prevent abuse or mistakes relating to vulnerable persons and the choice to die with dignity;

Recognising that in light of the values and rights set out above a person suffering from an unbearable and grievous medical condition that is either terminal or intractable has the right to choose to die with dignity;

Recognising that the right to die with dignity cannot be limited to those who can afford to access it but must be available to persons using public health services;

Recognising that a potential loss of benefits for the beneficiaries of a person wishing to choose the right to die with dignity should not be a necessary consideration in the making of such a decision.

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

ARRANGEMENT OF SECTIONS

1. Definitions

In this Act, unless the context otherwise indicates—

"competent" means capable of understanding and appreciating the nature and consequence of accessing the right to die with dignity including its finality;

"independent medical practitioner" means the medical practitioner assisting a person exercising their right to die with dignity and who —

(a) does not supervise the other required independent medical practitioner; and

(b) does not benefit as a beneficiary under a will, or in any other way, benefit financially or otherwise from that person's death, other than the standard and reasonable compensation for their services relating to the request; and

"independent witness" means any person who is an adult and who is mentally competent and who in addition understands the nature and import of medical assistance under this act may be an independent witness, except if he or she—

(a) knows or suspects the possibility of being a beneficiary of the requestor in any manner including through the requestor's will such that the death of the requestor may result in any financial or any other benefit for the witness;

(b) owns or manages or is a public official in the hospital or other health care facility where the requestor has made the request and/or is being treated and/or is resident;

(c) is engaged in the provision of health or personal care services to the requestor.

"**adult**" means any person over the age of 18 years;

"medical or non-medical interventions" means any machine, device or mechanism intended for the use of persons wishing to commit suicide without assistance by independent medical physicians provided for in this Bill.

"medical practitioner" means a person registered as such under the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);

"Minister" means the Minister responsible for Health;

"palliative care" means specialised care and treatment services offered to a terminal or irremediably ill patient to relieve pain and/or emotional suffering.

"requestor" means a person who requests assistance in dying under this Bill.

"right to die with dignity" means the right of a patient at the patient's request to secure the services of an independent medical practitioner to end their suffering by either—

(a) prescribing a lethal agent for the patient to self-administer and cause their own death; or

(b) administering a lethal agent which causes the death of the patient.

2. Circumstances in which and conditions under which the Right to Die with Dignity may be accessed by a patient

(1) The right to die with dignity may be accessed by a patient —

(a) upon request by the patient who is —

(i) an adult and is mentally competent; or

(ii) a child over the age of 14 who is certified in writing by a child psychologist or child psychiatrist as mentally competent, and is legally assisted by all surviving natural and legal guardians with the High Court acting as upper guardian should the minor have no surviving guardian; and

(b) who is suffering from an unbearable and grievous medical condition that is either terminal or intractable; and

(c) the patient had been properly informed regarding the medical condition suffered, the prognosis and treatment available including palliative care; and

(d) the request of the patient is based on a free and considered decision not made as a result of undue pressure; and

(e) the assisting of such patient to end their life is the only reasonable way that the patient can escape suffering.

(2) The assistance under this Bill in terminating a requestor's life may not be carried out by any person other than an independent medical practitioner.

3. Unbearable and grievous medical condition that is either terminal or intractable

(1) A person has a grievous and irremediable medical condition only if they meet all of the following criteria—

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

(b) that illness, disease or disability causes them enduring physical or psychological suffering that is unbearable to them and that cannot be relieved to an acceptable level to them under conditions that they consider to be acceptable; and

(c) the patient's natural death must either be such that in reasonable medical judgement the medical condition, will inevitably cause the untimely death of the patient concerned or the situation of the patient is intractable so that in either case the ending of the life of the patient is the only way for the patient to be released from the suffering.

4. Safeguards

(1) An independent medical practitioner may not give effect to a request for access to the right to die with dignity to any patient unless he or she has ensured that the following has been complied with—

(a) the patient is eligible to access the right in terms of section 2 and section 3 of this Act;

(b) he or she has conferred with a consulting independent medical practitioner who is not employed in the same medical practice and where an independent medical practitioner is in the employ of the state such independent medical practitioner shall make all decisions independent of any hospital or other policy imposed by the state as employer, and whose name and contact details he or she shall record in writing and who is a specialist regarding the requestor's illness and who has reviewed the requestor's medical history and performed a physical examination and who has confirmed in writing that he or she agrees with the first independent medical practitioner regarding the fact

that the patient is eligible to access the right in terms of section 2 and section 3 of this Act.

(c) should either independent medical practitioner not be certain as to the mental competence of the patient the first independent medical practitioner must engage a consulting psychologist or psychiatrist to examine the patient and determine whether the patient is competent to request access to the right to die with dignity. Only if the consulting psychologist or psychiatrist confirms in writing that the patient is mentally competent to make such a decision may the independent medical practitioner proceed with the request.

(d) the oral requests of the requestor include at minimum two clear requests separated by a minimum of 7 days, with the last request taking place within a period less than 72 hours before the independent medical practitioner offers the assistance.

(e) the independent medical practitioner and the consulting independent medical practitioner have been present when a duly completed certificate of request in clear and unambiguous terms was signed asking the independent medical practitioner to assist the patient to end the patient's life which is signed by either—

(i) the patient him or herself personally, or

(ii) if the patient is physically unable to sign the certificate of request, any adult person other than either of the independent medical practitioners who have confirmed eligibility and other than any person who would not qualify as an independent witness may, at the patient's request and in the presence of the patient and both the independent medical practitioners, sign the certificate on behalf of the patient.

(iii) immediately before the signing of the certificate of request the independent medical practitioner advises the patient that he or she may rescind the request and choose not to sign the certificate of request;

(f) two independent witnesses shall also witness the signing of the certificate of request and sign as independent witnesses thereon;

(g) both independent medical practitioners have been witnesses to the signature of the certificate of request by either the patient or his representative and the two independent witnesses;

(h) an interpreter who is fluent in the language of the requestor is required to be physically present to ensure proper communication when treatment decisions are contemplated if either of the independent medical practitioners are not fluent in the mother tongue or the preferred language of the requestor, and the interpreter must sign the certificate of request before the requestor, the two independent medical practitioners, and the two independent witnesses thereby indicating that the requestor understood the meaning, consequences, and import of the certificate of request;

(i) immediately before offering the requested assistance to access the right to die with dignity advise the patient that he or she may withdraw the request, and ensure that the assistance is only provided if an express and unambiguous confirmation from the patient is received before proceeding with the requested assistance.

(2) Medical or non-medical interventions that are designed to facilitate the committing of suicide are prohibited from being produced or being made available for use in South Africa where such interventions circumvent the requirements of this Bill and in particular the necessity of independent medical practitioners being required to access the right to die with dignity.

5. Medical practitioner may conscientiously object but must refer

(1) An independent medical practitioner who is requested by a patient to assist in accessing his or her right to die with dignity—

(a) may conscientiously object to assisting and must advise the patient personally within 48 hours of the request of the conscientious objection together with the contact details in writing of an independent medical

practitioner to whom the patient has been referred who is not a conscientious objector;

(b) the Minister responsible for Health shall ensure that there is reasonable access to independent medical practitioners who are not conscientious objectors throughout the public health system.

6. Medical practitioner's exemption from liability

An independent medical practitioner who assists a qualifying requestor under this Bill shall not be liable for civil, criminal or disciplinary liability for such act provided all material, procedural and other lawful measures have been duly and properly complied with.

7. Effect of accessing the right to die with dignity on contract, will or other agreement

(1) A provision in any contract, will, or other agreement whether written or oral, to the extent the provision would affect or be conditional upon whether a person may make, withdraw, or rescind a request for the right to die with dignity is *void ab initio*.

(2) A provision in any contract, or will, or other agreement whether written or oral, that affects any benefit accrued under the agreement as a result of a person making, withdrawing, or rescinding a request for the right to die with dignity or being conditional thereon is *void ab initio*.

(3) An obligation owing under any contract, will or other agreement affected by a person, withdrawing, or rescinding a request for the right to die with dignity or being conditional thereon is *void ab initio*.

(4) Any contract, including but not limited to a sale agreement, accident insurance agreement, health insurance agreement, annuity policy, or any rate charged under any agreement shall not be contingent upon making or rescinding the request for assisted dying. and any such provision shall be *void ab initio;* and, as such an act is not suicide for legal purposes a qualified patient dying by

accessing the right to die with dignity shall not affect life, health, or accident insurance or an annuity policy.

8. Regulations and Monitoring

(1) The Minister responsible for Health shall make any regulations that he or she considers to be necessary in order to ensure the identification, and collection of information required to monitor the Right to Die with Dignity, and the provision of such assistance granted under this Bill including—

(a) which information must be provided, when such information is to be provided by any person engaged in the process at any stage except where such information is subject to legal privilege, including by independent medical practitioners and pharmacists;

(b) the form, the manner, and the time at which the information required must be provided;

(c) the designation of an official responsible for ensuring the information is collected and properly analysed and stored;

(2) how the information, is to be collected, stored, analysed and publicised such that proper monitoring by parliament may be made annually;

(3) the disposal of any information;

(4) any related matter which it is necessary or expedient to prescribe for the proper implementation or administration of this Bill.

CHAPTER 7
CONCLUSION

7.1 The questions addressed

This thesis seeks to address the question: 'Given that South Africa is a pluralistic society with changing views on the morality and ethics concerning dying and the moment of death, does the South African Constitution, common law, and jurisprudence support a case for decriminalising physician assisted death by invoking a "right to die with dignity" that arises from the values and rights underlying South African constitutional law and jurisprudence in a similar manner in which it was held to have arisen in Canada from its Charter of Rights and Freedoms'? In doing so it considers, inter alia, whether decriminalisation is ethical and what safeguards, in the South African context, might be necessary to prevent abuse.

7.2 The ground covered

In the second chapter, the common law framework relating to 'mercy killing' including assistance in suicide and euthanasia were explored.

In the third chapter, the constitutional rights framework in South Africa and Canada were described together with an analysis of the jurisprudence relating to the limitations clauses in their constitutions. The assisted dying case in South Africa, *Stransham Ford*,[1] was discussed together with the leading cases in the Supreme Court of Canada being *Rodriguez*[2] where the applicant failed and *Carter*[3] where the applicant

[1] *Minister of Justice and others v Estate Stransham Ford* 2017 (3) SA 152 (SCA).
[2] *Rodriguez v British Columbia (AG)* [1993] 3 S.C.R. 519.
[3] *Carter v Canada* 2015 SCC 5 [Supreme Court Appeal].

succeeded in obtaining an order declaring the universal ban on assisted suicide unconstitutional.

In the fourth chapter, the main ethical arguments for and against assisted suicide were discussed leading to the conclusion that assisted dying laws are ethically acceptable.

In the fifth chapter, the importance of safeguards was highlighted to determine how these should be provided for in future South African legislation.

In the sixth chapter, the lessons from chapter five were applied to develop a proposed draft Bill for a South African assisted dying regime.

7.3 Findings

An analysis of the South African common law identifies areas of uncertainty. For example, a series of cases[4] relating to causation showed an inconsistent approach even when based on almost identical legal facts. This leaves the position unclear as to what is required for the presence of an intervening cause to be found which would break the chain of causation and allow an accused to avoid criminal liability from assisting in suicide.

In the recent South African Supreme Court of Appeal case, *Stransham-Ford,*[5] it was held that on a proper interpretation of the *Grotjohn*[6] case, assisting someone to commit suicide is not always a criminal offence. Whether it is will depend upon the facts relating to intention, unlawfulness, and causation. The conclusion is therefore that not all instances of physician assisted dying may be unlawful.[7] The court then went on to provide a roadmap showing what would be needed for an application to be successful including how a court would need to place the *Grotjohn*[8] principles in the present context given medical advancement in the half-century since it was decided and the injunction of the constitution to develop the common law in alignment with

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[4] *Rex Respondent v Peverett Appellant* 1940 AD 213; *R v Nbakwa* 1956 (2) SA 557 (SR); *S v Gordon* 1962 (4) SA 727 (N); *Ex parte die Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A); *S v Hibbert* 1979 (4) SA 717 (D); *S v Agliotti 2011* (2) SACR 437 (GSJ).
[5] *Stransham-Ford* supra n1.
[6] *Grotjohn s*upra n4.
[7] *Stransham-Ford* supra n1 para 54.
[8] *Grotjohn* supra n4.

the Bill of Rights. In terms of the roadmap, only once a court has held that the applicable criminal law provisions infringe the Bill of Rights would it then need to consider how the common law should be developed to allow physician assisted dying by adapting the law relating to causation, or intention, or unlawfulness, or a special defence for medical practitioners.[9]

In the cases reviewed, even where those who assisted suicide or performed euthanasia were found guilty, the sentences were nominal. This is so even in the early cases and suggests that such sentences reflect that the boni mores of South African society shifted long ago from its Roman-Dutch origins and that the wrongfulness of assisting suicide or performing euthanasia is in doubt, as evidenced by these nominal sentences.[10] This is amplified by the further dramatic shift in the boni mores that resulted since the advent of constitutional democracy in South Africa. When the boni mores change, the common law must follow.

The common law as it stands is at best ambiguous and in a proper case, a court may interpret *Grotjohn*[11] as authorising certain cases of physician assisted dying or recognise that the shifting boni mores require decriminalising certain cases of physician assisted dying.

It is noted in chapter 3 that in terms of the South African Constitution all laws are subject to an objective normative value system against which it is tested. In this context, the right to life and the right to dignity are inextricably linked, the right to life incorporating a right to dignity.[12] Where a person is suffering in a life absent of dignity the right to dignity necessarily demands a right to die with dignity. As death is an inevitable conclusion of life itself, the right to life incorporates the right to a dignified death.

A person physically incapable of suicide without assistance has their right to equality infringed when deprived of assistance. Furthermore, a person may commit suicide earlier than they otherwise might for fear that they may in the future become

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[9] *Stransham-Ford* supra n1 paras 55-56.
[10] See discussion on the boni mores under heading 2.6.3.
[11] *Grotjohn* supra n4.
[12] *S v Makwanyane and Another* 1995 (3) SA 391 (CC) paras 326-327.

physically incapable of committing suicide without assistance. Such a person would be denied the right to a dignified life in the absence of physician assisted dying laws.

The right to freedom and security of the person prohibits interference with a patient's autonomous decision making in respect of their body. This prohibition includes interference by the state that may impinge on personal security arising out of decision-making over one's body. It also includes the psychological stress imposed by the state on a patient as a result of the patient not having the option of assisted suicide.

In considering whether the limitations on identified rights were justifiable, the approach taken by the Canadian Courts is instructive. Particularly the *Rodriquez*[13] and *Carte*r[14] cases. In *Rodriquez* the physician assisted dying application was struck down but in *Carter,* it succeeded. Several factors can be identified as contributing to the divergent approaches taken by these courts.

First, that the legislative and social facts were different as more than two decades had passed between the two judgments during which a record had developed in jurisdictions with permissive physician assisted dying law and from which it was evident that the fear that safeguards could not adequately protect the vulnerable had been countered by evidence together with further proof that fear of a slippery slope was unfounded as it had not arisen in permissive jurisdictions.

Secondly, distinctly new legal approaches were evident in that for the first time it was not only the right to liberty and security of the person that was put into play but also the right to life directly. Taking this new approach, it was argued in the *Carter v Canada*[15] trial court that the applicant was deprived of her right to life through the absence of a physician assisted dying law as such absence compelled her to consider taking her own life whilst she was still physically capable of doing so on her own. This meant that she would need to commit suicide earlier than she might otherwise for fear that when she was ready to do so she may no longer be physically capable of doing so by herself without assistance. In this way, the absence of a dying law would cause her to shorten her life earlier than necessary thereby militating against her right to life.

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[13] *Rodriguez* supra n2.
[14] *Carter* supra n3.
[15] *Carter v Canada* [2012] BCSC 886 [the Trial Court] para 17.

Thirdly, certain developments in Canadian Constitutional jurisprudence.[16]

Fourthly, that developments in ethics discourse suggested that there was no bright-line ethical distinction between the existing end of life practices and physician assisted dying in appropriate circumstances.

The constitutional principles which were at play in *Carter*[17] may be expected to be applied in an analogous manner in South Africa. In fact, in this case, the key elements of the infringement of the applicant's right to liberty and security of the person were that,

> '[a]n individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy'.[18]

The Canadian Charter of Rights and Freedoms makes no mention of 'dignity' either as a right or as a value. Yet, despite this absence the *Carter*[19] judgment focused directly on the dignity of the individual. Such an approach is even more imperative in the South African context given the centrality of the value and right to dignity pertaining in that jurisdiction. This approach would not be contrary to the common law of South Africa as it presently stands because it has not closed the door on suicide assistance in all cases and the nominal sentences of those convicted, point to the necessity of a new judicial approach being required regarding assisted dying.

Expert evidence on both ethics and the practice of physician assisted dying in other permissive jurisdictions would be of assistance to a South African court required to determine the constitutionality of physician assisted dying law in South Africa. The following rights are violated by a blanket prohibition of physician assisted dying: the right to human dignity, the right to life, the right to equality, and the right to freedom and security of the person (which includes the right to bodily and psychological integrity, which includes the right— … to security in and control over their body). A blanket ban on physician assisted dying does not meet the standard of a justifiable limitation because a carefully crafted system of exceptions such as is proposed in the draft Bill in chapter 6 would be a 'less restrictive means to achieve the purpose' of

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[16] See discussion under heading 3.2.3.
[17] *Carter* supra n3.
[18] Ibid para 66.
[19] Ibid.

protecting weak and vulnerable persons. The safeguards incorporated into legislation would protect the weak and vulnerable in that a physician would only be exempt from civil, criminal, or disciplinary liability when all the prescripts have been adhered to and all the safeguards complied with. Failure to do so would expose the physician to the usual civil, criminal, and disciplinary sanctions as a consequence of such acts.

It would be preferable that the legislature considers implementing physician assisted dying legislation as that would result in a proper countrywide discussion of this important law and the form it should take, taking into account the various interests and stakeholder views across the nation as was last done in 1998.[20] However, should this not occur it is the duty of an appropriate court to make the necessary order. A similar position could pertain as in the *Carter*[21] judgment where an invalidity order was suspended for a specified period to allow parliament time to pass the necessary legislation.[22] Unfortunately, it is in the nature of physician assisted dying cases that the risk is taken that the applicant(s) dies before an order can be made. A solution to this is alluded to by Wallis, J in Stransham-Ford[23] of the possibility of bringing such an application in the form of a class action which would avoid this outcome.[24]

Postscript

At the time of writing, a matter in which Suzanne Walter and Diethelm Gunther Hark are the first and second plaintiffs together with other nomine officio plaintiffs being joint trustees of the 'Sue Dieter Trust' is before the Gauteng Local Division of the South African High Court. According to their amended particulars of claim in the matter, the first plaintiff suffers from myeloma and the second from motor neuron disease, both being terminal illnesses. They claim that in terms of the common law it is not unlawful for them to commit suicide and neither is it unlawful, in all circumstances, for a physician to prescribe to the plaintiffs, upon their free and voluntary request, medicine which will, upon self-administering, have the effect of ending their lives.

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[20] South African Law Commission Report (Project 86) *Euthanasia and the artificial preservation of life* (1998) available at https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf (accessed 16 December 2021).
[21] *Carter* supra n3.
[22] Ibid para 147.
[23] *Stransham-Ford* supra n1.
[24] Ibid para 14.

They claim this to be the case as intending to commit suicide, attempting to commit suicide or committing suicide is not unlawful. Also, a physician who prescribes lethal medication does not commit an unlawful act as the physician is neither encouraging nor intending an unlawful act. Finally, that the self-administration of prescribed lethal medicine constitutes a novus actus interveniens releasing the physician from legal causation.

They conclude that the common law does not prohibit suicide nor physician assisted suicide but only physician administered euthanasia. They accordingly claim that their constitutional right to dignity, right to life, right to freedom and security of the person, and right not to be treated in a cruel, inhuman or degrading way is infringed by the common law. Accordingly, their prayer is that the common law prohibition of physician administered euthanasia is unconstitutional for persons incapable of performing the necessary physical actions that remain required by physician assisted suicide or in the alternative, that the common law rule against physician assisted suicide is unconstitutional to the extent that a person may be physically incapable of committing suicide. An order is sought to direct the Health Professions Council of South Africa to amend their rules against physician assisted suicide and physician administered euthanasia and the Parliament of the Republic of South Africa to enact legislation or amend the Health Practitioner's Act to give effect to the Plaintiff's right to self-determination.

Interestingly, the application claims that physician assisted suicide is already lawful in South Africa and the effect of the judgment would be either to confirm this assertion or otherwise in addition to what it may hold regarding physician administered euthanasia.

It is hoped that in the absence of intervention by the legislature, this case will open the door to physician assisted dying law in South Africa. It is likely to be appealed ultimately to the Constitutional Court irrespective of the outcome of the judgment of the High Court and higher courts. It may be reasonably predicted however, that the application will ultimately succeed for the reasons set out in this thesis with the result that South Africa will join those jurisdictions that have come to the aid of those who desperately need a release from their unnecessary suffering by exercising their final human right.

APPENDIX A: YOU CAN'T PLAY GOD (POLITICAL CARTOON)

Reproduced here with permission of the artist Dr Jack & Curtis, EWN.

APPENDIX B: THE CROSSING (POLITICAL CARTOON)

Reproduced here with permission of the artist Carlos Amato which was first published in Curiosity, a print and digital magazine that tells the stories of groundbreaking research through the voices of talented researchers, students and academics at the University of the Witwatersrand in Johannesburg, South Africa.

BIBLIOGRAPHY

1. Cases

1.1 South Africa

Carmichele v Minister of Safety and Security and Another 2001 (4) SA 938 (CC)

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

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

Dawood and Another v Minister of Home Affairs and Others 2000 (3) SA 936 (CC)

Du Plessis and Others v De Klerk and Another 1996 (3) SA 850 (CC)

Ex parte die Minister van Justisie: In re S v Grotjohn 1970 (2) SA 355 (A)

Fischer and another v Ramahlele and another 2014 (4) SA 614 (SCA)

Lange v Lange 1945 AD 332

Minister of Home Affairs and Another v Fourie and Another 2006 (1) SA 524 (CC)

Minister of Justice and others v Estate Stransham Ford 2017 (3) SA 152 (SCA) [Stransham-Ford Appeal Court Case]

Minister van Polisise v Ewels 1975 (3) SA 590 (A)

Phillips v De Klerk Unreported 1983 TPD which is discussed in SA Strauss's *Doctor, Patient and the Law* 3 ed. (1991) 29-34

Prinsloo v Van der Linde and Another 1997 (3) SA 1012 (CC)

R v Davidow 1955 WLD unreported discussed in HP van Dyk 'Die davidow-saak' (The davidow case) (1956)19(4) *Tydskrif vir Hedendaagse RomeinsHollandse Reg (Journal for Contemporary Roman-Dutch Law*) 286-288.

R v McCoy 1953 (2) SA 4 (SR)

R v Nbakwa 1956 (2) SA 557 (SR)

Rex Respondent v Peverett Appellant 1940 AD 213

S v Agliotti 2011 (2) SACR 437 (GSJ)

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

S v Dodo 2001 (3) SA 382 (CC)

S v Eadie 2002 (3) SA 719 (SCA)

S v Gordon 1962 (4) SA 727 (N)

S v Grotjohn Unreported judgment in the WLD on the 13 February 1969

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

S v Hibbert 1979 (4) SA 717 (D)

S v Kgogong 1980 (3) SA 600 (A)

S v Laubscher 1988 (1) SA 163 (A)

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

S v Malgas 2001 (2) SA 1222 (SCA)

S v Marengo 1991 (2) SACR 43 (W)

S v McBride 1979 4 SA 313 (W)

S v Mokgethi en Andere 1990 (1) SA 32 (A)

S v Nkwanyana 2003 (1) SA 303 (W)

S v Robinson and others 1968 (1) SA 666 (A)

S v Smorenburg 1992 (2) SACR 389 (C)

S v Williams 1986(4) SA 1188 (A)

S v Zinn 1969 (2) SA 537 (A)

Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 50 (GP) [Stransham-Ford High Court Case]

1.2 Canada

Alberta v Hutterian Brethren of Wilson Colony 2009 SCC 37

Canada (Attorney General) v. PHS Community Services Society [2012] 244 CRR (2d) 209

Carter v Canada (AG) [2012] BCSC 886, [Trial Court]

Carter v Canada (AG) [2013] BCCA 435, [Appeal Court]

Carter v Canada 2015 SCC 5, [Supreme Court Appeal]

Chamberlain v Surrey School District No. 36 [2002] 4 S.C.R. 710

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

R v Big M Drug Mart [1985] 1 S.C.R. 295

R v Heywood [1994] 3 S.C.R. 761

R v Malmo-Levine [2003] 3 R.C.S. 571

R v Oakes [1986] 1 S.C.R. 103

Truchon v Canada (AG) 2019 QCCS 3792

1.3 Colombia

Carlos Gaviria Diaz. Judgment C-239, it demands for unconstitutionality. Constitutional Court. Colombia. 1997.

Luis Ernesto Vargas Silva. Judgment T-970, action of guardianship. Constitutional Court. Colombia. 2014.

Gloria Stella Ortiz Delgado. Judgment T-544 action of guardianship. *Constitutional Court*. Colombia. 2017.

1.4 The Netherlands

Queen v Boudewijn Chabot, Supreme Court (Penal Section), Nederlandse Jurisprudentie 1994, No. 656

Queen v Brongersma, Supreme Court (Penal section) Nederlandse Jurisprudentie 2003, No. 167

Queen v Ms Geertruida Postma, District court of Leeuwarden, Nederlandse Jurisprudentie 1973, No 183

Queen v Ms Wertheim, Rechtbank Rotterdam (The District Court of Rotterdam) [1982] Nederlandse Jurisprudentie 1982 No. 63

Queen v Schoonheim, Supreme Court (Penal Section) Nederlandse Jurisprudentie 1984, No. 407

1.5 United States of America

Baxter v. Montana, 2009 MT 449 available at https://law.justia.com/cases/montana/supreme-court/2009/50c59956-3100-468d-b397-4ab38f6eda4d.html (accessed 17 December 2021).

1.6 Germany

BVerfG, Judgment of the Second Senate of 26 February 2020 - 2 BvR 2347/15 -, paras. 1-343, available at http://www.bverfg.de/e/rs20200226_2bvr234715en.html (accessed 17 December 2021).

BVerfGE 39, 1 - *Schwangerschaftsabbruch*

1.7 Switzerland

Schweizerisches Bundesgericht: Entscheide 2A.48/2006 and *2A.66/2006* available at https://www.bger.ch/ext/eurospider/live/de/php/aza/http/index.php?highlight_docid=aza%3A%2F%2F03-11-2006-2A-48-2006&lang=de&type=show_document&zoom=YES& (accessed 17 December 2021).

2. Constitutions and Local Statutes

Constitution of South Africa 1993 (Interim Constitution)

Constitution of South Africa 1996 (Final Constitution)

Children's Act 38 of 2005

Criminal Procedure Act 56 of 1955

Criminal Procedure and Evidence (Amendment) Act 46 of 1935

National Health Act 61 of 2003

3. Constitutions and Foreign Statutes

3.1 Australian Jurisdictions

Commonwealth of Australia Constitution Act 1900 (Imp) 63 & 64 Vict, c 12, s 9 available at https://www.legislation.gov.au/Details/C2013Q00005 (accessed 17 December 2021)

State of Victoria, Australia: Voluntary Assisted Dying Act (VAD) No. 61 of 2017 (Vic.) available at https://content.legislation.vic.gov.au/sites/default/files/8caaf3b4-28f6-3ad1-acf3-e3c46177594e_17-61aa003%20authorised.pdf (accessed 17 December 2021).

State of Western Australia: Voluntary Assisted Dying Act (VAD No. 27 of 2019 (WA)) available at https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42491.pdf/$FILE/Voluntary%20Assisted%20Dying%20Act%202019%20-%20%5B00-00-00%5D.pdf?OpenElement (accessed 17 December 2021).

The Northern Territory of Australia: Rights of the Terminally Ill Act of 1995 available at *https://legislation.nt.gov.au/en/Legislation/RIGHTS-OF-THE-TERMINALLY-ILL-ACT-1995* (accessed 17 December 2021).

3.2 National States

Belgium: The Belgian Act on Euthanasia of May, 28th 2002 available at http://eol.law.dal.ca/wp-content/uploads/2015/06/Euthanasia-Act.pdf (accessed 17 December 2021).

Canada: The Medical Assistance in Dying (MAID) Act. An Act to amend the Criminal Code and to make related amendments to other Acts, Bill C-14 (Royal Assent) June 17, 2016 available at https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent#EH5 (accessed 17 December 2021).

Canada: Bill C-7 An Act to amend the Criminal Code (medical assistance in dying) available at https://www.parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent (accessed 17 December 2021).

Canada: Lord's Day Act, R.S.C. 1970, c. L-13, s. 4.

Colombia: Código Penal, Ley No. 599, 24 July 2000, available at https://www.refworld.org/docid/3dbd1fd94.html (in Spanish, accessed 17 December 2021).

Colombian Constitution, 1991 available at https://constituteproject.org/constitution/Colombia_2015.pdf?lang=en (accessed 17 December 2021).

German Criminal Code (Strafgesetzbuch – StGB) Criminal Code in the version published on 13 November 1998 (Federal Law Gazette I, p. 3322), as last amended by Article 2 of the Act of 19 June 2019 (Federal Law Gazette I, p. 844) available at https://www.gesetze-im-internet.de/englisch_stgb/index.html (accessed 17 December 2021).

Luxembourg: Act of 16 March 2009 on Euthanasia and Assisted Suicide available at https://legilux.public.lu/eli/etat/leg/loi/2009/03/16/n2/jo (accessed 17 December 2021).

New Zealand: End of Life Choice Act of 2019 available at https://www.legislation.govt.nz/bill/member/2017/0269/latest/DLM7285905.html (accessed 17 December 2021).

Swiss Criminal Code of 21 december 1937 (status as of 20 July 2020) available at https://www.droit-bilingue.ch/rs/lex/1937/00/19370083-unique-en-rm.html (accessed 17 December 2021).

The Netherlands: Termination of Life on Request and Assisted Suicide (Review Procedures) Act entered into force on 1 April 2002 available at https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/bro

chures/brochures/euthanasiecode/2018/euthanasia-code-2018/EuthanasieCode_2018_ENGELS_def.pdf (accessed 17 December 2021, text of Act from page 57 of downloaded pdf onwards).

3.3 United States of America Jurisdictions

District of Columbia: Death with Dignity Act of 2016 Law21-82 available at https://deathwithdignity.org/wp-content/uploads/2015/11/DC-Death-with-Dignity-Act.pdf (accessed 17 December 2021).

Oregon State Legislature: The Oregon Death with Dignity Act, Chapter 127.800-995 ORS available at https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx (accessed 17 December 2021).

State of California: End of Life Option Act AB-15 (2015-2016) available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520162AB15 (accessed 17 December 2021).

State of Colorado: End-of-Life Options Act, Colorado Revised Statutes s25-48-118 available at https://deathwithdignity.org/states/colorado/ (accessed 17 December 2021).

State of Hawaii: Our Care Our Choice Act H.B. No 2739 H.D.1. available at https://statelaws.findlaw.com/hawaii-law/hawaii-euthanasia-laws.html (accessed 17 December 2021).

State of Maine: Death with Dignity Act, Public Law Chapter 271 available at https://www.mainelegislature.org/legis/bills/bills_129th/billtexts/HP094801.asp (accessed 17 December 2021).

State of New Jersey: Medical Aid in Dying for the Terminally Ill Act (P.L. 2019, c. 59) available at https://www.njconsumeraffairs.gov/Statutes/Medical-Aid-in-Dying-for-the-Terminally-Ill-Act.pdf (accessed 17 December 2021).

State of Vermont: Patient Choice and Control at End of Life Act 39 of 2013 available at https://deathwithdignity.org/states/vermont/ (accessed 17 December 2021).

Washington State Legislature: The Washington Death with Dignity Act, Chapter 70.245 RCW available at https://app.leg.wa.gov/rcw/default.aspx?cite=70.245 (accessed 17 December 2021).

4. Books, Book Chapters and Theses

Annuario Pontificio 2018 (Pontifical Yearbook 2018 Catholic Church Directory), Vatican Publishing House LEV.

Anthony,F. & Sterkens, C. 'Religion and the right to (dispose of) life: A study of the attitude of Christian, Muslim and Hindu students in India concerning death penalty, euthanasia and abortion' in H Ziebertz & F Zaccaria (eds) *Euthanasia, abortion, death penalty and religion – The right to life and its limitations* (2019). Springer.

Aquinas, T. *Summa Theologica* (1911-1925) (trans. Fathers of the English Dominican Province). New York: Benziger Brothers.

Asad, M. *The message of the Qur'an* (2008) (Kindle Locations 7085-7086). The book foundation. Kindle edition.

Beabout, G. 'Morphine use for terminal cancer patients: An application of the principle of double effect' in P.A. Woodward (ed) *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle* (1989). Notre Dame, Indiana: The University of Notre Dame Press.

Benatar, D. 'Assisted suicide, voluntary euthanasia and the right to life' in J Yorke (ed) *The right to life and the value of life* (2010) 291. Ashgate Publishing Limited.

Bergen, D.L. *War and genocide, a concise history of the holocaust* 3 ed (2016). Rowman and Littlefield Publishers, Lanham Maryland.

Boggenpoel, Z. & Draga, L. et al 'The Bill of Rights and the enforcement of the Constitution' in P de Vos & W Freedman (eds) *South African constitutional law in context* (2020). Oxford University Press.

Bognetti, G. 'The concept of human dignity in European and U.S. constitutionalism' in G Nolte (ed) *European and US constitutionalism* (Science and Technique of Democracy No. 37) Council of Europe (2005).

Bok, S. 'Suicide' in G Dworkin, R Frey & S Bok *Euthanasia and physician-assisted suicide* (1998) 93-106 Cambridge: Cambridge University Press.

Brockopp, J.E. 'The "good death" in Islamic theology and law' in JE Brockopp (ed) *Islamic ethics of life: abortion, war and euthanasia* (2003). University of South Carolina Press.

Burchell, J. *Principles of Criminal Law* 5 ed (2016) Juta.

Church, J. 'Religion and the constitution' in WA Joubert (ed) *The law of South Africa* 3ed (2021) 34 para 252.

Currie,I. & de Waal, J. *The Bill of Rights handbook* 6 ed (2013) 250. Juta, Lansdowne South Africa.

Cheadle, M.H. 'Limitation of rights' in MH Cheadle, DM Davis & NRL Haysom (eds) *South African constitutional law: The Bill of Rights* (Last Updated May 2017). Lexis Nexis Butterworths.

Cheadle, M.H., Davis, D.M., Haysom, N.R.L 'Introduction' in MH Cheadle, DM Davis & NRL Haysom (eds) *South African constitutional law: The Bill of Rights* (Last Updated May 2017). Lexis Nexis Butterworths.

Davis, D.M. & Youens, P. 'Euthanasia' in MH Cheadle, DM Davis & NRL Haysom (eds) *South African constitutional law: The Bill of Rights* (Last Updated May 2017). Lexis Nexis Butterworths.

Devenish, G.E. *A commentary on the South African Bill of Rights* (1999). Butterworths, South Africa.

Dowbiggin, I. *A Concise History of Euthanasia: Life, Death, God, and Medicine* (2005). Rowman and Littlefield Publishers, Lanham Maryland.

Dubose, E.R. 'Historical perspectives: Physician aid-in-yying (Active Voluntary Euthanasia)' in GE McCuen (ed) *Doctor-Assisted suicide and the euthanasia movement* (1999) Gary E. McCuen Publications Inc.

Dworkin, R. *Life's dominion: An argument about abortion and euthanasia* (1993). Harper Collins Publishers.

Harvey, P. *An Introduction to Buddhism: Teachings, History and Practices* 2 ed (2013). Cambridge University Press.

Haysom, N.R.L. 'Dignity' in MH Cheadle, DM Davis & NRL Haysom (eds) *South African Constitutional Law: The Bill of Rights* (Last Updated May 2017).

Heckmann, J.E. & Amaler, A.S. 'Public policy in ALS/MND care: South African perspective' in RH Blank, JE Kurent & D Oliver (eds) *Public Policy in ALS/MND Care an International Perspective* (2020). Palgrave Macmillan (Springer Nature Singapore Pte Ltd).

Hester, M.H. *End-of-life care and pragmatic decision making – A bioethical perspective* (2010) Cambridge University Press.

Hoctor, S.V. *Snyman's Criminal Law* 7 ed (2020). Lexis Nexis.

Hoctor, S.V. 'Causation' in WA Joubert (ed) *The law of South Africa (Criminal Law)* 3ed (2021).

Jakobovits, I. *Jewish medical ethics. A comparative and historical study of the Jewish religious attitude to medicine and its practice* (1959). New York: Bloch Publishing.

Johnson, T.M. & Grim,B.J. *The World's Religions in Figures: An Introduction to International Religious Demography* (2013). John Wiley and Sons Ltd.

Kant,I. *Groundwork of the Metaphysic of Morals* (1785).

Kant, I. *Critique of Practical Reason* (1788).

Kant, I. *Metaphysics of Morals* (1797).

Keown, J. *Euthanasia, ethics and public policy: An argument against legalisation* 2 ed (2018). Cambridge: Cambridge University Press.

Kuhse, H. 'Euthanasia' in P Singer (ed.) *A companion to ethics* (1993) 294–302, Blackwell Publishers, Oxford.

Larue, G.A. *Euthanasia and Religion: A Survey of the Attitudes of World Religions to the Right-to-Die* (1985) The Hemlock Society.

Lindsay, R.A. 'Euthanasia' in Hugh LaFollette (ed) *The international encyclopedia of ethics* (2013). Blackwell Publishing Ltd.

Marquis, D. 'Doctrine of double effect' in Hugh LaFollette (ed) *The international encyclopedia of Ethics* (2013). Blackwell Publishing Ltd.

Mill, J.S. *On liberty* 1859 Batoche Books Kitchener.

Pappas, D. *The Politics of Euthanasia and Assisted Suicide: A Comparative Case Study of Emerging Criminal Law and the Criminal Trials of Jack 'Dr. Death' Kevorkian* (unpublished Ph.D. Thesis. Arizona State University 2011).

Paterson, C. *Assisted suicide and euthanasia a natural law ethics approach* (2008). Ashgate Publishing Limited, Hamphire, England.

Peaslee, A. *International government organizations – Constitutional documents* 3 ed Part 1 (1974).

Schulman, A. 'Human dignity and bioethics' in A Schulman, FD Davis & DC Dennett et al *Bioethics and the question of human dignity: Essays commissioned by the President's Council on Bioethics* (2008) Washington DC.

Strauss, S.A. *Doctor, patient and the law* 3 ed. (1991) 29-34. Van Schaik, Pretoria.

Strauss, S.A. 'Euthanasia: A South African view' in A Carmi (ed) *MedicoLegal Library 2: Euthanasia* (1984) Springer-Verlag Berlin Heidelberg New York Tokyo.

Sumner, L.W. *Assisted death: a study in ethics and law* (2011). Oxford University Press.

Swiss Academy of Medical Sciences (SAMS) *Management of dying and death* (2018) available at https://www.samw.ch/en/Publications/Medical-ethical-Guidelines.html (accessed 17 December 2021).

Weyers, H. 'The legalization of euthanasia in the Netherlands: *Revolutionary normality*' in SJ Youngner & GK Kimsma (eds) *Physician-assisted death in perspective: Assessing the Dutch experience* (2012) Cambridge University Press.

Williams, G. *Intention and Causation in Medical Non-Killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide* (2007). Routledge-Cavendish, 2 Park Square, Milton Park, Abingdon, OX14 4RN, UK.

Wood, A.W. *Kant's ethical thought* (1999). Cambridge University Press.

5. Journal Articles

Alexander, L. 'The ontology of consent' (2014) 55(1) *Analytic Philosophy,* University of San Diego.

Appel, J.M. 'A suicide right for the mentally ill? A Swiss case opens a new debate' (2007) 37(3) *Hastings Center Report* 21-23, available at http://www.jstor.com/stable/4625742 (accessed 17 December 2021).

Baeke, G., Wils, J. & Broeckaert, B. 'There is a time to be born and a time to die (Ecclesiastes 3:2a): Jewish perspectives on euthanasia' (2011) 50(4) *Journal of Religion and Health (Springer)* 778-795.

Bartsch, C., Landolt, K., Ristic, A. et al 'Assisted suicide in Switzerland: An analysis of death records from Swiss institutes of forensic medicine' (2019) 116 *Deutsches Arzteblatt international (German International Medical Journal)* 545–552. Available at https://doi.org/10.3238/arztebl.2019.0545 (accessed 18 August 2021).

Benatar, D. 'A legal right to die: responding to slippery slope and abuse arguments' (Oct 2011) 18(5) *Current Oncology: A Canadian Cancer Research Journal* 206-207.

Benavides, L.L.L. 'The right to die with dignity in Colombia' (2018) 6(426-29) *Forensic Research & Criminology International Journal*.

Benson, I. 'Taking pluralism and liberalism seriously: The need to re-understand faith, beliefs, religion, and diversity in the public sphere' (2010) 23(1/2) *Journal for the Study of Religion* 17-41. Association for the Study of Religion in Southern Africa (ASRSA).

Bernheim, J.L., Distelmans, W., & Mullie, A. et al 'Questions and answers on the Belgian model of integral end-of-life care: Experiment? Prototype?' (2014) 11(4) *Journal of Bioethical Inquiry*.

Bernheim J.L.& Raus K.'Euthanasia embedded in palliative care. Responses to essentialistic criticisms of the Belgian model of integral end-of-life care' (2017) 43 *Journal of Medical Ethics.*

Boer, T.A. 'Euthanasia, ethics and theology: A Dutch perspective' (2014) 6(2) *Revista Ecumenica Sibiu* 197-213.

Campbell, S. 'Euthanasia and religion' (2000) 53(1) *The UNESCO Courier Journal.*

Choudry, S. 'So what is the real legacy of *Oakes*? Two decades of proportionality analysis under the Canadian *Charter*'s Section 1' (2006) 35(2d) *Supreme Court Law*

Review at 501, available at http://ssrn.com/abstract=930436 (accessed 14 December 2021).

Cohen-Almagor, R. 'Belgian euthanasia law: a critical analysis' (2009) 35 *Journal of Medical Ethics* 436-9.

Cohn-Sherbok, D. 'Judaism and euthanasia' (2011) 52(3) *Modern Believing* 27-33. Available at https://search-ebscohost-com.ezproxy.uct.ac.za/login.aspx?direct=true&db=rfh&AN=ATLA0001847812&site=ehost-live (Ebscohost subscription required, accessed 13 September 2021).

Eberle, E. J. 'The Methodology of Comparative Law' (2011) 16(1) *Roger Williams University Law Review* 51-72. Available at http://docs.rwu.edu/rwu_LR/vol16/iss1/2

Emanuel, E.J., Onwuteaka-Philipsen, B.D., Urwin, J.W. et al 'Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe' (2016) 316(1) *Journal of the American Medical Association* 79–90.

Fleming, J.I. 'Death, dying, and euthanasia: Australia versus the Northern Territory' (2000) 15(3) *Issues in Law and Medicine Journal* 291-305.

Freire de Andrade Neves, M. 'States of uncertainty: plural laws and affective governance in the context of assisted suicide in Germany' (2018) 50(3) *The Journal of Legal Pluralism and Unofficial Law* 317-329.

Goligher, E.C., Ely, E.W.,Sulmasy, D.P. et al 'Physician-assisted suicide and euthanasia in the ICU' (2017) 45 (2) *Critical Care Medicine* 149–155.

Griffiths, J. 'Assisted suicide in the Netherlands: The Chabot case' (1995) 58 *Modern Law Review* 232. Blackwell Publishers, 108 Cowley Road, Oxford OX4 IF and 238 Main Street, Cambridge, MA 02142, USA.

Grosse, C. & Grosse, A 'Assisted suicide: Models of legal regulation in selected European countries and the case law of the European Court of Human Rights' (2015) 55(4) *Medicine, Science and the Law* 246-58.

Guillod, O. & Schmidt, A. 'Assisted suicide under Swiss law' (2005) 12(1) *European Journal of Health Law* 25-38, Koninklijke Brill N.V. Printed in the Netherlands.

Hoctor, S. 'Non-pathological criminal incapacity relating to provocation or emotional stress – an overview of developments in South African law' (2019) 49(2) *South African Journal of Psychology* 177-187 180. Sage.

Hurd, H.M. 'The moral magic of consent' (1996) 2(2) *Legal Theory,* HeinOnline.

Hurst, S.A. & Mauron, A. 'Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. (Education and debate)' (2003) 326(7383) *British Medical Journal* 271–3.

Jackson, V.C. 'Constitutional law in an age of proportionality' (2015) 124(8) *Yale Law Journal* 3094-196.

Jaspers, B., Müller-Busch, H.C. & Nauck, F. 'Integral palliative care: a contradiction in terms?' (in German) 2009 (10) *Zeitschrift Palliativmed* 162–6.

Kamisar, Y. 'Against assisted suicide – Even a very limited form' (Summer 1995) 72(4) *University of Detroit Mercy Law Review* 735-770. HeinOnline.

Kemp, G. 'Specific crimes: Murder, assisted suicide and the euthanasia debate' (2011) 4 *Juta's Quarterly Review of South African Law (Criminal Law).*

Keown, D. & Keown, J. 'Killing, karma and caring: Euthanasia in Buddhism and Christianity' (1995) 21 *Journal of Medical Ethics* 265-9.

Koenane, M. 'Euthanasia in South Africa: Philosophical and theological considerations' (2017) 38(1) *Verbum et Ecclesia Journal* available at https://doi.org/10.4102/ve.v38i1.1549 (accessed 14 December 2021).

Lemmens, T., Kim, H. & Kurz, E. ‘Why Canada's medical assistance in dying legislation should be *C(h)arter* compliant and what it may help to avoid’ (2017) 11(1) *McGill Journal of Law and Health* S66.

Love, S.M. ‘Kant After Marx’(2017) 22(4) *Kantian Review* 579-598. University of Pittsburgh.

Mangan, J.T. ‘An historical analysis of the principle of double effect’ (1949) 10 *Theological Studies* 40-61.

McCrudden, C. ‘Human dignity and judicial interpretation of human rights’ (1 September 2008) 19(4) *European Journal of International Law.*

McMorrow, T. ‘MAID in Canada: Debating the constitutionality of Canada's new medical assistance in dying law’ (2018) 44(1) *Queen's Law Journal* 81.

McMorrow, T. ‘The waxing & waning of informed consent: Medical assistance in dying and the question of advance requests’ (2021) 58(2) *Osgoode Hall Law Journal* 287.

Novak, A. ‘Capital sentencing discretion in Southern Africa: A human rights perspective on the doctrine of extenuating circumstances in death penalty cases’ (2014) 14(1) *African Human Rights Law Journal* 24-42.

Oderkerk, M. ‘The Need for a Methodological Framework for Comparative Legal Research: Sense and Nonsense of “Methodological Pluralism” in Comparative Law’ (July 2015) 79(3) *The Rabel Journal of Comparative and International Private Law* 589-623, Mohr Siebeck GmbH & Co. KG.

Palomino, E. ‘How to die in Colombia: A constitutional dilemma’ (2017) 10(2) *Asia Pacific Journal of Health Law & Ethics* 51–68.

Perrett, R.W. ‘Buddhism, euthanasia and the sanctity of life’ (1996) 22(5) *Journal of Medical Ethics* 309-13.

Preston, R. ‘Death on demand? An analysis of physician-administered euthanasia in The Netherlands’ (2018) 125(1) *British Medical Bulletin* 145-55.

Raus, K. ‘The extension of Belgium’s euthanasia law to include competent minors’ (2016) 13(2) *Journal of Bioethical Inquiry* 305.

Rautenbach, C. & du Plessis, L. ‘In the name of comparative constitutional jurisprudence: The consideration of German precedents by South African constitutional court judges’ (2013) 14(8) *German Law Journal* 1539-77.

Rautenbach, I.M. ‘Proportionality and the limitation clauses of the South African Bill of Rights’ (2014) 7(1) *Potchefstroom Electronic Law Journal* pages 2229 – 67 available at http://dx.doi.org/10.4314/pelj.v17i6.01 (accessed 13 December 2021).

Reeves, N. ‘Euthanasia and (D)evolution in speculative fiction’ (2017) 45(1) *Victorian Literature and Culture* 95. Cambridge University Press.

Rietjens, J.A.C., van der Maas, P.J. & Onwutea-Philipsen, B.D. et al ‘Two decades of research on euthanasia from the Netherlands. What have we learnt and what questions remain?’ (2009) 6(3) *Journal of Bioethical Inquiry.*

Ryan, C.J. & Kaye, M. ‘Euthanasia in Australia’ (1996) 334(5) *The New England Journal of Medicine* 326-8.

Sprung, C.L et al ‘Physician-assisted suicide and euthanasia: Emerging issues from a global perspective’ (2018) 33(4) *Journal of Palliative Care (SAGE)* 197–203.

Steck, N., Egger, M., & Zwahlen, M. ‘Assisted and unassisted suicide in men and women: Longitudinal study of the Swiss population’ (2016) 208(5) *British Journal of Psychiatry* 484-90.

Svenson, A.G. ‘Montana’s courting of physician aid in dying could Des Moines follow suit?’ (2010) 29(2) *Politics and the Life Sciences* 2.

Terblanche, S.S. 'Sentencing in South Africa: Dominated by minimum sentences' (2020) 33(1) *South African Journal of Criminal Justice* 4-22.

Van den Block. L., Deschepper, R. & Bilsen, J. et al 'Euthanasia and other end of life decisions and care provided in final three months of life: nationwide retrospective study in Belgium' (2009) 339 (b2772) *British Medical Journal.* Available at https://www.bmj.com/content/bmj/339/bmj.b2772.full.pdf (accessed 17 December 2021).

Verhagen, E., & Sauer, P. 'The Groningen protocol — Euthanasia in severely ill newborns' (2005) 352 (10) *The New England Journal of Medicine* 959 , available at https://www.nejm.org/doi/full/10.1056/nejmp058026 (accessed 6 August 2021).

White, B. P., Del Villar, K., Close, E. & Willmott, L. 'Does the voluntary assisted dying act 2017 (Vic) reflect its stated policy goals?' (2020) 43 (2) *University of New South Wales Law Journal* 417-51.

Willmott, L., White, B. & Stackpoole, C. et al '(Failed) voluntary euthanasia law reform in Australia: Two decades of trends, models and politics' (2016) 39(1) *University of New South Wales Law Journal*.

Woolman, S. 'The amazing vanishing Bill of Rights' (2007) 124(4) *South African Law Journal* 762-94.

Zavala, A. 'The history of euthanasia and physician-assisted suicide' (2015) 1(3) *Journal of Anesthesia History.*

6. Online Sources, Policy Documents, Reports, Media Articles, and Conference Papers

Christine Hauser 'A 3-D Printed Pod Inflames the Assisted Suicide Debate' *The New York Times* 16 December 2021 available at https://nl.nytimes.com/f/newsletter/2gwt7UnJs1MK2l_gkP81pQ~~/AAAAAQA~/RgRjnqyWP0T7aHR0cHM6Ly93d3cubnl0aW1lcy5jb20vMjAyMS8xMi8xNi93b3JsZC9ldXJvcGUvc3VpY2lkZS1wb2RzLXN3aXR6ZXJsYW5kLmh0

bWw_Y2FtcGFpZ25faWQ9NTEmZW1jPWVkaXRfbWJlXzIwMjExMjE3Jmluc3RhbmNlX2lkPTQ4MDUyJm5sPW1vcm5pbmctYnJpZWZpbmclM0EtZXVyb3BlLWVkaXRpb24mcmVnaV9pZD0xMDgyMDU5NzYmc2VnbWVudF9pZD03NzI0MyZ0ZT0xJnVzZXJfaWQ9YWM1OTZiZTM0YWZkMWJlZGIwMjZmMzU3OWFjMzBkNjdXA255dEIKYbuWJ7xhYVkAy1IXaGFsdG9uQGNoZWFkbGVsYXcuY28uemFYBAAAAAA~ (accessed 18 December 2021).

Columbia Protocol for the Application of the Euthanasia Procedure in Colombia available at https://encolombia.com/medicina/materialdeconsulta/aplicacion-eutanasia/eutanasia-colombia/ (accessed 17 December 2021).

Columbia Resolution 1216 of 2015 available at https://www.icbf.gov.co/cargues/avance/docs/resolucion_minsaludps_1216_2015.htm (accessed 17 December 2021).

De Vito, L. 'Dutch euthanasia law always meant for groups that now receive euthanasia; the euthanasia law options have not been expanded' delivered at #AssistedDying2018 conference, hosted by the World Federation of Right-to-Die Societies, in association with DignitySA on 7-8 September 2018, Cape Town, available at https://www.worldrtd.net/news/article-negate-slippery-slope-argument-published (accessed 7 September 2021).

South African Law Commission Report (Project 86) *Euthanasia and the artificial preservation of life* (1998) available at https://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf (accessed 18 December 2021).

South African Law Commission (Project 82) Report: *Sentencing (A new sentencing framework)* (2000) available at https://www.justice.gov.za/Salrc/reports/r_prj82_sentencing%20_2000dec.pdf (accessed 24 September 2021).

The German Reference Centre for Ethics in the Life Sciences (DRZE) 'In focus euthanasia legal regulations' (2020) available at http://www.drze.de/in-focus/euthanasia/legal-regulations (accessed 17 December 2021).

The new Jerusalem Bible: Regular edition, The Very Reverend Dom (Joseph) Henry Wansbrough.

The Oxford English Dictionary (updated 2021) available at https://www-oed-com.ezproxy.uct.ac.za/view/Entry/65140 (accessed 5 December 2021).

The Structured Torah arranged by Moshe Kline available at http://www.chaver.com (accessed 14 December 2021).

Vermont Department of Health (Prepared by: David C. Englander, Esq.) *Report concerning patient choice at the end of life in accordance with Act 27 of 2015* (15 January 2018) available at https://legislature.vermont.gov/assets/Legislative-Reports/2020-Patient-Choice-Legislative-Report-2.0.pdf (accessed 17 December 2021).

Victoria State Government, *Health and Human Services ministerial advisory panel on voluntary assisted dying (Final Report)* (21 July 2017) 221-228 available at https://www2.health.vic.gov.au/about/publications/researchandreports/ministerial-advisory-panel-on-voluntary-assisted-dying-final-report (accessed 17 December 2021).

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