

DIGNITY IN DEATH

A critical analysis of whether the right to human dignity serves as appropriate justification for the legalisation of assisted death.



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Declaration

By submitting this research paper, I declare that the entirety of the work contained therein is my own, original work, that I am the authorship owner thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Table of Contents

1	Introduction	4
2	Terminology	8
2 1	Classification of euthanasia and assisted suicide	8
2 2	Dead or alive	11
2 3	Killing versus letting die	12
3	The development of assisted death	13
4	A comparative analysis of assisted suicide laws	15
4 1	Justification for the comparative analysis	15
4 2	The Northern Territory	15
4 3	The Netherlands	16
4 4	Belgium	20
4 5	Luxembourg	20
4 6	The United States of America	21
4 7	Switzerland.....	23
4 8	Recent developments in assisted death	25
4 9	Conclusion.....	26
5	Arguments in favour of and against the legalisation of assisted death as well as opposing arguments	28
5 1	Introduction	28
5 2	The principle of autonomy in relation to human dignity	28
5 3	Compassion and the prevention of suffering.....	30
5 4	The role of medical practitioners	31
5 5	Persons with disabilities	33
5 6	Sanctity and value of life.....	34
5 7	Slippery slope arguments	35
5 8	Conclusion.....	36
6	The relationship between human dignity and assisted death	37
6 1	Defining dignity	37
6 2	Defining human dignity	38
6 3	Human dignity in the South African context	40
6 4	Human dignity as justification for assisted death.....	41
6 4 1	<i>Arguments that human dignity is an appropriate justification for assisted death</i>	41

6 4 2	<i>Arguments that human dignity cannot be relied upon as justification</i>	42
6 5	Conclusion.....	44
7	Assisted death in South Africa	45
7 1	Introduction	45
7 2	The current legal position in South Africa	45
7 3	Steps taken by the South African Law Commission.....	47
7 4	Why we should not legalise assisted death in South Africa.....	50
7 5	Current efforts to legalise assisted death.....	52
8	Concluding remarks	54
9	List of sources	57
(a)	Books.....	57
(b)	Journals.....	57
(c)	Bills	58
(d)	Case law	58
(e)	Constitutions.....	59
(f)	Correspondence.....	60
(g)	Dictionaries	60
(h)	Legislation.....	60
(j)	Reports and Discussion Papers by the South African Law Commission.....	61
(k)	Websites	61

1 Introduction

The modern world is changing and developing at an immense rate. Improvements in the field of technology and science take place every day. These developments have affected not only the way we live, but also our thought processes and the views that we express. Social changes have empowered us to select options in accordance with our personal preferences in every aspect of our social life – this is also true in relation to health care. It is evident that major developments and advances in the medical sciences and technology now make it possible to prolong living and the dying process in a way that was previously not possible.¹ New medicines and drugs have been produced to treat illnesses and diseases and innovative medical technologies make it possible to prolong living.

These developments in medicine and science do however have two possible outcomes: they can either lead to the prolonging of a person's meaningful life or can result in an existence without meaning. The inherent relationship between the law and morality is emphasised by these two possibilities. The advances in medicine and the prolonging of life have indicated the need for answers to serious moral questions that arise when dealing with the debate on assisted death.² The dilemma encountered by medical practitioners in their attempt to provide appropriate patient care, whilst at the same time respecting patient autonomy, plays a central role in the assisted death debate. The legal system is consequently called upon to define the boundary between the rights of a patient and the responsibilities of the medical practitioner with regard to potential life-limiting treatment decisions.³ The legality of assisted death has consequently become a pressing legal issue.

The debate regarding assisted death is not novel; in fact it is an ancient debate.⁴ Recently it has however attained a high level of relevance and urgency and has consequently become the topic of public debate and of possible legislative reform. The prominence of the assisted death debate can be attributed to a few key factors. As indicated above, advances in medical science have led to the institutionalisation of the process of dying. Western societies have also indicated a rise in the proportion of elderly people, due to general improvements that have been made in nutrition and health services. Although the issue of assisted death is not restricted to the elderly, those who are entering the later stages of life are more focused on the manner of their dying and therefore more likely to contemplate a form of assisted death.

¹ Biggs H *Euthanasia, death with dignity and the law* (2001) 9.

² Slabbert M & Van der Westhuizen C "Death with dignity in lieu of euthanasia" (2007) 22 *SAPR/PL* 366.

³ Biggs *Death with dignity* 10.

⁴ See chapter three for further discussion on the development of assisted death.

The growing awareness of patients' rights in relation to health care has also contributed to the prominence of the assisted death debate.⁵

Another factor is the rise of the AIDS epidemic. Since many of its victims are well informed of the unpleasant manner of death that they will face, the demand for control over the manner and time of one's death has intensified. A gradual change in the attitude toward death and the process of dying has also been significant in the assisted death debate. For a very long time the topic of death was deemed as off limits and was viewed as a very private matter. This attitude has gradually been changing as many have indicated their support for the legalisation of assisted death and have demanded a dignified death. The final factor that has contributed to the debate is the influence and the role of the media. Increased media coverage and easy access to all matters relating to the debate has resulted in a growing community that has become more informed of assisted death.⁶

All these factors have been and still are central to the movement for the legalisation of physician-assisted death and/or active voluntary euthanasia.⁷ The question that this dissertation will focus on is whether the legalisation of physician-assisted suicide and active voluntary euthanasia can be justified on the basis of the right to human dignity. Under what circumstances would it be justified for one person to kill another or to assist that person in taking his own life? Should this person have a terminal disease, and suffer excruciating pain and loss of dignity? Which circumstances and which practices will justify such behaviour? Why is assisted death such a controversial and debatable topic? Should we be able to act with compassion and protect someone's dignity by ending their life or supplying the means to do it themselves, or should the sanctity of life be safeguarded? The list of questions is endless and there are many arguments that can be invoked in favour and against the practice of assisted death. These are difficult questions that must be answered.

What is however evident is that, with the advances in medicine and science, the law is required to develop in order to provide solutions. The law must fill the gaps left by these advances in order to establish if and when actions will be deemed lawful. Legal regulation is necessary to ensure that abuses do not occur that could have been avoided through means of legislation.

The ability to choose whether one's life should be prolonged or not, and also to have this choice be respected by the law, is valued as a manner of exercising and maintaining

⁵ Otlowski M *Voluntary euthanasia and the common law* (1997) 1.

⁶ Otlowski *Voluntary euthanasia* 2.

⁷ Otlowski *Voluntary euthanasia* 2.

control over one's life. This can in turn aid in preserving the individual's dignity in dying. Autonomy and the ability to exercise a decision is central to the argument for legalising assisted death as choice indicates volition and a voluntary act signifies self-determination. All of these elements are closely associated to the concept of human dignity. It is on this basis that the dissertation will examine whether human dignity serves as appropriate justification for the legalisation of active voluntary euthanasia and assisted suicide.⁸

In order to fully examine this research question, attention will first be paid to all the relevant terminology used on this subject so as to explain how these concepts are related, and to provide context as this subject can often become confusing. Euthanasia and assisted suicide will therefore be defined, classified and compared in chapter two. The concepts of killing versus letting die will also be discussed as this forms a central part of the debate regarding legalisation of the practices. Chapter three then focuses on the development of assisted death by tracing it back to the history and origin of suicide. This chapter will focus on the views of society and scholars and also how societal changes have influenced our views.

The fourth chapter entails a comparative analysis of how different forms of assisted death have been legalised and regulated in various jurisdictions. The chapter sets out a brief justification for this comparative analysis and then continues to discuss the position in the different jurisdictions and the way that they have been received and approached. The Netherlands, Belgium and Luxembourg form the main part of the discussion as they are currently the pioneers on this front. All three nations have legalised the practice of euthanasia, with the Netherlands being the first in the year of 2002. The Netherlands has also legalised the practice of physician-assisted suicide. In 2002 and 2013 the Netherlands and Belgium respectively extended their euthanasia law to children. The chapter discusses the applicable legislation and the regulation of the practice so as to avoid prosecution as well as the criteria the law set in order to qualify. The United States of America's position will also be discussed as recent case law and legislation has made physician assisted suicide legal in five states; active euthanasia is however still illegal. The legal position in the United Kingdom, Switzerland and Canada is also examined.

Chapter five examines the most commonly relied on arguments against and in favour of the legalisation of assisted death and each argument will be dealt with in a separate

⁸ Biggs *Death with dignity* 1.

section. The arguments as well as their counter arguments will be discussed in order to shed more light on the assisted death debate.

Chapter six focuses on the relationship between human dignity and assisted death. This chapter is of significant importance as it emphasises the role of human dignity in the dissertation and will be central to answering the question whether human dignity serves as appropriate justification for the legalisation of assisted death, specifically active voluntary euthanasia and physician-assisted suicide. The history and development of the concept of human dignity will be briefly discussed in order to indicate the imprecise nature of the notion and to point out the specific elements of the concept that will be focused on in the dissertation to support the argument. The role of human dignity in the South African context will be examined by referring to the Constitution of the Republic of South Africa, 1996 (the Constitution) as well as constitutional jurisprudence relating to the interpretation and application of human dignity. The following part of the chapter examines whether human dignity serves as an appropriate justification for the legalisation of assisted death. This examination will be two-fold, considering arguments from both sides of the spectrum – those arguing that human dignity serves as proper justification as well as those that contend that it cannot be relied on to justify legalisation. The last part will summarise the arguments and come to a conclusion.

The penultimate chapter, chapter seven, focuses on the question whether assisted death should be legalised in South Africa and also which form is more desirable. This is done by examining the current position in terms of South African law, jurisprudence on the subject as well as the review by the South African Law Commission and current attempts by DignitySA to legalise assisted death.

The last chapter, chapter eight, comes to a conclusion on the question whether human dignity serves as an appropriate justification for the legalisation of assisted death, on the basis of the analyses in the previous chapters.

2 Terminology

2.1 Classification of euthanasia and assisted suicide

Before the relationship between human dignity and assisted death can be examined, it is first necessary to define the relevant terms that are used in the literature. There are different types or forms of assisted death and it is important to distinguish between them. It is also necessary to provide a definitional framework for these concepts before one can evaluate them on a moral and legal level.⁹ The following terms are relevant and will therefore be defined: euthanasia, voluntary euthanasia, non-voluntary euthanasia, involuntary euthanasia, assisted suicide/physician-assisted suicide, active euthanasia, passive euthanasia and, lastly, assisted death.

As there are clear sides to the debate, those in favour of legalisation and those against, various self-serving definitions have been advanced, but these definitions are used as a way of gaining an undeserved definitional edge. When defining the concept of euthanasia it is therefore imperative to avoid a definitional bias that could possibly give an unmerited advantage to either side.¹⁰ “Euthanasia” finds its origin in Greek and if broadly translated it can mean ‘happy death’ or ‘good death’ as it is derived from the words *eu* meaning good or well, and *thanatos* meaning death.¹¹ Euthanasia is commonly defined as the practice or action of one person deliberately/intentionally killing another, not because of threat or punishment for a committed crime, but rather to bring about a painless and gentle death. Euthanasia is most commonly associated with those that have a terminal illness where treatment will have no further effect or the patient has no hope of recovery. These patients are usually in great physical pain and endure suffering to such an extent that palliative care no longer suffices.¹² In this dissertation the practice of euthanasia will not be restricted to those suffering from a terminal illness. When one defines euthanasia too narrowly one risks disregarding some of the most important arguments in favour of legalising euthanasia; it also does not take into account the Netherlands, where euthanasia has been legalised, and where the practice of euthanasia has not been limited to only those who suffer from a terminal illness.¹³ The situations of patients with terminal illnesses as well as those not suffering from terminal illnesses will therefore be taken into account in order to ensure an encompassing and

⁹ Amarasekara K & Bagaric M *Euthanasia, morality and the law* (2002) 9.

¹⁰ Amarasekara & Bagaric *Morality* 10.

¹¹ Biggs *Death with dignity* 12.

¹² Biggs *Death with dignity* 12.

¹³ Amarasekara & Bagaric *Morality* 10.

comprehensive analysis of whether the legalisation of assisted death can be justified on the ground of human dignity.

Legalised euthanasia typically involves a doctor giving a patient a lethal injection in order to end the patient's life. In the instance that a close family member ends the life of that person so as to relieve suffering or pain, it is generally regarded as 'mercy killing' and not a form of euthanasia.¹⁴ The way in which legalised euthanasia is defined in terms of legislation will therefore determine which acts would be regarded as forms of legalised euthanasia and would be therefore be permissible.

Euthanasia is then classified as voluntary, non-voluntary or involuntary. Voluntary euthanasia is when the patient requests his death or gives consent to his death.¹⁵ On the opposite end is non-voluntary euthanasia, where no permission or request is given by the patient as the patient is unable to express an opinion due to lack of capacity. Another person, in most cases a relative or physician, believes that the patient would want their life to end and then ends the patient's life.¹⁶ Involuntary euthanasia takes place when the patient has not agreed to the procedure and is therefore not a willing participant.¹⁷ Involuntary euthanasia thus takes place against the patient's wishes and is occasionally based on the idea or belief that euthanasia would be economically efficient. This form of euthanasia is widely rejected and considered as murder, and it is most commonly associated with genocide in Germany by the Nazi regime.

Voluntary, non-voluntary and involuntary euthanasia can further be categorised to be either passive or active euthanasia. Passive euthanasia takes place by means of an omission, whereas active euthanasia occurs through a commission.¹⁸ Selective non-treatment, which includes circumstances where life-prolonging medicine is withheld or withdrawn, is understood to be passive euthanasia as death is brought about by the lack of a positive action.¹⁹ When dealing with passive euthanasia it is also important to note that some authors believe that a distinction should be drawn between 'killing' and 'letting die'. Passive euthanasia allows a patient who is mentally competent to refuse medical treatment, even when this refusal will most likely lead to the patient's death. This behaviour will be defined as a form of 'letting die'. Active euthanasia, where a deliberative act directly causes the death

¹⁴ Jackson E & Keown J *Debating euthanasia* (2012) 2.

¹⁵ Azize J "Human dignity and euthanasia law" (2007) 9 *University of Notre Dame Australia Law Review (UNDALR)* 47.

¹⁶ Azize (2007) *UNDALR* 47.

¹⁷ Biggs *Death with dignity* 12.

¹⁸ Azize (2007) *UNDALR* 47.

¹⁹ Biggs *Death with dignity* 12.

of the patient, is in contrast regarded as ‘killing’.²⁰ This distinction between active and passive euthanasia plays a central role in the debate regarding the legalisation of euthanasia, as it is here where the opposing sides have been the most vocal. This is of course understandable given the practical significance that accompanies the distinction. The significance of the distinction between active and passive euthanasia can be related to the acts and omissions of doctors as well as the difference between ordinary and extraordinary medical treatment.²¹

Assisted suicide deals with the situation where an ill person is assisted by another so as to take his own life.²² This is done by providing the means or information to carry out the action. Most commonly this will be by providing lethal drugs, but it can also be through providing a prescription for the drugs or indicating a lethal dosage.²³ In the instance where a doctor is the person to provide assistance one can refer to the occurrence as physician-assisted suicide. Physician-assisted suicide is the form of assisted suicide that is lobbied for legalisation.

From the definitions of euthanasia and assisted suicide one can see that there are similarities between the practices, but one must take note of the significant difference – those involved in the final act.²⁴ It is therefore very important to note that in the case of euthanasia the patient does not take his own life, but it is through the act of another that the patient’s death occurs. The person involved, most commonly a medical practitioner, will therefore be the one to administer the lethal drug. Contrary to this, assisted suicide takes place when the patient takes the final step to take his own life.²⁵ This is however only possible because of the help of another, who will in most cases provide the medicine to make the suicide possible. In cases of assisted suicide the patient is mentally competent so as to request the help of another.

When the term ‘assisted death’ is used throughout the dissertation, it will refer to all the different forms. When arguing or referring to the legalisation of assisted death, it will only be in relation to physician-assisted suicide and active voluntary euthanasia and not any other type. In most instances reference will explicitly be made to these two types of assisted death, but if not I refer only to them. When only referring to a specific form of assisted death it will therefore be clearly indicated.

²⁰ Slabbert & Van der Westhuizen (2007) *SAPR/PL* 366. See section 2.3 for further discussion.

²¹ Amarasekara & Bagaric *Morality* 11.

²² Amarasekara & Bagaric *Morality* 11.

²³ Amarasekara & Bagaric *Morality* 11.

²⁴ Amarasekara & Bagaric *Morality* 11.

²⁵ In favour of consistency this dissertation will only refer to the male counterpart, but includes both men and women. In other instances ‘they’ is used for the plural form.

This dissertation will primarily focus on the legality of voluntary active euthanasia and assisted suicide by examining if the right to human dignity serves a proper justification for the legalisation of assisted death. Passive euthanasia will only be discussed to the extent necessary to provide context for the legalisation of assisted death. Passive euthanasia will therefore not be discussed in any detail. As the dissertation will focus on the argument of securing death with dignity by the avoidance of futile suffering and the maintenance of personal control, only voluntary euthanasia will be discussed in detail.²⁶

2.2 Dead or alive

A determination on the relationship between the law of homicide and assisted death is very important in the manner that they relate to the concept of human dignity. Before one can analyse how these three concepts interact, it is first necessary to ascertain when life ends and death begins on a legal, moral and philosophical level.²⁷ Aided by advances in technology and science, medical professionals now have the ability to keep a body alive even after the brain has died and they can also revive a person who previously would have been regarded as dead. Consequently it is necessary to both clinically and legally define what should be understood when interpreting the concept 'dead'.²⁸

The definition of medically dead took a new turn after the first heart transplant surgery was performed by Doctor Barnard in South Africa in 1967. For a heart transplant to be successful the operation must be performed before the organ stops functioning so as to ensure that the organ is not damaged. However if death is defined in relation to circulation and respiration, then the removal of the heart would directly lead to the death of the patient and then be regarded as murder. One can clearly perceive that a definition of death is essential in order to offer patients the benefit of organ transplants and artificial ventilation, while at the same time protecting medical practitioners from criminal sanctions.²⁹

The position in South Africa can be found in different pieces of legislation as there is no general legal definition of what should be understood with the concept of 'death'. The *National Health Act*³⁰ serves as one example which defines 'death' as being brain dead. The general position in South African law is that death is established if the patient is brain dead. This is also the international position.

²⁶ Biggs *Death with dignity* 12.

²⁷ Biggs *Death with dignity* 16.

²⁸ Biggs *Death with dignity* 16.

²⁹ Biggs *Death with dignity* 17.

³⁰ 61 of 2003.

2.3 Killing versus letting die

Legally, the practice of treatment withdrawal is considered to be standard medical treatment, whilst assisted death could amount to murder. Everything therefore comes down to the distinction between killing and letting die, and the difference between omissions and positive acts.³¹ The moral distinction between killing and letting die relates directly to the difference between failing to help the patient and positively harming someone.³² Both these forms of conduct will lead to the death of patient, but does the difference between giving a lethal injection and the removal of a feeding tube justify the completely different responses and consequences that the law applies?³³ It is here where the distinction between active and passive euthanasia is so important, as it plays a central role in debates on the legalisation of assisted death.

Emily Jackson, Professor of Law and a leading author on the euthanasia debate, argues, in my view convincingly, in favour of legalising euthanasia and makes the contention that the differences between these two types of actions are not sufficient to bear the moral weight that the law ascribes to it.³⁴

³¹ Jackson & Keown *Debating euthanasia* 30.

³² Jackson & Keown *Debating euthanasia* 31.

³³ Jackson & Keown *Debating euthanasia* 30.

³⁴ Jackson & Keown *Debating euthanasia* 30.

3 The development of assisted death

Assisted suicide is not known in Roman Dutch law, but suicide is addressed by certain writers of the time. Grotius explained that those who had committed suicide were not buried immediately after death, but their corpses were disgraced to serve as a form of punishment. In later years Van der Linden commented that whilst suicide should still be considered an unlawful act, it should not be condemned publicly. He argued that persons who have committed suicide should rather be buried in silence and without ceremony.³⁵

Matthaeus in his study of suicide made a distinction between types of suicide based on the motive behind the action. Those that committed suicide because of guilt feelings or knowledge of their guilt (*conscientia criminis*) were punished more severely than those who had committed suicide for reasons relating to pain, sickness or grief (*sin doloris impatientia, aut morbi, luctusve*). Voet made the contention that Seneca and the Stoics were in favour of suicide, except where it was the consequence of criminal conscience. At that time Voet's contention was not accepted by the community and those that committed suicide could still be punished after death by confiscation of their property.³⁶ Even though the community did not approve, it still serves as an indication that the assisted suicide debate was relevant even at that stage. It is clear that throughout history this has been a contentious issue.

In ancient Greece, scholars like Socrates and Plato promoted euthanasia, whereas Hippocrates opposed the practice. In ancient Greece hemlock was used to hasten death in cases where the person suffered from a terminal and painful illness. This practice was apparently widespread and accepted, which contributed to the practice continuing through the 16th and 17th centuries. With the passing of time, opposition to the practice started to rise due to the influence of Christian thinkers, like Thomas Aquinas, and the professionalising of the medical fraternity.³⁷ The Hippocratic Oath is indicative of Hippocrates' opposition to the practice in the Ancient World. However, the Hippocratic Oath had no legal standing and was only supported by a small group of Greco-Roman physicians.³⁸

One can derive that even in the Ancient World the topic of assisted death was deemed contentious as different opinions and views were rife. During the 19th century the issue gained new support and advocacy for assisted death resurfaced in North America and Europe.

³⁵ Slabbert & Van der Westhuizen (2007) *SAPR/PL* 369.

³⁶ Slabbert & Van der Westhuizen (2007) *SAPR/PL* 370.

³⁷ Ncayiyana DJ "Euthanasia – no dignity in death in the absence of an ethos of respect for human life" (2012) 102 *South African Medical Journal (SAMJ)* 334.

³⁸ Egan A "Should the state support 'the right to die'?" (2008) 1 *South African Journal of Bioethics and Law (SAJBL)* 47.

One of the first attempts to legalise assisted death took place in a number of states in the United States of America in the early 1900s, these attempts were however unsuccessful. Voluntary euthanasia and assisted suicide societies advocating for reform nevertheless thrived in Europe and the United States of America.³⁹ Although the practice was not legal in the USA, Britain and the Netherlands, cases directly dealing with assisted death were treated with notable leniency.⁴⁰

With the passing of time developments have occurred, with some jurisdictions legalising or decriminalising the practices of physician-assisted suicide and/or active voluntary euthanasia. These developments are fully addressed in chapter four dealing with the position in different jurisdictions. With the advancements in medicine and science, societal views have also changed. The relationship between a paternalistic state that must protect its citizens and the demand of those citizens for greater autonomy has become increasingly important as we are more aware than ever before of our human rights. The need to create a balance between the state's duty to protect its citizens, while at the same time respecting their rights and autonomy has become more prominent.

It is thus clear that the assisted death debate is not a novel occurrence, but has developed and has continuously become more important since ancient times. As we rely on our human rights to claim more autonomy, the pressure is on the state to find a balance through appropriate legislation.

³⁹ Egan (2008) *SAJBL* 47.

⁴⁰ See chapter four for further discussion regarding the legal position in different jurisdictions.

4 A comparative analysis of assisted suicide laws

4.1 Justification for the comparative analysis

Not many jurisdictions have legalised euthanasia and/or physician-assisted suicide as many legal systems still regard it as murder or culpable homicide and therefore, as a criminal offence that is punishable by law.⁴¹ This chapter is devoted to those jurisdictions that have already taken steps to legalise or currently in the process of legalising assisted death. A comparative legal study of different jurisdictions is necessary in order to establish the methods of regulation that are applied to euthanasia and physician-assisted suicide. By comparing different jurisdictions one can also ascertain whether a specific type of assisted death is favoured, and if so for which reasons. The reasons and justifications given for legalising or decriminalising euthanasia and/or physician-assisted suicide in the jurisdictions to be discussed, will contribute greatly in answering the question whether legalising euthanasia and physician-assisted suicide is justifiable on the basis of human dignity.

The jurisdictions that will be focused on include the Northern Territory in Australia, the Netherlands, Belgium, Luxembourg, Switzerland and the United States of America. Recent developments will also be discussed by referring to the position in Canada and the United Kingdom. The position with regard to children will also be discussed in a separate section by referring specifically to the Netherlands and Belgium. The comparative nature of this chapter will also aid in establishing whether, if South Africa were to legalise a form of assisted death, both euthanasia and physician-assisted suicide should be considered or just one of the two.⁴²

4.2 The Northern Territory

The Northern Territory in Australia was the first jurisdiction in the world to sanction the practice of euthanasia. The *Rights of the Terminally Ill Act 1996* (NT) was the result of lobbying to end unbearable pain and to grant self-determination to patients suffering from incurable diseases and to request their medical practitioner to accelerate their death because of these circumstances. The *Rights of the Terminally Ill Act* required that the request made by the patient must be voluntary, the patient's condition must be hopeless, proper reflection must be made, and lastly that the death occur in the most humane manner. This Act legalised both

⁴¹ Egan (2008) *SAJBL* 47.

⁴² One should note that all the jurisdictions discussed in this chapter are developed countries. The position of South Africa as a developing country will be discussed by referring to the position in Colombia in chapter 7.

voluntary euthanasia by a medical practitioner as well as physician-assisted suicide for patients suffering from a terminal illness.⁴³ On July 1st 1996 the Act was proclaimed and it survived scrutiny in *Wake v Northern Territory Australia*.⁴⁴ Problems however arose as the Federal Government was heavily opposed to the Act. The opposition of the Federal Government led to the enactment of the *Euthanasia Laws Act 1997* which removed the power from the Northern Territory to pass legislation on this matter.⁴⁵ This was possible because the Northern Territory, the Australian Capital Territory as well as the Norfolk Island form part of Territory government and are therefore not completely independent in relation to government as the states of Australia are.⁴⁶ The Commonwealth legislation, the *Euthanasia Laws Act 1997*, consequently overturned the *Rights of the Terminally Ill Act*, but the *Euthanasia Laws Act* does not apply retrospectively.⁴⁷

These developments indicate that euthanasia has been highly contentious in Australia: while many members of the public were in favour of legalising euthanasia, the federal government was opposed to it. The passing of the *Euthanasia Laws Act* consequently criminalised euthanasia.⁴⁸

4.3 The Netherlands

This jurisdiction has a rich legal history regarding assisted death and has made the most advances in comparison to other jurisdictions.⁴⁹ With the enactment of the Dutch Penal Code in 1881 came the criminalisation of euthanasia as well as assisted suicide.⁵⁰ Even though these acts are explicitly prohibited in terms of the Dutch Penal Code, case law since 1973 has determined that acts of euthanasia and assisted suicide should receive a lesser punishment than prescribed in legislation.⁵¹ The *Postma*-case⁵² serves as the catalyst in the assisted death debate in the Netherlands. The accused in this case was a medical doctor who provided a deadly dose of morphine to her mother after she had made numerous requests to

⁴³ Amarasekara & Bagaric *Morality* 13.

⁴⁴ 1996 5 NTLR 170.

⁴⁵ Amarasekara & Bagaric *Morality* 13.

⁴⁶ <<http://australia.gov.au/about-australia/our-government/state-and-territory-government>> (accessed 2 August 2014).

⁴⁷ Amarasekara & Bagaric *Morality* 14.

⁴⁸ Amarasekara & Bagaric *Morality* 13.

⁴⁹ Amarasekara & Bagaric *Morality* 14.

⁵⁰ Article 293 and 294 of the Code.

⁵¹ Article 293 of the Dutch Penal Code sets a maximum of twelve years imprisonment or a fine as the appropriate sanction for killing a person at his express and serious request, i.e. euthanasia. For the crime of assisted suicide article 294 of the Penal Code prescribes a fine or up to three years imprisonment; Amarasekara & Bagaric *Morality* 14.

⁵² NJ 1973 183; *Nederlandse Jurisprudentie* 1973 no 183 District Court of Leeuwarden 21 February 21 1973.

end her life. Doctor Postma was found guilty of euthanasia by the Regional Court in Leeuwarden. The significance of the judgment can be found in the sentence imposed by the court. In this instance the court opted for a token sentence, which consisted of a suspended sentence of one-week imprisonment as well as one year probation. This was considered to be a just sentence, but also served to establish the view that euthanasia would be effectively sanctioned in those circumstances where the patient had voluntarily requested his death and had no other means of relief.⁵³

Just less than ten years after the *Postma* judgment the Dutch Supreme Court was faced with a case of similar facts - the *Alkmaar*-case.⁵⁴ In this instance the accused, doctor Schoonheim, euthanised his 85-year-old patient by way of lethal injection. The court went even further in this case by exonerating the accused instead of opting for a conviction accompanied by a light sentence. The court went on to find that euthanasia could be justifiable if the circumstances allowed it. The formal basis for excusing euthanasia and assisted suicide in these circumstances was the defence of necessity. The court stated that even though euthanasia and assisted suicide was ordinarily punishable, doctors were faced with conflicting duties in these circumstances – professional ethical obligations and the request of a patient to die with dignity. In these circumstances an investigation was necessary in order to ascertain whether the decision of the medical practitioner was responsible and in line with the criteria as set by medical ethics.⁵⁵

One should however not disregard the rationale followed by the courts in these instances. The court in its judgment focused on the conflicting duties of medical practitioners, instead of following the traditional arguments of liberty, autonomy and dignity.⁵⁶ This is very important as the emphasis is on the accused's rights rather than the rights of the patient who requested to die with dignity. This is also in direct contrast to other jurisdictions where the focus of the debate is on the constitutional rights of the patient, which include dignity, privacy and equality.⁵⁷

Following the decision by the Dutch Supreme Court, the Royal Dutch Medical Association set out further guidelines so as to clarify the circumstances in which euthanasia would be justifiable and therefore stipulated the conditions for a medical practitioner to have a defence. The guidelines were adopted by the Ministry of Justice and confirmed that medical

⁵³ Amarasekara & Bagaric *Morality* 14.

⁵⁴ *Nederlandse Jurisprudentie* 1985 no 106.

⁵⁵ Amarasekara & Bagaric *Morality* 15.

⁵⁶ Amarasekara & Bagaric *Morality* 15.

⁵⁷ Amarasekara & Bagaric *Morality* 15.

practitioners would not be prosecuted for euthanasia or assisted suicide if they followed the guidelines.⁵⁸ The guidelines focused on the nature of the request,⁵⁹ the condition of the patient,⁶⁰ steps to be taken by the medical practitioner,⁶¹ and the existence of alternatives.⁶²

Towards the end of 2000 the legality of euthanasia and assisted suicide became even more certain with the passing of the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001*. Even though euthanasia and assisted suicide were effectively approved and accepted before the enactment of the Act, more clarity is provided by the Act.⁶³ The Act consequently goes a step further by formally legalising euthanasia and physician-assisted suicide. The Act of 2001 thus amends the Penal Code so that when a medical practitioner carries out the termination of life on request or assists in the suicide of a patient, he will not be guilty of a criminal offence – but only if the criteria as set out in the Act are met. The two basic conditions that must be met by the medical practitioner are the due care requirement and the reporting requirement.⁶⁴

The changes brought about by the Act are realised through the incorporation of an exemption from the punishment as specified in the Penal Code.⁶⁵ If the requirements of the Act are not met, the exemption will not apply and the medical practitioner could still be punished in terms of the Penal Code. The requirements as set out in the Act⁶⁶ are very similar to those of the guidelines as discussed above.⁶⁷ The reason for not tightening or restricting the due care and reporting criteria, lies in the intention of the legislature as they felt that the only change necessary was to formulate the grounds more broadly.⁶⁸ The Act sets out that the medical practitioner must be satisfied that the patient's request is both voluntary and carefully considered. The medical practitioner must also be satisfied that the patient's suffering was unbearable as well as that there was no prospect of improvement of the patient's condition. The medical practitioner is also required to have informed the patient of his prospects and

⁵⁸ Amarasekara & Bagaric *Morality* 16.

⁵⁹ The request from the patient must be voluntary, competent and durable. It is also required that the request be based on full information.

⁶⁰ It is required that the patient be in a situation of intolerable and hopeless suffering; this can be either physical or mental.

⁶¹ It is necessary for the medical practitioner to consult another medical practitioner before euthanasia can be performed.

⁶² No other acceptable alternatives to euthanasia should exist.

⁶³ Amarasekara & Bagaric *Morality* 14.

⁶⁴ Amarasekara & Bagaric *Morality* 16.

⁶⁵ Article 20 of the Act explains this exemption from article 293 and 294 of the Penal Code.

⁶⁶ Article 2(1) the Act sets out the due care requirements that must be adhered to.

⁶⁷ Amarasekara & Bagaric *Morality* 16.

⁶⁸ Amarasekara & Bagaric *Morality* 17.

must then, together with the patient, reach the conclusion that no other alternative than that of euthanasia or assisted suicide is available to the patient. The medical practitioner is furthermore required to consult at least one other, independent medical practitioner that has seen the patient so as to give a written opinion on the previous mentioned due care criteria. Lastly the medical practitioner is under the obligation to end the patient's life or assist with the suicide with due medical attention and care.⁶⁹ It is also required that the medical practitioner who carries out the euthanasia or assistance for the suicide, must be the patient's own doctor. What this means is that the Dutch have excluded the opportunity for persons from other jurisdictions to travel to the Netherlands in order to access euthanasia and assisted suicide.⁷⁰

Five regional review committees still exist in terms of the Act, as they did in terms of the guidelines, but their role has changed to some degree. Under the previous guidelines, the medical practitioner was required to report the termination of a patient's life not only to a coroner, but also to one of these review committees. The committee consists of a minimum of one lawyer, one ethicist and one doctor – this composition is the same in the guidelines as well as in the Act.⁷¹ After the matter was reported to the committee, it was responsible for submitting a report to the Public Prosecutor Service in order to determine whether action should be taken against the medical practitioner. This has however been changed by the enactment of the Act. In circumstances where the committee is of the opinion that all due care criteria have been met by the medical practitioner, the case is over and it is therefore no longer necessary to inform the Public Prosecutor Service of all instances. The level of scrutiny of doctors is effectively watered down by this change. The Public Prosecutor is thus only informed in the instance where the committee is not convinced that all the criteria have been met by the medical practitioner. If the Public Prosecutor suspects a criminal act, it is within his power to then launch an investigation so as to ascertain whether criminal charges should be pressed.⁷²

Much progress has been made in the Netherlands since the Postma-judgment and many positive developments have been implemented in regulation of assisted death. The model followed by the Dutch is detailed and one can argue that the safeguards implemented such as the due care and reporting requirements together with the fact that euthanasia and

⁶⁹ Article 2 of the Act; Amarasekara & Bagaric *Morality* 16.

⁷⁰ Jackson & Keown *Debating euthanasia* 63; See section 4 7 on Switzerland where assisted suicide is possible for foreigners at certain clinics.

⁷¹ Article 3(2) of the Act sets out the composition of the committee.

⁷² Amarasekara & Bagaric *Morality* 17.

assisted suicide can only be accessed by residents, serve to prevent abuse of the system whilst at the same time ensuring the dignified death of those that request it. The position in the Netherlands indicates that the government took into account public opinion when the legal status of assisted death was considered.

4.4 Belgium

Following the example of the Dutch, Belgium was the next European jurisdiction to legalise euthanasia. In comparison to the Netherlands, Belgium did not have a gradual development of their law on assisted death. Nonetheless the *Euthanasia Act* of 2002 was passed by the Belgian parliament after the public indicated considerable support for the legalisation of euthanasia.⁷³ The *Euthanasia Act* shares many similarities with the Dutch legislation. For instance, it includes both the due care requirement and the reporting requirement. Euthanasia is however not restricted to terminally ill persons as the law provides that non-terminal patients in similar conditions to that of a terminal patient may request to be euthanised. In these circumstances a third physician, psychologist or specialist in the illness that the patient suffers from must be consulted.⁷⁴ The circumstances in which euthanasia could be allowed are thus wider in Belgium than in the Netherlands.

The Belgian legislation shares many similarities with the Dutch legislation as the Belgians based the formulation of the *Euthanasia Act* on the Dutch legislation. There is however a very important difference between the two pieces of legislation. The *Euthanasia Act* of Belgium only provides for euthanasia, whereas the Netherlands has legalised euthanasia as well as physician-assisted suicide.

4.5 Luxembourg

In order to pass legislation on euthanasia and physician-assisted suicide, Luxembourg's parliament first had to vote in favour of a constitutional amendment to curtail the powers of the monarch. This was necessary as Grand Duke Henri refused to sign the euthanasia bill into law. After the constitutional amendment it is no longer a requirement that the monarch sign legislation before passing into law.⁷⁵ After passing the legislation, Luxembourg became the third European country to legalise euthanasia and physician-assisted

⁷³ Jackson & Keown *Debating euthanasia* 67.

⁷⁴ Smets T & Bilsen J et al "Legal euthanasia in Belgium: characteristics of all reported cases" (2010) 48 *Medical Care* 187.

⁷⁵ The Guardian "Luxembourg strips monarch of legislative role" 12 December 2008 <<http://www.theguardian.com/world/2008/dec/12/luxembourg-monarchy>> (accessed 8 August 2014).

suicide in specific circumstances. The legislation was passed by the parliament and entered into force on the 1st of April 2009. The legislation requires the medical practitioner to consult a colleague in order to ensure that the patient suffers from a terminal illness, that the patient's condition is grave and incurable, and that the patient has repeatedly requested to die.⁷⁶

4 6 The United States of America

In the United States of America only a few states have gone so far as to legalise physician-assisted suicide, thus providing only for state law and not federal law. In the United States provision is only made for physician-assisted suicide and not euthanasia. These states are: Oregon, Washington, Vermont, New Mexico and Montana, but their method of legalising differs as some states have passed legislation on the matter and others have only dealt with the issue in their case law.⁷⁷ Physician-assisted suicide is however only an option to residents, so as to avoid becoming a destination for physician-assisted suicide tourism.⁷⁸ Patient autonomy and informed consent are two concepts that are firmly entrenched in American law and together with constitutionally protected rights, such as the right to privacy and the right to liberty, serve as the basis for the rights that patients insist on when receiving medical care.⁷⁹

The first American state to legalise physician-assisted suicide was the state of Oregon, situated in the Pacific Northwest of the United States. The Oregon Death with Dignity Act was the result of a citizens' initiative and was passed by Oregon voters in November 1994 for the first time. A legal injunction caused the delay of the implementation of the Act, but the Supreme Court of Appeals denied the petition and consequently also lifted the injunction on the 27th of November 1997. Following the decision made by the Supreme Court of Appeals, measure 51 was placed on the general election ballot requesting the voters of Oregon to repeal the Death with Dignity Act. This attempt was unsuccessful as voters rejected measure 51, thus retaining the Death with Dignity Act and thereby confirmed Oregon as the first and only state in the United States, at that time, to legalise physician-assisted suicide.⁸⁰

⁷⁶ Watson R "Luxembourg is to become third country to allow euthanasia" 24 March 2009 *British Medical Journal (BMJ)* <<http://www.bmj.com/content/338/bmj.b1248>> (accessed 4 August 2014).

⁷⁷ Oregon, Washington and Vermont has passed legislation to regulate to regulate the practice of physician-assisted suicide (See Oregon Death with Dignity Act, Washington Death with Dignity Act and also the Patient Choice and Control at End of Life Act for Vermont. New Mexico and Montana have sanctioned physician-assisted suicide in terms of their case law.

⁷⁸ Jackson & Keown *Debating euthanasia* 68.

⁷⁹ Slabbert & Van der Westhuizen (2007) *SAPR/PL* 374.

⁸⁰ Slabbert & Van der Westhuizen (2007) *SAPR/PL* 376.

The path after enactment of the Death with Dignity Act was however not that smooth, as many considered it to be controversial and consequently the Act came under attack. The United States Attorney General issued a new interpretation of the Controlled Substances Act in 2001 which resulted in the prohibition of doctors prescribing controlled substances in the practice of physician-assisted suicide. In response to the action taken by the Attorney General, the state of Oregon filed against the state and a district court answered by issuing a temporary restraining order against the ruling made by the Attorney General whilst a new hearing was pending. A United States District Court Judge ruled in favour of the state of Oregon and upheld the Death with Dignity Act. This decision was appealed against by the Attorney General, but a three-judge panel denied the appeal. The Attorney General was still not satisfied and filed an appeal that a judging panel of 11 judges was necessary to rehear his motion, this was consequently also denied by the court. The Attorney General then went even further by requesting the United States Supreme Court to review the decision. After hearing arguments in the case, the Supreme Court affirmed the decision of the lower court, thereby declaring the legality of the Death with Dignity Act. The result of this entire process is that the Death with Dignity Act still remains in force.⁸¹

The Oregon Death with Dignity Act therefore allows medical practitioners to prescribe a lethal dose of medication to a patient, if the criteria in the Death with Dignity Act are met. It is necessary for the patient to be in the final six months of his life due to terminal illness. Two oral requests as well as a written request that are separated by two weeks is necessary. Furthermore, two medical practitioners must confirm the patient's diagnosis before a prescription can be given.⁸² The patient that is requesting the prescription must be mentally competent and the drugs that are prescribed must be administered by the patient themselves. Lastly physician-assisted suicide is only available to residents of the state, which in terms of the Act can be determined by being in the possession of a valid driver's license.⁸³

Following the developments in Oregon, other states started to follow suit. The state of Washington passed its Death with Dignity Act in 2009, which is very similar to the Oregon legislation and Vermont passed its Patient Choice and Control at End of Life Act.⁸⁴ In the state of Montana the issue was dealt with in case law when the State District Court

⁸¹ Slabbert & Van der Westhuizen (2007) *SAPR/PL 376; Gonzales Attorney General et al v Oregon et al* 546 U S (2006) No 04-623.

⁸² Bhamjee S "Is the right to die constitutionally guaranteed? *Baxter v Montana* and other developments in patient autonomy and physician assisted suicide" (2010) *Obiter* 334.

⁸³ Bhamjee (2010) *Obiter* 336.

⁸⁴ Bhamjee (2010) *Obiter* 336.

confirmed the patient's right to physician-assisted suicide. This position differs from that of Oregon and Washington as the court based its decision on the constitution of Montana instead of specific legislation. The court based its judgment on the argument that the right to die with dignity without state intrusion was guaranteed by the Montana Constitution.⁸⁵ The Oregon Death with Dignity Act serves as a guideline to other states that want to take steps in legalising assisted death.

In the United States of America two approaches have been used to legalise physician-assisted suicide – through specific legislation or in terms of case law. Both of these approaches focus on the rights of the patients and his/her right to die with dignity. When examining the approaches followed by these states it can be argued that they are very similar, grounding the argument in the right to die with dignity, thereby focusing on autonomy and the prevention of state intrusion in the private life. Certain criteria must be met and the circumstances must allow for the physician-assisted suicide to be regarded as valid. These criteria serve as an important method of regulation and assure that the practice of physician-assisted suicide is not abused. One must also note that these specific states have only legalised physician-assisted suicide, and not euthanasia. This is because this model focuses on mental capacity and the fact that responsibility lies with the patient to take the final step in ending his own life. A prescription can therefore be given by a medical practitioner, but the patient still has a choice whether to administer the drugs or not.

4.7 Switzerland

Swiss law makes a clear distinction between euthanasia and assisted suicide in articles 114 and 155 of the Swiss Penal Code. The practice of euthanasia is not recognised by Swiss law, but article 114 of the Penal Code states that whilst murder upon request by the victim remains illegal, it is considered as less severe than those instances where death is not requested.⁸⁶ The Swiss have not taken explicit steps to legalise assisted suicide in terms of specific legislation, but rather opted to set out their legal stance in terms of their Penal Code. According to the Swiss Penal Code assisted suicide will only be considered a crime if the motive behind it is selfish.⁸⁷ It is thus held that the only requirement is the establishment of the intention of the person helping another to end his life, it is therefore necessary to find that the person acted out of selflessness. In comparison to other jurisdictions this requirement is

⁸⁵ Bhamjee (2010) *Obiter* 338.

⁸⁶ Slabbert & Van der Westhuizen (2007) *SAPR/PL* 379.

⁸⁷ Article 115 of the Swiss Penal Code.

fairly minimal and the law itself does not provide the same safeguards as other jurisdictions do, such as psychiatric assessment or due care requirements.⁸⁸

Even though the law does not make provision for these safeguards, Switzerland has right to die societies which do impose rigorous requirements.⁸⁹ The two most important right to die societies in Switzerland are Dignitas and EXIT. The safeguards and requirements imposed by these societies do however differ in some regards. EXIT insists that the patients must be older than 18 years, must be mentally competent and must be suffering from unbearable health problems. In contrast to the assistance provided by Dignitas, EXIT only offers help to Swiss nationals. Foreigners that wish to access assisted suicide in Switzerland are therefore limited to Dignitas clinics.⁹⁰

What is noteworthy about the Swiss model on assisted suicide is that it provides foreigners with the opportunity to travel to Switzerland and then to access assisted suicide through an established Dignitas clinic. This process is quite expensive, but research has indicated that many foreigners, especially Europeans, have made use of this relatively simple way around their own country's law. There have been attempts to exclude foreigners from joining right to die societies, however these attempts were all unsuccessful. A 2011 referendum indicated that there remains a substantial majority supporting the position that foreigners be allowed to access assisted death.⁹¹

A further fact that makes the Swiss model distinctive is that non-physicians may take part in assisting a patient with his suicide. In most jurisdictions the assistance is restricted to medical practitioners. This distinctive element of the Swiss model is possible because the law explicitly distinguishes between the issue of whether certain circumstances allow assisting in suicides and whether or not physicians/medical practitioners should partake.⁹²

When examining the Swiss model it becomes clear that the model is much more lenient than models implemented in other jurisdictions. The patient requesting assistance in his suicide does not have to be terminal and the assistance can be given by a medical practitioner as well as non-physicians. There is also no legislation that specifically regulates the practice of assisted death. Of all the models the Swiss one is the least rigid.⁹³ Once again provision is only made for recognising assisted suicide and not euthanasia. This model is also

⁸⁸ Jackson & Keown *Debating euthanasia* 34.

⁸⁹ Jackson & Keown *Debating euthanasia* 34.

⁹⁰ Jackson & Keown *Debating euthanasia* 64.

⁹¹ Jackson & Keown *Debating euthanasia* 34.

⁹² Slabbert & Van der Westhuizen (2007) *SAPR/PL* 379.

⁹³ Slabbert & Van der Westhuizen (2007) *SAPR/PL* 383.

different from others as the law does not stipulate specific criteria, but it is the clinics that have their own set of rules that must be adhered to before steps will be taken. One could argue whether the law should also provide guidelines, but this will depend on whether the practice is abused or not.

4 8 Recent developments in assisted death

With the passing of time more developments are being made in terms of assisted death, specifically in relation to children. The majority of jurisdictions that have legalised euthanasia, physician-assisted suicide or assisted suicide have made the practice only applicable and available to those that have attained majority age – thus not available to children. Those under the age of 18 can therefore not make use of the practice, even if it is legal in their home country. Two countries have however recognised that children should also be afforded the right to die with dignity, namely the Netherlands and Belgium. In the Netherlands euthanasia and physician-assisted suicide is legal for children over the age of 12 years and if parental consent is given.⁹⁴ The law in Belgium differs from that in the Netherlands as of February 2014, when the 2002 law was amended to extend the right to die with dignity to children – with no age restriction. A child of any age suffering from an unbearable and irreversible pain has the right to die with dignity. The amendment imposes strict requirements: the child must be terminally ill, mentally capable of making and understanding the nature of the request and fully understand the choice they are making. Before approval for the assisted death is given a team of doctors, psychologists and caregivers will assess the request and come to a final decision.⁹⁵ As expected this has garnered both support and opposition, but the law still provides children access to assisted death.

A major consequence of the legalisation of euthanasia and/or assisted suicide in the jurisdictions referred to above has been that those in other jurisdictions are starting to challenge their legal system and claiming their right to die with dignity as well. The British House of Lords is currently debating on the issue as Lorde Falconer has introduced proposed legislation for assisted death based on the model employed in Oregon.⁹⁶ The issue regarding

⁹⁴ Crawford D “Belgium’s parliament votes through child euthanasia” 13 February 2014 <www.bbc.com/news/world-europe-26181615> (accessed 6 August 2014).

⁹⁵ McDonald-Gibson C “Belgium extends euthanasia law to kids” 13 February 2014 Time Magazine <time.com/7565/Belgium-euthanasia-law-children-assisted-suicide/> (accessed 4 August 2014).

⁹⁶ Mason R “House of Lords debate evenly split over assisted dying legislation” 18 July 2014 the Guardian <<http://www.theguardian.com/society/2014/jul/18/assisted-dying-legislation-debate-house-lords>> (accessed 4 August 2014).

assisted death remains relevant and contentious and it will be very interesting to see what happens in the future in other jurisdictions.

As with any aspect of the law, it can be seen that the law changes and develops in order to take changing societal norms and views into account. This same is also true in regard to assisted death. Societal views have changed with regard to death and the rights to dignity and autonomy underlie this change.

4 9 Conclusion

When comparing the legal position in these jurisdictions, it is important to take note of the fact that the models employed are the product of the social and cultural context of those specific jurisdictions. Differences in the method and regulation preferred are thus not only apparent, but in many instances also necessary. One can therefore not just export an existing model from one jurisdiction and transplant it in another and expect it to be successful.⁹⁷ I therefore argue that physician-assisted suicide and euthanasia legislation should be sensitive to the jurisdiction's specific context.⁹⁸

The point of departure for the legalisation of euthanasia and assisted suicide and the manner of its development in these jurisdictions is also noteworthy. In jurisdictions such as the Netherlands and Switzerland, change occurred through a gradual development of the law by changes in the Criminal Code, positive approaches followed in case law and then only later enacting legislation. A possible advantage of this method is that support could be more easily garnered if the changes are incremental rather than sudden. At the same time the argument can be made that incremental change does not provide the public with the same opportunity to express their views and to openly scrutinise the proposed legislation or stance to be followed by the legal system.⁹⁹

From the examination of the jurisdictions discussed above it appears as if physician-assisted death is accepted more easily than euthanasia. In most instances there are criteria that must be met for the assisted suicide or euthanasia to be considered legal. The argument of whether these criteria truly fulfill their purpose can be swayed to both sides. Some argue that the criteria serve as appropriate safeguards against abuse, whereas others feel that the criteria are mere guidelines and therefore not true safeguards in ensuring the protection of the vulnerable. This will be addressed when an evaluation of assisted death on the basis of human

⁹⁷ Jackson & Keown *Debating euthanasia* 65.

⁹⁸ This matter will be discussed further in chapter eight which focuses on the South African context and the comparison of the position in developed countries to that of developing countries.

⁹⁹ Jackson & Keown *Debating euthanasia* 65.

dignity is made in chapter seven. The success and/or abuse of assisted death in these jurisdictions have also been met with different opinions, but a thorough examination of this specific aspect of assisted death will not be pursued further as the main objective of the dissertation is to ascertain whether assisted death is justifiable on the basis of the right to human dignity.

What has been made abundantly clear is that the topic of ‘death’ is no longer regarded as unmentionable and that patients are increasingly relying on their human rights to ensure that they will indeed die with dignity. Many different methods have been adopted in different jurisdictions, but the central argument remains the same throughout – the dignity and autonomy of the patient must be respected. It is on this foundational basis that jurisdictions have passed legislation and allowed patients to end their life. Whether assisted death is in fact justifiable on the basis of human dignity will be discussed further in chapter six, when the right and value of human dignity will be examined.

5 Arguments in favour of and against the legalisation of assisted death as well as opposing arguments

5.1 Introduction

The debate on legalising assisted death tends to become quite heated, as both proponents and opponents of legalisation argue very strongly for their case. For every argument that can be made in favour of legalisation, there is a counter-argument. This chapter examines the arguments and counter-arguments that are most commonly relied on in the assisted death debate, with a particular focus on active voluntary euthanasia and assisted suicide.

5.2 The principle of autonomy in relation to human dignity

One of the main arguments in support of the legalisation of assisted death is founded on the principles of autonomy and self-determination. These two concepts are inextricably linked to the value and right of human dignity and it is these two elements of human dignity that form the foundation of arguments in favour of legalising assisted death. The interpretation of human dignity and the way that it can be defined plays a central role as the concept of human dignity can be described as having a nebulous nature. The argument is made that according to these principles each person has inherent value, is a bearer of rights and freedoms, and therefore the determinant of his/her destiny. It is this self-determination and the capacity to make choices that are essential components of human dignity and rational personhood that the argument of autonomy is founded on.¹⁰⁰ The argument of autonomy stems from the idea that patients as human beings have certain rights to decide for themselves what is good for them – meaning the treatment that they wish to receive or not, to have some control over their bodies and decisions relating to their bodies, health and wellbeing.¹⁰¹

Proponents of assisted death argue that if a legal system prohibits active voluntary euthanasia and assisted suicide, it unjustifiably infringes on the liberty of those making an informed decision to have their lives ended in terms of active voluntary euthanasia or assisted suicide. The life and choices of the individual is highlighted by this argument.

When dealing with the moral permissibility of assisted death the argument of autonomy requires that we not only respect the individual, but also his or her autonomous

¹⁰⁰ Otlowski *Voluntary euthanasia* 189.

¹⁰¹ Egan (2008) *SAJBL* 48.

choices – as long as these choices do not cause harm to others.¹⁰² Autonomy is further linked to self-determination as the argument is made that the choice to end one's life is a private matter and that autonomous choices that do not impact others negatively must be respected. I would argue that this is a private matter and that a choice that an individual makes must be respected – those that are in favour of legalising assisted death must be respected, and those that are not should also be respected; the most important aspect of this argument is that the choice must be given to the patient.

From the outset it must however be made very clear that not all individuals that suffer from a debilitating disease are in favour of assisted death. Not all patients experience their suffering as undignified and not all feel a complete loss of control – every situation is unique and should be treated as such. There are some patients that are severely incapacitated and fully dependent on others, but still gain meaning and value from their lives. It must be acknowledged that there are individuals that are extremely ill and dependent, but would not choose assisted death under any circumstances. These individuals must be treated with the utmost respect and their choices must be valued. Circumstances differ from individual to individual and people have different views and opinions and that should be respected.¹⁰³ The diversity of opinions is indicative of the fact that choice and autonomy remains central to assisted death.¹⁰⁴

Of course there are those that object to the argument of autonomy and self-determination as justification for assisted death, as they believe that by respecting individual autonomy in relation to assisted death we then raise this right above that of the value of sanctity of life.¹⁰⁵

It becomes quite clear that dignity and autonomy are central concepts when examining the justifiability of assisted death. The relationship between dignity and death will be examined further in chapter six by scrutinising the different interpretations of human dignity, the manner in which it relates to assisted death and whether it serves as justification for the legalisation of assisted death. Chapter six will explore the different elements of human dignity, specifically autonomy and self-determination, and the role that these elements play in the assisted death debate.

¹⁰² Young R *Medically assisted death* (2007) 22.

¹⁰³ Jackson & Keown *Debating euthanasia* 39.

¹⁰⁴ Jackson & Keown *Debating euthanasia* 40.

¹⁰⁵ Young *Medically assisted death* 22. The sanctity of life argument is further examined in section 5.6.

5.3 Compassion and the prevention of suffering

The need to alleviate pain and suffering is a common argument that is raised in favour of the legalisation of assisted death and it is in relation to this argument that some have referred to the notion of ‘mercy killing’. Compassion for the suffering of these patients is a key moral argument for the legalisation of assisted death. This argument relies on the relieving of pain and suffering and views assisted death as a compassionate act where the patient, due to his circumstances of pain and suffering, no longer wants to live. This argument places more emphasis on the role of the carer or medical practitioner than on the patient and is thus in most instances relied on by those that are in favour of assisted death as a last resort.¹⁰⁶

This argument is however rejected by many – specifically the hospice movement and proponents of palliative care. The counter argument consequently supports the use of palliative care and believes that modern medicine and drugs can provide relief from all possible pain and distress that a patient could possibly suffer. In order to sedate patients so that they no longer feel the pain they are in, they are in many instances no longer aware and alert. Supporters of voluntary active assisted death have defined this state as ‘terminal sedation’ and regard this state as indistinguishable from death as the patient is so severely sedated.¹⁰⁷ Proponents of assisted death thus feel that palliative care does not always result in a dignified death as the patient is so severely sedated that the circumstances are closer to death than life.

Proponents of assisted death maintain that this argument of compassion must not be examined or employed in isolation, but rather in conjunction and in the light of autonomy. It is necessary to view compassion together with autonomy as the argument of compassion as justification is applicable to all patients – meaning those that are competent and have requested a medically assisted death as well as those that are not and have not. The element of autonomy is therefore also necessary in addition to compassion and the prevention of suffering.¹⁰⁸ Once again the focus must be on the patient and the autonomous choices of the patient. Compassion and the relieving of pain and suffering is therefore a very important factor that must be taken into account in the assisted death debate, but it is even more important that we do not rely on compassion and relieving pain as justifications on their own – but rather together with the patient’s right to autonomous choices.

¹⁰⁶ Young *Medically assisted death* 23.

¹⁰⁷ Young *Medically assisted death* 24.

¹⁰⁸ Young *Medically assisted death* 24.

5.4 The role of medical practitioners

When dealing with assisted death the most important role player, other than the patient, is the medical practitioner. In the instance of physician assisted suicide, it is the medical practitioner that must assess the circumstances of the patient and make the decision whether the patient meets the necessary requirements to receive a lethal prescription. If the requirements are met, the medical practitioner can then give the patient a prescription for a lethal dose of medication (usually barbiturates) so that the patient can administer the drugs himself. In this instance the medical practitioner is somewhat removed or distanced from the patient and the administering of the lethal drugs. Those that oppose the legalisation of physician assisted suicide argue that there are severe risks that are involved when the medical practitioner is distanced from the proximate cause of the patient's death.¹⁰⁹ The lack of supervision of the patient in the self-administering of the drugs as well as the precise use of the drugs has been a concern for many.¹¹⁰

The risks of drug abuse and the use of the prescribed drugs to kill another are also concerns that have been raised by opponents of assisted death. This argument is also related to the fact that the medical practitioner is distanced from the proximate cause of the patient's death. The focus of this critique is that patients are given a prescription or the drugs to end their lives, but without proper supervision. The fear is that the drugs will not be used to end the patient's life, but the life of another innocent party.¹¹¹

This argument played a significant role in Switzerland when the proposal of establishing a suicide clinic was debated. The proposed clinic would give patients the opportunity to make an appointment at the clinic and receive the lethal drugs after the necessary requirements/criteria have been met. The patient can then self-administer the drugs away from the clinic in the environment of his choosing. The total lack of supervision that accompanied the self-administering of the drugs in the private arena was met with considerable opposition. Those criticising the method argued that the risk that the drugs could be used for another purpose than that of facilitating the patient's death was too high. The risk of misuse by others, the possibility of accidental misuse, or even the possibility that the drugs could be used by another to commit suicide, were deemed to be too serious to disregard.¹¹²

If the private sector then opposes this distance between the patient and the medical practitioner in the administering of the drugs, what can be done? One could argue, why not

¹⁰⁹ Young *Medically assisted death* 45.

¹¹⁰ Young *Medically assisted death* 45.

¹¹¹ Young *Medically assisted death* 45.

¹¹² Young *Medically Assisted death* 45.

simply require that the lethal drugs must be self-administered in the presence of the medical practitioner? As obvious as this argument may seem, it is not as simple. Medical practitioners are not always available and it will therefore not be possible for them to supervise the self-administering at all times. Patients stockpiling drugs at the cost of great suffering, is also a possibility that must be taken into account. If patients are not subject to around-the-clock watch, regulating the administering of drugs becomes more difficult. One could therefore make the argument that if a patient is sufficiently determined to stockpile the drugs, it could definitely be possible.¹¹³

This situation can easily be compared to that of other potentially lethal items that may be used in the private sphere, such as firearms or poisons. Risks will always be present when dealing with potentially harmful objects and materials –it is not possible to eliminate all risks entirely. Efforts can however be made to minimise these risks and it is therefore incumbent that medical practitioners educate and warn their patients of the risks involved in drug misuse when they prescribe drugs.¹¹⁴ One must also acknowledge that in most jurisdictions where assisted suicide has been legalised, the regulations and processes that one must go through before a prescription of drugs is given to the patient are quite strict and rigorous. A patient will not simply be able to receive a prescription after one appointment with one medical practitioner. The process is long, time consuming and regulated strictly to prevent abuse of the system. I would argue that it would be unlikely that an individual would go through all the trouble of seeing different medical practitioners to be analysed and assessed, only to then sell the drugs after a prescription has been given. If the necessary safeguards are implemented in the screening process these risks can definitely be minimised. The medical practitioner must therefore educate and inform the patient of the dosage and nature of the drugs, explain what the patient must do if things do not go according to plan, and be available if the patient so wishes.

The argument of autonomy once again becomes relevant as some patients do not want their physicians present and also wish to take the drugs in the privacy of their own homes. Privacy and autonomy in the context of human dignity once again becomes very important. If the autonomy of these patients is to be respected, then some of these reservations should be set aside in order to respect the patient's rights.¹¹⁵ Opponents of assisted death have argued that it would be unjust to expect all medical practitioners to partake in assisting their patients

¹¹³ Young *Medically assisted death* 46.

¹¹⁴ Young *Medically assisted death* 46.

¹¹⁵ Young *Medically assisted death* 47.

to die. I would suggest that in order to move beyond this problem, only doctors that are willing to partake should do so and those that are opposed to assisted death should not be forced.

5.5 Persons with disabilities

The position of persons with disabilities is employed as arguments in favour of legalisation of assisted death, as well in opposition to. The Canadian case of *Rodriquez v British Columbia (Attorney General)*¹¹⁶ serves as a striking example of the use of the disabilities of a person to argue for the legalisation of assisted death. In this instance Sue Rodriquez suffered from motor neurone disease and argued that the prohibition on physician-assisted suicide deprived her of her liberty rights, and discriminated against her based on her disabilities.¹¹⁷ She argued that those that are unable to perform suicide without the help of assistance are discriminated against if physician assisted suicide was prohibited as she was unable to perform suicide on her own. Rodriquez was joined by the Coalition of Provincial Organizations of the Handicapped (COPOH), which is the largest disability advocacy group in Canada.¹¹⁸ Motor neurone disease results in patients being unable to swallow, speak or move without assistance. Ultimately patients lose the ability to breathe and eat on their own, thus needing a respirator and gastronomy in order to live. Rodriquez argued that section 241(b) of the Canadian Criminal Code of 1985, which prohibits the giving of assistance to another in order to commit suicide, violated her right to liberty and security of the person as guaranteed by section 7 of the Canadian Charter. Her case was dismissed by the Supreme Court of Canada, with the majority finding that the values of liberty and security of the person could not be divorced from the value of the sanctity of life that is also protected in section seven.¹¹⁹ Five of the nine judges rejected her appeal, but four judges upheld her claim. Public sympathy and support for Rodriquez was overwhelming and played a substantial role in the developments and review of the Canadian law on physician assisted suicide.¹²⁰

Discrimination against disable persons has also been used as an argument against the legalisation of assisted death. It is argued that it could lead to pressuring those that are disabled to use methods of assisted death, as legalisation would make them more vulnerable and would make them feel burdensome. The suggestion has been made that it would be very

¹¹⁶ 1993 3 SCR 519.

¹¹⁷ *Otlowski Voluntary euthanasia* 86-94; *Young Medically assisted death* 50.

¹¹⁸ *Young Medically assisted death* 50.

¹¹⁹ *Otlowski Voluntary euthanasia* 87.

¹²⁰ *Otlowski Voluntary euthanasia* 92.

difficult to protect the vulnerable among the disabled, whilst at the same time respecting competent disabled persons making the decision to use assisted suicide. I argue that this notion should be rejected. Respecting the autonomy of all individuals becomes important once again, as we see that not all persons with disabilities share the same views – some are in favour of assisted death while others are not.

5.6 Sanctity and value of life

The intrinsic value of every life is the fundamental basis of this argument and there are two possible strands to this argument. The first strand relates to religious opposition and the second is based on the idea that some lives are not worth living. Religious opposition to assisted death is based on the belief that we are not in control of our own life and therefore not in the position to end our life when we deem it fit. The argument is therefore made that assisted death usurps God's power and does not respect the gift of life that is given by God to every individual. Religious freedom must be respected, but at the same time it must be acknowledged that we live in a secular society and public policy is therefore immensely important.¹²¹

The belief that God alone has the power to take an individual's life is of utmost importance to some and could consequently determine their stance on assisted death. Not all people however share this belief and one can therefore not justify restricting the choices and autonomy of those that do not share in these religious views.¹²²

The argument has also been made that modern medicine has, to a great extent, influenced God's monopoly on determining death. The life and death of patients is determined by the medical profession through means of life-sustaining treatment or administering a life-threatening dose of pain medication. It should be acknowledged that the medical treatment is in the most instances intended to prolong life and thus delaying the natural progression of a disease. In most cases the patient's death would have come about much sooner if there were no medical assistance and/or artificial assistance. The argument thus relies on the fact that medical assistance already plays such a central role in the determination of life and death.¹²³

The second strand of the sanctity of life argument relates to the value of human life and that if assisted death is legalised it diminishes the worth of an individual's life and thus

¹²¹ Jackson & Keown *Debating euthanasia* 37.

¹²² Jackson & Keown *Debating euthanasia* 37.

¹²³ Jackson & Keown *Debating euthanasia* 38.

classifies their life as not worthy of living.¹²⁴ The argument is therefore made that the prohibition on assisted death ensures that everyone, irrespective of their mental state or physical suffering, is treated equally and assures that all lives are equally valuable. The counter argument in this instance is that there is a clear difference between saying that an individual's life no longer has worth and accepting that the individual's life no longer benefits him.¹²⁵ Proponents of assisted death do not argue that some lives are not of equal worth compared to others – the focus of their arguments relies on the choice and autonomy of the suffering patient. In those instances where family members or loved ones have accompanied or assisted the patient to end his life – either by taking the person to the medical practitioner or clinic, or even carrying out the euthanasia – it was not because they felt that the patient's life was worthless. These acts of help and support are rather motivated by love and compassion.¹²⁶

5.7 Slippery slope arguments

The slippery slope argument is used in many different situations and is also relied on by opponents of assisted death. The slippery slope argument is commonly relied on by opponents of legalisation as they claim that even if we start with the best of intentions and restrict assisted death to a very specific group of individuals and regulate the process and practice very strictly, we would still end up sliding down the slope and broaden the categories of persons that qualify for assisted death, which would in the end lead to unethical practices. Opponents of legalisation of assisted death generally point out three types of 'slopes': the logical slippery slope, the empirical slippery slope, and the psychological slippery slope.¹²⁷

The logical slippery slope argument is the most common and claims that if we were to allow assisted death in one type of circumstance, it will lead to allowing it in another set of circumstances. Once assisted death is allowed, the categories and guidelines will evidently be broadened as time passes.¹²⁸ The empirical slippery slope involves the likelihood of what would happen once we take the first steps down the slope. The most common version of this argument relates to the claim that once we legalise active voluntary euthanasia, it will lead to involuntary euthanasia becoming more common. Once voluntary euthanasia is legalised, it

¹²⁴ Jackson & Keown *Debating euthanasia* 38.

¹²⁵ Jackson & Keown *Debating euthanasia* 39.

¹²⁶ Jackson & Keown *Debating euthanasia* 39.

¹²⁷ Jackson & Keown *Debating euthanasia* 53.

¹²⁸ Jackson & Keown *Debating euthanasia* 41.

will directly lead to involuntary euthanasia being practiced.¹²⁹ The psychological slippery slope argument claims that once we legalise assisted death and become accustomed and familiar to the idea of assisted death, it will be less alarming when we take a step down the slope.¹³⁰

Those that use the slippery slope argument believe that legalising assisted death will lead to doctors being able to do as they please and then make their own decisions without the consent of the patient – whether it is because of laziness, indifference to patients or pressures of medical expenditures.¹³¹

All three varieties of the slippery slope argument thus entail that we will be unable to draw a line between circumstances where assisted death would be permissible and other situations where it would not. Surely this argument does not have merit as it basically entails that once assisted death is allowed in very strict circumstances it will eventually end in any person asking for assisted death and being afforded the right. In a modern legal society such as ours I simply cannot accept this argument as it is not well formulated or even in fact logical. It places no faith in humanity and ignores the reasons why so many are fighting for the legalisation of assisted death.¹³²

5 8 Conclusion

The reason that the assisted death debate is so contentious is directly related to the above discussed argument. There will always be two sides to every argument, and this is also evident when one examines the arguments raised in favour and against assisted death. The weight accorded to these arguments are in most instances sensitive to context, thus meaning that the specific jurisdiction and its conditions will determine the way that they are interpreted by the law and the public.

¹²⁹ Jackson & Keown *Debating euthanasia* 59.

¹³⁰ Jackson & Keown *Debating euthanasia* 60.

¹³¹ Egan (2008) *SAJBL* 49.

¹³² Jackson & Keown *Debating euthanasia* 53.

6 The relationship between human dignity and assisted death

6.1 Defining dignity

The medical profession's ability to preserve life regardless of trauma and terminal disease has led to more individuals demanding the right to die with dignity, rather than enduring the indignity that is said to accompany a dependent existence. It is, accordingly, often argued that assisted death is a means of upholding individual autonomy and of assuring dignity in death. The relationship between assisted death and human dignity, as both a right and value, thus plays a central role in the assisted death debate. Human dignity is nevertheless a nebulous concept that is amenable to a range of interpretations. This complicates the role of human dignity in the assisted death debate.¹³³ Whether dignity can be promoted through assisted death will depend not only on the individual circumstances of each case and the form of assisted death that is relevant, but also on the definition given to human dignity.¹³⁴ It is therefore necessary to determine what exactly the concepts of 'dignity' and 'human dignity' entail, before examining the relationship between human dignity and assisted death.

The word 'dignity' as we know it today finds its etymological origin from the Latin "*dignitas*" with the roots of "*dec*" and "*nus*", which is translated into the 'quality of worthiness' or the quality of having value.¹³⁵ To have dignity thus means that one has worth or value. The most important definition given to human dignity by the Romans can be found in Cicero's *De Officiis*. Cicero used the concept to distinguish between humans and animals by indicating the superiority of humans. In this sense dignity means more than mere worth, it is used to indicate humanity and intelligence. The concept also had a political meaning and was closely related to the reputation of the individual. The dignity of the person was to be respected and not every person possessed the same degree of dignity. Dignity was variable in degrees depending on the reputation of the individual and his social and political position.¹³⁶ In the Roman Republic those who possessed the highest degree of *dignitas* were generally in a position of power as the highest levels of authority were entrusted to them.¹³⁷ Dignity also had an aesthetic meaning in the ancient times as it was linked to male beauty; this is in

¹³³ Azize (2007) *UNDALR* 47.

¹³⁴ Biggs *Death with dignity* 11.

¹³⁵ Azize (2007) *UNDALR* 54.

¹³⁶ Azize (2007) *UNDALR* 55.

¹³⁷ Azize (2007) *UNDALR* 55.

contrast to ‘*venestas*’, which was used to indicate female beauty. Once again dignity was used as a method of differentiation.¹³⁸

In the Roman Republic the concept of dignity had various undertones and thus also several meanings and interpretations. These various interpretations are still present today, as is evident by looking up the meaning of ‘dignity’ in any modern dictionary. The Oxford English Dictionary for example lists at least five possible interpretations that can be applied accordingly.¹³⁹ The first possibility relates to the quality or state of being worthy of honour or respect. A second interpretation of dignity is used to indicate an honourable or high estate, position or honour. A third definition employs dignity to refer to an honourable office, rank, or title – for example a dignitary. The fourth definition refers to a composed or serious manner or style, for example he bowed with great dignity. Lastly dignity is used to indicate a sense of pride in oneself, thus meaning self-respect or self-worth.¹⁴⁰ It is consequently clear that ‘dignity’ can be open to interpretation as the applicable definition will be determined by the context in which it is applied.

6 2 Defining human dignity

The notion of human dignity as it was used in the Roman Republic and the ancient world endured and was developed and employed by early Christianity. During the 13th century in Europe, Christian theologians claimed that humans possess a moral nature that must be respected unconditionally. These theologians made the submission that humans have a unique quality that gives them incomparable value. The implication of this value is that human dignity is intrinsically bound to all human beings and not derived from an external source or factor. Human dignity is therefore intrinsically linked to that which makes us human.¹⁴¹

These notions regarding human dignity endured and were echoed by Immanuel Kant and Ronald Dworkin. For the classical Kantian school of thought, respecting the autonomy of all rational beings demonstrates the inherent value of every individual and the esteem and inherent dignity of which each human is worthy.¹⁴² Human rationality and autonomy are the two central concepts related to Kant’s interpretation of human dignity. To Kant the killing of another, even with the latter’s consent, would be the antithesis of respecting that individual’s

¹³⁸ Azize (2007) *UNDALR* 55.

¹³⁹ *The Oxford English Dictionary* 2 Volume VI (1989) 656; Azize (2007) *UNDALR* 55.

¹⁴⁰ *The Oxford English Dictionary* 2 ed Volume VI (1989) 657.

¹⁴¹ Azize (2007) *UNDALR* 58.

¹⁴² Biggs *Death with dignity* 9.

human dignity. Kant believed suicide to be contrary to respecting human dignity as it meant treating oneself as a means to an end.¹⁴³ For Kant, a moral law exists which serves as the guiding force for human will – it reveals what matters most and how to act accordingly.¹⁴⁴ The free will that each human possesses and the autonomy that accompanies our free will, must nonetheless still adhere to the moral law. Our free will is thus restricted by the moral law, meaning that we cannot always do as we wish.¹⁴⁵ In terms of the moral law, Kant argues that no one is at another's arbitrary disposal – not even at his own disposal. This argument is founded on the belief that these actions contradict the notion that human beings are ends in themselves.¹⁴⁶ This means that even though classical Kantian thought is grounded on autonomy, it does not mean that our autonomy is absolute. Autonomy can consequently only function properly in accordance with the moral law.

Ronald Dworkin argues that the recognition of universal human dignity is the most important feature of Western political culture, as it gives every individual the moral right to examine and challenge the meaning and value of his/her own life.¹⁴⁷ Dworkin argues that respect for human dignity requires respecting the ability of the individual to make autonomous moral decisions. In contrast to Kant, he believes that this freedom extends to choices relating to life and death. Since freedom is essential to self-respect, assisted death should be permissible on request.¹⁴⁸

The clear difference between the views of Kant and Dworkin is a strong indication of the contested nature of human dignity. Both view autonomy and self-determination as central to human dignity, but they reach opposite conclusions.

Human dignity encompasses self-determination and the ability to make autonomous choices. It also implies a quality of life that is in line with this autonomy.¹⁴⁹ In this specific context, the close association between assisted death and death with dignity reflects the contemporary emphasis on self-determination as a way of expressing individual autonomy.¹⁵⁰ Autonomy and self-determination as two important elements of human dignity therefore form an important part of the assisted death debate. The way that human dignity fits into the assisted death debate will be discussed, first, with reference to the centrality of human dignity

¹⁴³ Amarasekara & Bagaric *Morality* 103.

¹⁴⁴ Uleman JK *An introduction to Kant's moral philosophy* (2010) 1.

¹⁴⁵ Uleman *Kant's moral philosophy* 2.

¹⁴⁶ Timmerman J *Kant's groundwork of the metaphysics of morals: a commentary* (2007) 99.

¹⁴⁷ Dworkin R *Life's dominion: an argument about abortion and euthanasia* (1993) 166; Biggs *Death with dignity* 145.

¹⁴⁸ Amarasekara & Bagaric *Morality* 103.

¹⁴⁹ Biggs *Death with dignity* 29.

¹⁵⁰ Biggs *Death with dignity* 11.

to the South African Constitution, and secondly, by analysing the two different sides of the debate.

6.3 Human dignity in the South African context

Whether or not assisted death would be justifiable based on the right to human dignity will depend in part on the role that the right to human dignity plays in that specific jurisdiction's constitution and legislation. It is therefore important to take into account that the legalisation of assisted death is case sensitive – meaning that one cannot simply apply the policy of one country directly to another. The specific legislation, public policy and conditions of the specific country will be vital in determining how assisted death can be legalised. It is therefore necessary to examine the role of human dignity in the South African context.

The importance of human dignity as a founding value of the Constitution of the Republic of South Africa¹⁵¹ (hereafter the Constitution) cannot be overemphasised. Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern. This right therefore is the foundation of many of the other rights that are specifically entrenched in chapter 2 of the Constitution. The Constitution provides specifically for the right to human dignity in section 10 and holds that every person has inherent dignity and the right to have their human dignity respected and protected.

The Constitutional Court of South Africa has also emphasised the importance of human dignity in several cases. In *Dawood v Minister of Home Affairs*¹⁵² the court stated that human dignity is not only a justiciable and enforceable right, but also a value that is central to the interpretation of other fundamental rights.¹⁵³ The interpretation of human dignity was also central in case law relating to the right to vote,¹⁵⁴ protection against cruel, inhuman and degrading punishment,¹⁵⁵ and privacy.¹⁵⁶ Human dignity is also employed in the limitation enquiry as set out in section 36 of the Constitution. The Constitutional Court confirmed in *Christian Education South Africa v Minister of Education*¹⁵⁷ that when balancing rights in

¹⁵¹ The Constitution of the Republic of South Africa, 1996.

¹⁵² 2000 3 SA 936 (CC).

¹⁵³ *Dawood v Minister of Home Affairs* 2000 3 SA 936 (CC) 35.

¹⁵⁴ *August v Electoral Commission* 1999 3 SA 1 (CC). Paragraph 17 specifically states that “the vote of each and every citizen is a badge of dignity”.

¹⁵⁵ *S v Williams* 1995 3 SA 632 (CC).

¹⁵⁶ *Investigating Directorate: Serious Economic Offences v Hyundai Motor Distributors (Pty) Ltd* 2000 10 BCLR 1079 (CC).

¹⁵⁷ 200 4 SA 757 (CC).

terms of the section 36 enquiry, one must determine the way in which the central value of human dignity is affected by the limitation.¹⁵⁸

The centrality of the right to human dignity was furthermore highlighted by the Constitutional Court in *S v Makwanyane*¹⁵⁹ which concerned the constitutionality of the death penalty. O'Regan J in her judgment stressed the importance of the intrinsic relationship between the right to life and the right to human dignity and made the following argument:

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.¹⁶⁰

The centrality of the right to human dignity is firmly established in South African law, but the exact role that it will play in legal developments relating to assisted death is yet to be seen. Much reliance is however placed on human dignity as the primary catalyst for the justification of assisted death. The relationship between assisted death and human dignity in South Africa is examined in chapter seven. This is done by scrutinising previous and current attempts at legalisation and the link that it has to human dignity as a right and value.

6 4 Human dignity as justification for assisted death

6 4 1 *Arguments that human dignity is an appropriate justification for assisted death*

It has been shown that human dignity is open to a range of interpretations. In the assisted death debate, patients rely on their right to human dignity to indicate that their illness affects their independence and autonomy in such a way that they no longer possess dignity. Their sense of self is affected by their circumstances in such a way that they feel they are living an undignified life.¹⁶¹

Respect for human dignity means respecting the intrinsic worth that every individual possesses. This belief dictates that at the end of life, the dying process should be afforded the same degree of dignity that was present during the life of the individual. This respect reinforces the importance of individual autonomy that is central to the quality of any person's

¹⁵⁸ *Christian Education South Africa v Minister of Education* 2000 4 SA 757 (CC) para 15.

¹⁵⁹ 1995 3 SA 391 (CC).

¹⁶⁰ *S v Makwanyane* 1995 3 SA 391 (CC) para 327.

¹⁶¹ Jackson & Keown *Debating euthanasia* 10.

life. The control and autonomy that one has over one's life and personal choices must thus be extended to include control of life ending decisions.¹⁶²

Those who examine the meaning and value of their lives in light of the imminent death they face, frequently express apprehension and concern regarding the prolonging of the process of dying. This concern is in many instances directly associated with the possibility that their dignity may be compromised if their death is prolonged. The argument is therefore made that the way to achieve dignity in death is to maintain some manner of control over the life that one has led by being able to make autonomous choices relating to death.¹⁶³

It is sometimes argued by the hospice movement and others that assisted death is not justified, as the patient's pain and suffering can be eased through the application of palliative care. However, it is questionable whether this argument sufficiently addresses concerns relating to the quality of life of the patient and the destruction of his human dignity.¹⁶⁴ Medical technology makes it possible to prolong the dying process, but this intervention is often quite obtrusive. Competent patients have the right to refuse life-prolonging treatment by withholding consent to any medical treatment or procedure or by signing DNR orders, which in many instances lead to their death. This omission of treatment is classified as passive euthanasia or passive assisted death. Why should we only respect the autonomous choice of the patient in relation to passive assisted death, but not the patient's self-determined decision to employ active voluntary assisted death? Are these two so different or are they two sides of the same coin if both are founded on the autonomous choice that the patient makes?

Those that argue for death with dignity thus base their argument on autonomy and self-determination as elements of human dignity and demand that the autonomous choices of patients that are requesting euthanasia or assisted suicide must be respected.

6 4 2 Arguments that human dignity cannot be relied upon as justification

Those that are of the opinion that human dignity cannot be used as justification for the legalisation of assisted death believe that human dignity is an inalienable human characteristic that all people have. They argue that the widely shared perception that those that are severely ill and dying lose their dignity due to the effects of their illness, is in fact incorrect. This argument centres on the notion that a patient can never lose his dignity. It rests on the belief that human dignity is inalienable and that despite the patient's suffering,

¹⁶² Biggs *Death with dignity* 145.

¹⁶³ Biggs *Death with dignity* 29.

¹⁶⁴ Biggs *Death with dignity* 146.

frailties and circumstances his human dignity subsists even if he believes otherwise. The submission is thus made that human dignity cannot be lost, as it remains an inherent human quality. The legalisation of assisted death can therefore not be justified on the basis of the right to human dignity.¹⁶⁵

The sense of loss that patients experience has been explained by some as a learned response, which is closely related to social beliefs and attitudes. It is argued that society above all else values youth, vigour and self-control, and identifies human dignity with these qualities. Corresponding to this is the belief that loss of self-control, capability and independence results in an individual leading an undignified existence. The physical effects of illness and old age are deemed to be personally degrading and a source of embarrassment for the individual, rather than an unavoidable part of the cycle of life.¹⁶⁶ It has been suggested that we should rather help these individuals to restore their sense of dignity by means of therapy and palliative care, or by educating terminally ill patients and enabling them to make peace with their circumstances.¹⁶⁷

Opponents of assisted death therefore reject relativistic theories and argue that human dignity cannot and should not be reduced to particular human qualities or properties. Rationality and autonomy are important elements of human dignity, but do not exhaust its meaning. Opponents of human dignity as justification for assisted death submit that, since human dignity encompasses all aspects of human existence, it is wrong to single out only some elements, or to elevate them above others.¹⁶⁸

I understand the arguments that opponents of legalisation make and agree that human dignity is an inherent quality that all individuals possess, but if the individual no longer feels that he possesses this quality due to the effects of his illness, who are we to question his belief? It is essential, when establishing whether the human dignity of an individual has been infringed, to consider the individual's subjective experience. The manner in which the specific individual's circumstances affect his human dignity must be taken into account – a mere objective approach to and application of human dignity will not respect the right to human dignity that all persons have.¹⁶⁹ The balance between dignity's subjective and

¹⁶⁵ Azize (2007) *UNDALR* 73.

¹⁶⁶ Azize (2007) *UNDALR* 74.

¹⁶⁷ Azize (2007) *UNDALR* 73.

¹⁶⁸ Azize (2007) *UNDALR* 74.

¹⁶⁹ See, on the distinction between dignity as an objective norm and a subjective right, Botha H "Human dignity in comparative perspective" (2009) 20 *Stell LR* 180. The Constitutional Court has recognised that dignity has a subjective element. O'Regan J stated, in a different context, that human dignity connotes 'both the personal sense of self-worth as well as the public's estimation of the worth or value of an individual'. *Khumalo and Others v Holomisa* 2002 5 SA 401 para 27.

objective dimensions is skewed when the State, in exercising its duty to protect human dignity, unduly limits an individual's autonomous choices and, as a consequence, his right to human dignity.¹⁷⁰

The subjective element is of immense importance in the assisted death debate as it will ensure that it was indeed the wish of the patient to have his life ended in order to have a dignified death. A balance must be struck between the objective and subjective elements in order to create equilibrium between the state's duties to respect and protect dignity. If this is done it will ensure that the individual's fundamental human rights are respected, as well as those of the broader community.

6.5 Conclusion

One of the identifying characteristics of the concept of 'human dignity' is its nebulous nature and the way in which it can relate to so many different situations at the same time. This should not be seen as a negative or undesirable characteristic, but should rather be welcomed. Human dignity is viewed by many as a grounding principle, because of this very characteristic. Human dignity comprises many different interpretations and elements which makes the concept rather flexible. Moreover, human dignity has both a subjective and objective element and if we do not apply both, it will lead to injustice. The subjective element of human dignity must be acknowledged in order to ensure that the individual's right to human dignity is respected. If the notion that human dignity has a subjective element is acknowledged, the argument made by opponents that we can never be without human dignity simply cannot be accepted.

After considering the different interpretations of human dignity, I argue that human dignity serves as an appropriate justification for the legalisation of assisted death. It is clear that human dignity has a central role in South African case law and in the Constitution. I would argue that the Constitutional Court has indicated that a life without dignity diminishes that human life.¹⁷¹ The centrality of human dignity and the respect that accompanies this right is indicative that human dignity should be an appropriate justification for legalisation.

¹⁷⁰ Botha (2009) *Stell LR* 182.

¹⁷¹ *S v Makwanyane* 1995 3 SA 391 (CC) para 327.

7 Assisted death in South Africa

7.1 Introduction

The assisted death debate has also made its way to South Africa. Organisations are fiercely lobbying for the right to die with dignity and the circumstances surrounding the recent deaths of Nelson Mandela, Craig Schonegevel and Mario Ambrosini have put the spotlight on assisted death. In order to establish if assisted death is justifiable in South Africa, it is necessary to examine the current legal position and then to discuss recent initiatives aimed at legalising assisted death.

7.2 The current legal position in South Africa

At this time neither voluntary active euthanasia nor assisted suicide is legal in South Africa.¹⁷² Suicide and attempted suicide is no longer a crime in South Africa, but encouraging or assisting another to commit suicide could be deemed murder or culpable homicide, depending on the circumstances. The South African courts have dealt with different cases over the years that centred on suicide and assisted death. These cases give some indication on how matters of assisted death are dealt with in South Africa.

In the case of *R v Davidow*¹⁷³ the accused's mother had suffered from a terminal illness that was accompanied by severe pain. The accused did everything in his power to ensure that his mother had the best medical treatment, but her condition was incurable and she consequently became depressed as her condition deteriorated. She expressed the wish to be relieved of her suffering. The accused became more and more concerned about his mother's condition and, in a state of emotional turmoil, shot his mother. The accused was charged with murder, but was ultimately found not guilty as he could not be deemed accountable due to his emotional state during the commission of the act. Even though the accused was found not guilty, the unlawfulness of his actions was not questioned.¹⁷⁴

In *S v De Bellocq*¹⁷⁵ a young married woman gave birth to a premature baby. After a few weeks in the hospital the baby was diagnosed with toxoplasmosis, a disease which meant that the child could not drink or eat and suffered from a form of retardation. Doctors informed the mother that the child would never be able to live a normal life and would not live long. After the hospital could do no more for the child, the parents were allowed to take

¹⁷² Slabbert & Van der Westhuizen (2007) *SAPR/PL* 367.

¹⁷³ 1955 WLD unreported.

¹⁷⁴ SA Law Commission Euthanasia and the Artificial Presentation of Life Project 86 Report (1998) 67.

¹⁷⁵ 1975 3 SA 538 (T).

the child home. On bathing the child, the mother suddenly decided to drown the child in order to spare the infant the suffering. De Wet JP found the mother guilty of murder, but acknowledged that it was clear that overwhelming extenuating circumstances were present. She was sentenced in terms of section 349 of the old Criminal Procedure Act and was accordingly discharged on the condition that she entered into recognisance and had to appear for sentencing if called upon by the court.¹⁷⁶

A very important case which sheds light on the judiciary's stance on euthanasia is that of *S v Hartmann*.¹⁷⁷ The accused was a medical practitioner and the son of the deceased. The deceased was an 87-year old man who had been suffering from a carcinoma of the prostate for a number of years. The father's condition had weakened over time and a secondary cancer had manifested in some of his bones. The accused had treated his father over a long period of time and as time progressed, the father had become completely bedridden, very emaciated and on pain medication. He furthermore suffered a pulmonary embolism¹⁷⁸ and a laryngeal stridor.¹⁷⁹ After this, his condition worsened progressively and he was injected with morphine. The accused then injected his father with a lethal dose of Pentothal which immediately caused his death.¹⁸⁰

The accused was convicted of murder, but the court recognised the presence of mitigating factors. Van Winsen J was of the view that this case called for a total suspension of the sentence, but that the law did not permit this. He therefore made the order that the accused must be imprisoned for a term of one year. The accused was detained until the rising of the court and the balance of the sentence was suspended for one year.¹⁸¹

Two more recent cases also contributed to the assisted death debate in South Africa: *S v Marengo*¹⁸² and *S v Smorenburg*.¹⁸³ In *S v Marengo* the accused admitted to killing her 81-year old father who was suffering from cancer. She pled guilty to the charge of murder, but stated that her reason for shooting her father was to relieve him of his suffering as he was in constant pain and in a hopeless state. The main issue that the court had to deal with in this case was the sentencing. In this instance the court not only focused on the view that the

¹⁷⁶ SA Law Commission Euthanasia and the Artificial Prolonging of Life Report 68; *S v De Bellocq* 1975 3 SA 538 (T) page 7,8.

¹⁷⁷ 1975 3 SA 532 (C).

¹⁷⁸ This occurs when the main artery of the lung is blocked by a substance, many times a blood clot, which has travelled from another part of the body through the bloodstream.

¹⁷⁹ The obstruction of the airway results in a high-pitched breathing sound that is caused by turbulent air in the larynx.

¹⁸⁰ *S v Hartmann* 1975 3 SA 532 (C) page 88.

¹⁸¹ *S v Hartmann* 1975 3 SA 532 (C) page 92.

¹⁸² 1991 3 All SA 784 (W).

¹⁸³ 1992 2 SACR 389 (C).

accused was acting out of mercy, but also examined the personal circumstances of the accused and the effect her father's illness had on her health and state of mind. The court held that the accused had suffered from personality disintegration and that she could not be held liable for her actions.¹⁸⁴ Gordon AJ found this case very similar to that of *S v Hartmann* and concurred with the order of a suspended sentence delivered in *Hartmann*. Gordon AJ accordingly sentenced the accused to three years' imprisonment that was suspended for five years.¹⁸⁵

In the *Smorenburg*-case a nursing sister was charged with two counts of attempted murder after she attempted to end the life of two of her patients. This was done by administering large doses of insulin to each of them.¹⁸⁶ She admitted to both of the charges, but submitted that she had acted the way she did as it was the patients' wish and that she wanted to relieve their suffering.¹⁸⁷ On each count the accused was sentenced to three months' imprisonment, totally suspended for 12 months.

When one examines and compares the case law discussed above, some inferences can be drawn. The case of *S v Marengo* shares some similarities with *S v Hartmann* as both dealt with terminally ill parents that were killed by their children. *S v Smorenburg* and *S v Hartmann* also share resemblances as both involved medical professionals. What is also clear is that the specific facts and surrounding circumstances of every case played a determining role in establishing the sentence of the accused. Most important is that in all the cases the motive behind the act was to relieve the suffering of the patient and to assist them in finding a dignified death. In all of the discussed cases, the accused's actions were deemed unlawful as assisted death is still regarded as murder in terms of South African law. The light sentences imposed by the courts in these instances are however indicative of the fact that the judiciary does not feel that a heavy sentence will reflect a sense of justice. The presence of extenuating circumstances was vital in these cases and indicates that the courts deal with each case on its own merits.

7.3 Steps taken by the South African Law Commission

The advances that have been made in medical science during the 20th century and the consequences of these advances did not escape the attention of the South African Law Commission (as it was then known). These advances resulted in patients living longer, which

¹⁸⁴ *S v Marengo* 1991 3 All SA 784 (W) page 786.

¹⁸⁵ *S v Marengo* 1991 3 All SA 784 (W) page 787.

¹⁸⁶ *S v Smorenburg* 1992 2 SACR 389 (C) page 390.

¹⁸⁷ *S v Smorenburg* 1992 2 SACR 389 (C) page 391.

increased the interest in patient autonomy and the assisted death debate in many jurisdictions. The Law Commission consequently deemed it necessary to clarify the South African position and to make recommendations in relation to patient autonomy and end of life decisions. This resulted in the Report on Euthanasia and the Artificial Preservation of Life (hereafter referred to as the Report) as well as the End of Life Decisions Bill 1998 (hereafter the Bill) that dealt with the regulation of end of life decisions.¹⁸⁸

During the initial stages of the investigation, the Commission was primarily concerned with the legality of the Living Will and instances where the treatment of the patient was ceased. Developments in the Netherlands, Northern Australia and the United States of America however drew the attention of the Commission to jurisdictions that decided to legalise assisted death. It was consequently decided that the scope of the Commission's investigation should be broadened to include end of life decisions.¹⁸⁹

The Commission's Report does not clearly distinguish between assisted suicide and euthanasia. This is viewed as a shortcoming as these differences are quite significant to the assisted death debate. In some instances the language used in the Report can be understood to include both assisted suicide and euthanasia, but in other instances reference is only made to euthanasia. If new legislation were to be drafted, attention must definitely be paid to defining the different practices of assisted death.¹⁹⁰ Clarity in this instance is of utmost importance.

The Commission did not make a specific recommendation, but identified three possibilities and drew up a proposed draft Bill based on the information gathered from its investigation.¹⁹¹ Option one recommends that the present legal position must be confirmed as the arguments in favour of legalising euthanasia are inadequate to weaken the prohibition on intentional killing.¹⁹² This option acknowledges that there may be individual cases where euthanasia might seem appropriate, but concludes that they do not establish the basis of a general pro-euthanasia policy. It is argued that it would be impossible to prevent abuse as sufficient safeguards cannot be established.¹⁹³ No legislative enactment is required for option one to be put into effect.¹⁹⁴

¹⁸⁸ SA Law Commission Euthanasia and the Artificial Prolonging of Life Report x.

¹⁸⁹ SA Law Commission Euthanasia and the Artificial Prolonging of Life Report 1.

¹⁹⁰ For definitions please see chapter two.

¹⁹¹ SA Law Commission Euthanasia and the Artificial Prolonging of Life Report xi.

¹⁹² SA Law Commission Euthanasia and the Artificial Prolonging of Life Report xi.

¹⁹³ SA Law Commission Euthanasia and the Artificial Prolonging of Life Report xii.

¹⁹⁴ SA Law Commission Euthanasia and the Artificial Prolonging of Life Report xvii.

Option two, as set forward in Discussion Paper 71,¹⁹⁵ proposes legislative reform that would enable a medical practitioner, upon a request from the patient, to determine whether the patient qualifies for assisted death or not. The medical practitioner can provide or administer a lethal dose of drugs with the purpose of ending the patient's unbearable suffering. The patient must however be terminally ill and mentally competent to qualify, and the medical practitioner must adhere to strict safeguards to prevent abuse.¹⁹⁶ Section 5 of the Bill seeks to give effect to option two, as recommended by the Commission. In terms of section 5(1) the medical practitioner can only give effect to the patient's request if he is satisfied that the patient is suffering from a terminal or intractable and unbearable disease; that the patient is mentally competent and over 18 years of age; and that the ending of the patient's life on request is the only way to release the patient from his suffering. Specific requirements are set in relation to the consent of the patient. The medical practitioner must be satisfied that the patient has been duly informed of his illness, his prognosis and the treatment or care that is available; that the request made by the patient is based on a free and considered decision; that the patient has repeated his request without self-contradiction on two separate occasions that are at least seven days apart; that the last request was made no more than 72 hours before the medical practitioner gives effect to the patient's request; that a certificate of request was signed by the patient; and that the signature was witnessed by the medical practitioner.¹⁹⁷

The Bill specifically states that the termination of the patient's life may only be effected by a medical practitioner and that the medical practitioner shall not suffer any civil, criminal or disciplinary liability.¹⁹⁸ The Bill furthermore provides for instances where the patient makes an oral request,¹⁹⁹ the regulation and filing of patients' requests²⁰⁰ and that the patient may at any time and in any manner rescind his request.²⁰¹

Section 5 clearly envisages euthanasia performed by a medical practitioner as well as physician-assisted suicide. Provision is made for terminal patients as well as those suffering from other intractable and unbearable illnesses. The Bill makes euthanasia only accessible to mentally competent persons over the age of 18.

¹⁹⁵ SA Law Commission Discussion paper 71 (1997).

¹⁹⁶ SA Law Commission Euthanasia and the Artificial Prolonging of Life Report xii, 141.

¹⁹⁷ SA Law Commission Euthanasia and the Artificial Prolonging of Life Report xviii, 141.

¹⁹⁸ SA Law Commission Euthanasia and the Artificial Prolonging of Life Report 142.

¹⁹⁹ Section 5(1)(f) and (g) as well as section 5(6) of the End of Life Decisions Bill 1998.

²⁰⁰ Section 5(8) of the End of Life Decisions Bill 1998.

²⁰¹ Section 5(7) of the End of Life Decisions Bill 1998.

Option three recommends that the practice of euthanasia must be regulated by legislation, which provides that a multi-disciplinary panel or committee be established in order to process requests for euthanasia. A specific set of criteria must be met.²⁰² The Bill provides that the committee must consist of the following persons: two additional medical practitioners other than the practitioner attending to the patient; one lawyer; one member with the same home language as the patient;²⁰³ one member from the multi-disciplinary team; and a family member.²⁰⁴ The request for euthanasia must be heard by the committee within three weeks of receipt and in order to approve such a request, the committee must certify in writing that the patient's request is free, considered and continued. It must also be certified that the patient suffers from a terminal or intractable and unbearable illness and that euthanasia is the only way to release the patient from his suffering. The committee must report to the General Director of Health and the Director General may request a report from the committee if further information is required.²⁰⁵ Option three is thus very similar to option two, except that the request must be approved or denied by a committee instead of a medical practitioner.

In my view, option one is no longer a viable option, as legislative reform is needed to protect patients' dignity. Of the two remaining options, option two seems preferable, but I would recommend that the medical practitioner must report to a committee in order to ensure proper regulation.

Even though the Law Commission introduced this Bill in Discussion Paper 71 and gave further comments in its Report, not much was done to further its cause. These important documents and its recommendations have continued to languish on the shelves of Parliament. As a consequence the State has not fulfilled its responsibility to promote its citizens' human rights – specifically human dignity.²⁰⁶ It is unfortunate that this opportunity was not fully embraced by Parliament.

7 4 Why we should not legalise assisted death in South Africa

The argument has been made that even if assisted death is in principle justifiable, it does not necessarily follow that South Africa is a safe and suitable country for legalised assisted death. This argument is based on the belief that assisted death can only be justified in a country that has the necessary infrastructure – meaning the best medical care for all, well-

²⁰² SA Law Commission Euthanasia and the Artificial Prolonging of Life xii.

²⁰³ This is needed for purposes of translation.

²⁰⁴ SA Law Commission Euthanasia and the Artificial Prolonging of Life xx; 145.

²⁰⁵ SA Law Commission Euthanasia and the Artificial Prolonging of Life xxi; 146.

²⁰⁶ Dolny H "Statement: Dignity South Africa Executive Committee – 6th October 2014" 5 October 2014 <www.dignitysa.org/blog> (accessed 6 October 2014).

organised palliative care that is easily and widely accessible, proper medical and judicial institutions, and lastly a strong ethos of respect for human life. Those opposed to legalisation in South Africa argue that South Africa's health system is too heavily constrained and that there is a lack of resources that makes it nearly impossible to accommodate assisted death. The state of the South African health system means that there is the possibility that euthanasia could become a substitute for proper healthcare for the terminally ill.²⁰⁷ Opponents therefore argue that South Africa does not have the necessary infrastructure to properly regulate assisted death if it were to be legalised.

Opponents further argue that there is a lack of respect for human life in South Africa, as is evident from the number of violent crimes that occur every day. Unnecessary deaths also occur in our hospitals due to indifference and neglect on the part of medical staff. Opponents of legalisation of assisted death thus argue that the current conditions are not suitable for assisted death to be legalised and that we should rather focus on more urgent needs that can improve the quality of life of South African citizens before we focus our attention on assisted death.²⁰⁸

Of course the situation in South Africa as a developing country is very different from the developed countries that have legalised assisted death. However, another developing country, Colombia, has declared physician-assisted suicide to be legal in 1997. The Constitutional Court of Colombia declared that assisted death should be permitted for terminally ill patients who give their express consent by means of a request. A distinction is made between different illnesses, as those suffering from cancer, renal deficiency, or AIDS are permitted to have an assisted death whilst those who suffer from degenerative diseases such as Parkinson's or Alzheimer's are not allowed.²⁰⁹

We must however recognise that South Africa is lauded internationally for its Constitution and respect for human rights. The argument from opponents that we must rather focus on more pressing issues before concentrating our attention on assisted death cannot be accepted. Assisted death is truly a pressing issue – patients are in the final stages of their life and do not have time to wait. Denying them the right to choose to die rather than to endure unbearable pain and suffering, is to violate their fundamental right to human dignity.

²⁰⁷ Ncayiyana (2012) *SAMJ* 334.

²⁰⁸ Ncayiyana (2012) *SAMJ* 334.

²⁰⁹ Stewart GP, Cutrer WR, Demy TJ et al *Basic questions on suicide and euthanasia: are they ever right?* (1998) 51.

7.5 Current efforts to legalise assisted death

DignitySA, the leading organisation lobbying for the right to die with dignity, is currently in the process of trying to secure this right and hope to do so in the next five years. One of the executive members of DignitySA, Professor Sean Davidson, gained notoriety in 2006 after he had assisted his terminally ill mother to end her life in New Zealand.²¹⁰ Davidson injected his mother with a lethal dose of morphine after she had been unsuccessful with a hunger strike and had pleaded with him to help her. He was found guilty of attempted murder and had to serve a detention period of five months.²¹¹

Certain events of the past few years have highlighted the organisation's cause and helped them secure more support. In 2008 the case of Craig Schonegevel made headlines. Schonegevel, a 28-year old South African, had suffered from neurofibromatosis and ended up taking his own life by taking 12 sleeping pills and suffocating himself by pulling plastic bags over his head. He did this as there was no hope for recovery, and he wanted to end his unbearable suffering because he believed he was leading an undignified existence.²¹² The passing of Nelson Mandela and the circumstances surrounding his death gave rise to criticism from, amongst others, Emeritus Archbishop Desmond Tutu. Motivated by the deaths of Craig Schonegevel and Nelson Mandela, the Archbishop came out in strong support of the legalisation of assisted death in South Africa in July 2014. He stated that the current legal position in South Africa did not grant Craig Schonegevel the right to die with dignity and that palliative care cannot secure this right in all circumstances. He further argued that the Constitution espouses the right to human dignity and that our law must be revisited in order to align it with the Constitution and the human dignity that it envisages.²¹³

DignitySA is determined to legalise assisted death. On 4 December 2014 the organisation met with human rights lawyers, constitutional experts and five Senior Councils to discuss the way forward.²¹⁴ Two possible strategies were identified. The first is to approach the Ministers for Justice and Constitutional Development, Health, and Social Welfare together with the relevant Parliamentary Committees to request a review of the Law Commission Report.²¹⁵ The death of parliamentarian Mario Ambrosini presumably sensitised

²¹⁰ Marais A "Tutu help saak vir genadedood in SA" *Die Burger* (2014-07-14) 1.

²¹¹ Sapa-AFP and Staff Writer "I support assisted dying, says Tutu" *Cape Times* (2014-07-14) 3.

²¹² Sapa-AFP and Staff Writer *Cape Times* (201-07-14) 1; For further information on the story of Craig Schonegevel see: M Thamm *The last right: Craig Schonegevel's struggle to live and die with dignity* (2013).

²¹³ Sapa-AFP and Staff Writer *Cape Times* (201-07-14) 1.

²¹⁴ 2014 Last L Email Correspondence with DignitySA 2014-09-08 <lee.dignitysa@gmail.com>.

²¹⁵ Dolny H "Statement: Dignity South Africa Executive Committee – 6th October 2014" 5 October 2014 <www.dignitysa.org/blog> (accessed 6 October 2014).

many members of Parliament to the need for legislative reform. Ambrosini was in the final stage of lung cancer and shot himself in order to be free of his suffering. The Deputy Minister of Justice, John Jeffrey, said that assisted death is an important issue that must be debated in parliament. DignitySA has made contact with other parliamentarians who also agree.²¹⁶

Several terminally ill citizens have approached DignitySA and the second measure is thus to initiate a court case to ensure that these individuals will die with dignity.²¹⁷ They hope to launch their application in the High Court in March 2015, but foresee the possibility that some of the applicants could die before that time, and are therefore working on urgent applications. Time is clearly of the essence. DignitySA believes that, whichever way the High Court rules, the likelihood of the case ending up before the Constitutional Court is almost a certainty.²¹⁸

DignitySA's lobbying for the legalisation of assisted death, and its efforts to educate and mobilise the public around this issue, could lead to important legal developments in the near future.

²¹⁶ 2014 Last L Email Correspondence with DignitySA 2014-12-02 <lee.dignitysa@gmail.com>.

²¹⁷ Dolny H "Statement: Dignity South Africa Executive Committee – 6th October 2014" 5 October 2014 <www.dignitysa.org/blog> (accessed 6 October 2014).

²¹⁸ 2014 Last L Email Correspondence with DignitySA 2014-12-02 <lee.dignitysa@gmail.com>.

8 Concluding remarks

Today, South Africans are much more aware of their individual autonomy and right to self-determination than ever before – the Constitution has enabled this awareness.²¹⁹ They are also better informed regarding their rights as patients, as incorporated by DNR orders and other documents given to patients in order to have more control over their treatment.²²⁰ The ability to make a decision which is respected by the authorities, serves as a means of maintaining control over one's life and of preserving one's human dignity.²²¹

South Africans have become more aware of the assisted death debate due to larger exposure accredited to international news and broadcasting. Technology is changing the medical world and with it the way we live and die. The dying process is in many instances prolonged due to medical interference. Some jurisdictions have responded to these changes by legalising assisted death. In most of these jurisdictions, legalisation is justified on the basis of the right to die with dignity. Most of the jurisdictions that have legalised assisted death favour physician-assisted suicide, but some have opted to legalise active voluntary euthanasia. It is argued that physician-assisted suicide is favoured, as the final act remains with the patient, thus meaning that the patient must administer the drugs himself. The jurisdictions that have legalised assisted death have established comprehensive criteria that must be met in order for a patient's request to be considered. In most instances the criteria are set out in legislation in order to facilitate the regulation of requests and to prevent abuse. These jurisdictions are of immense importance as they aid in determining which methods work and which do not. Risks are established and we can then learn from them in order to lower the risks. Their legislation serves as very good examples that can serve as the basis for new legislation to be drafted.

I have argued that South Africa must legalise physician-assisted suicide. Physician-assisted suicide can be regulated properly, as the experience in other jurisdictions shows. The resources that are necessary to practise assisted death, will not be an undue burden for the health system. Comprehensive legislation must be drafted and presented to parliament. If possible, specific institutions should be established or selected from existing institutions where assisted dying can be carried out. Identifying specific institutions will enable better regulation and lessen the risk of abuse. Medical practitioners should not be forced to

²¹⁹ Slabbert & Van der Westhuizen (2007) *SAPR/PL* 367.

²²⁰ Slabbert & Van der Westhuizen (2007) *SAPR/PL* 367.

²²¹ Biggs *Death with dignity* 1.

participate, but should be given a choice. A central committee must also be established for the medical practitioners to report to, as implemented in the Netherlands.²²² This will facilitate the reporting and administrative elements. Furthermore physician-assisted must only be available to South African residents. This will ensure that South Africa does not enable assisted death tourism. This corresponds with most jurisdictions that have legalised assisted death. Currently only Switzerland makes it possible for non-residents to have access to assisted death at their clinics.

Even if South Africa were to legalise assisted death, the legislation cannot replace the moral decision that every individual can still make in relation to his personal views. If assisted death is legalised it does not mean that it must be practised by all – it merely gives one the option to do so. An informed and autonomous decision is still one of the primary requirements. No one can be forced to participate if he does not wish to do so.

Even though there are numerous arguments in favour of and against the legalisation of assisted death, I contend that the right to human dignity is the central argument. The right to human dignity is a fundamental right afforded to all citizens. I argue that assisted death is justifiable on the basis of the right to human dignity. Human dignity has a subjective element which means that it is not only an inherent quality, but also refers to an individual's personal feelings of self-worth. Some people who suffer from a terminal illness and are in the final stages of their life feel that they are leading an undignified existence, while others do not feel this way. Dignity requires that we respect both. If we legalise assisted death in South Africa, the choice remains with the patient to determine for himself whether he can continue to live a life of dignity. To make this decision on behalf of the patient, on the basis of the argument that dignity cannot be lost, is to violate the patient's autonomy and human dignity.

The steps that DignitySA are taking are once more stimulating the assisted death debate and informing South African citizens that they are entitled to die with dignity. Their endeavours will hopefully deliver positive results in the near future to ensure South Africans' dignity and autonomous decisions will be respected.

The legalisation of assisted death ensures that those who wish to have assistance with ending their suffering in a dignified manner have this right. We must respect the human dignity of all our citizens, even if we do not necessarily agree with their autonomous choices. We can no longer turn a blind eye to cases such as Craig Schonegevel's. It should not be necessary for an individual to take such drastic steps to end his life in order to bring his

²²² Section 3(2) of *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001*.

unbearable suffering to an end. We must acknowledge and respect the wish of South Africans to have a dignified death by means of assistance from a medical practitioner. Legalisation of assisted death is justifiable on the basis of the right to human dignity. The South African government must take the necessary steps to ensure that its citizens' right to human dignity is respected.

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