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Challenges in Medical Ethics:

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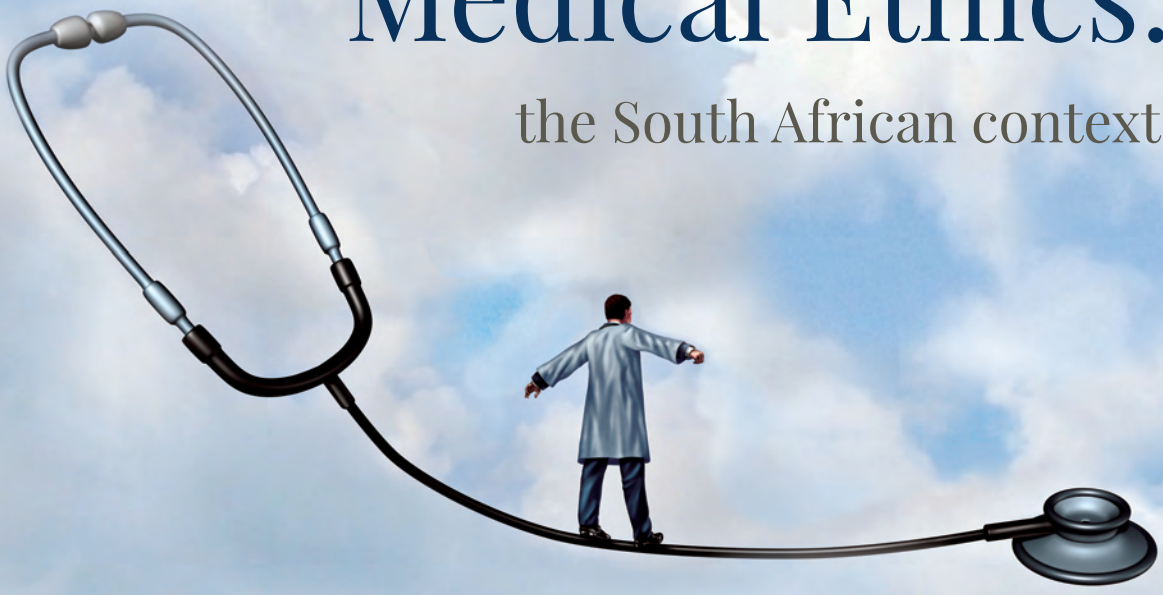

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11

End-of-Life Choices

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Keywords: advance directive; assisted dying; assisted suicide; constitutional rights; health care power of attorney; living will; right to bodily and psychological integrity; right to dignity; right to freedom and security of the person; right to security of and control over one's body; surrogacy; terminal pain management; voluntary euthanasia

11.1 INTRODUCTION

For some, dying is a peaceful and dignified process or event, without much suffering, perhaps even serene, and at the end of a completed life.

Others are less fortunate. For them, dying is a protracted process, a *via dolorosa* suffused with uncertainty, fear, suffering, and loss of dignity, in which a once fully human life is agonisingly dismantled. However, should this be our destiny, we are not entirely delivered to the inevitable. We have choices and can take some control.

End-of-life choices can be divided into four categories (Landman, 2001, 2012):

- End-of-life pain management that hastens death;
- Refusal of and refraining from life-sustaining treatment;
- Advance directives; and
- Assisted dying – assisted suicide and voluntary euthanasia.

In South Africa, unfortunately, each one of these options poses unresolved legal issues. Both end-of-life pain management and refraining from life-sustaining treatment that ought to be standard-of-care medical practices are mired in uncertainties. The legal status of advance directives, such as a living will, is unclear. Assisting with suicide and practising voluntary euthanasia constitute the common-law crime of murder.

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What exactly is at issue in these end-of-life practices, and how could each of them assist to make dying gentler, more compassionate, and more dignified?

11.2 END-OF-LIFE PAIN MANAGEMENT THAT HASTENS DEATH

First, end-of-life pain management that hastens death seeks to ease suffering during the dying process. Suffering is a complex, intensely personal experience induced by physical pain, mental distress, or both. At the end of life, suffering may be unbearable and intractable. It may become so all-consuming that continued life becomes increasingly undesirable and devoid of meaning and purpose.

Throughout our lives, we seek to remove or alleviate others' suffering as far as it is within our power to do so. It should be no different at the end of life. Adequate end-of-life pain management, however, may have the foreseen, unintended, yet inevitable, secondary *consequence* of hastening death.

But then such terminal pain management resulting in inevitable death would appear to be indistinguishable from voluntary euthanasia that terminates life *in order to* terminate pain. Or, at the very least, any distinction would appear to be tenuous. After all, both result in ending pain as well as life. So, the difference between the lawful and the unlawful would appear to hinge precariously on the description of the exact mental content – the intention – of the medical practitioner without there necessarily being any overt or perceivable behavioural difference.

Unfortunately, perceived legal risk associated with terminal pain management is a factor in under-treatment of pain. Ideally, end-of-life pain management should be located in a comprehensive palliative care setting, based on clinical judgement, and informed by consultation with patient and family. And the law should create an enabling and protective environment for medicine to do what it should.

In its final report on end-of-life choices, the South African Law Commission (SALC) (RSA, 1998:59)[1] appended a draft bill – the "End of Life Decisions Act" – stating that if pain medication proves to be inadequate, then a medical practitioner or nurse may increase the dosage with the object of relieving pain even if the secondary effect is the shortening of the patient's life. This report was shelved by Parliament, which means that uncertainty about legal liability, and therefore unnecessary suffering, persist. This lost opportunity compromises responsible medicine in an increasingly litigious environment. Standard-of-care

1 At the time of the report's publication, the South African Law Reform Commission (SALRC) was known as the South African Law Commission (SALC).

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medical practice, unlike medical malpractice, should not be the domain of the courts (Landman, 2012:38-39).

The Supreme Court of Appeal (SCA) stepped into this partial legal void when a full bench of five SCA judges held the following in the Stransham-Ford case (2016:Para 34):

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

Thus the SCA confirms the common law and goes some way towards addressing ignorance and fear of litigation.

However, explicit legislation – along the lines proposed by the SALC (RSA, 1998:59) – is required to communicate unambiguously the common-law position, thus allaying unfounded fear of legal risk and creating a more enabling and comforting legal environment for all concerned – patient, family, and medical practitioner.

11.3 REFUSAL OF AND REFRAINING FROM LIFE-SUSTAINING TREATMENT

Modern medicine can extend biological life to the point where it is no longer good, desired, or dignified. When would a medical practitioner be legally justified to refrain from life-sustaining treatment (medication, procedures, life-support machines, and the like) by withholding (before it commences) or withdrawing (once commenced) such treatment (Landman, 2012:41-62)? And whose choice should it be?

Decisions to refuse and refrain from[2] life-sustaining treatment – a second category of end-of-life choices – involve both competent and incompetent individuals.

2 Referring to refraining from, withholding, or withdrawing life-sustaining treatment as 'passive euthanasia' attracts unnecessary controversy towards a routine medical practice by dint of mere terminological association with 'active euthanasia'. Other things being equal, 'active' and 'passive' euthanasia are morally equivalent (Landman, 1982). Whether one's action is an act (active) or an omission (passive), one can be held morally and legally accountable for either, so nothing of moral or legal substance hinges on the active-passive distinction *in itself*.

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11.3.1 Competent persons

The National Health Act (RSA, 1996:Sec 7(1)(e)) prohibits the provision of "a health service" without a person's informed consent, that is, *any* medical treatment, routine or life-sustaining, regardless of the person's health status. Thus, competent[3] persons are legally entitled to *refuse* contemporaneously life-sustaining treatment – while continuing to receive palliative care – and medical professionals should accordingly *refrain* from such treatment.

There are, of course, recognised exceptions to the general requirement of informed consent, such as a medical or public-health emergency.

The SALC (RSA, 1998:43) confirmed our common law's "unambiguous recognition and acceptance of the right of the patient, who need not be terminal, to refuse life-saving medical intervention". This is consistent with the constitutional right to bodily integrity (RSA, 1996:Sec 12(2)), which includes the right to control over one's body (RSA, 1996:Sec 12(2)(b)).

The SCA (Stransham-Ford, 2016:Para 31. Emphasis added.) stated the ethical and legal principles regarding refusal of and refraining from life-sustaining treatment as follows:

> A person may refuse treatment that would otherwise prolong life. This is an aspect of *personal autonomy* that is constitutionally protected and would not ordinarily be regarded as suicide. Medical treatment without the patient's consent is regarded as *assault* so that the patient is *always* entitled to refuse medical treatment.

Thus, by refusing life-sustaining treatment – which may include artificial nutrition and hydration – the patient allows natural processes to take their course so that the underlying illness becomes the proximate cause of death (Stransham-Ford, 2016:Para 31).

Manipulating information to obtain informed consent undermines patient autonomy. Medical practitioners might do this for several reasons, such as managing perceived risk, ignorance of the law, traditional views of professional authority, personal religious persuasions, or monetary gain.

3 In a health care context, 'competence' refers to the capacity of persons to understand, reason about, make decisions, and communicate about their health care. Competence is task-specific. Thus, one may be competent to choose chocolate rather than vanilla ice cream, but incompetent to make an irreversible, life-changing decision (Landman, 2012:42).

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11.3.2 Incompetent individuals without advance directives

Incompetent[4] individuals lack the necessary mental competence and legal capacity to make decisions about their continued health care, including life-sustaining treatment. They could be *formerly* competent individuals or individuals who have *never* been, and will never become, competent, for example seriously defective newly born infants.

How should we make decisions about continued life for incompetent individuals?

Some jurisdictions have dedicated legislation creating the *right to a natural death*, free from intrusive medical interventions. Thus, North Carolina (NC, 1977: 90-320 to 90-322) provides for refraining from (withholding or withdrawing) life-sustaining treatment, including artificial nutrition and hydration, for incompetent patients, that is, patients who are:

- Comatose without any reasonable possibility of returning to cognitive function *or* mentally incompetent; *and*
- Either terminal and incurable *or* in a permanent vegetative state (PVS – see footnote 4); *and*
- Sustained by extraordinary means *or* artificial nutrition and hydration.

Should all these clinical conditions obtain – mental, physical, and dependence – then the incompetent individual's attending physician may refrain from life-sustaining treatment, with the concurrence of the surrogate.

South Africa has no equivalent legislation regulating refraining from life-sustaining treatment. The effort by the SALC (RSA, 1998) was fruitless expenditure. But we have developed relevant common-law principles.

In the Clarke (1992) case, the court ruled that discontinuing medical treatment would not be unlawful. The patient, Dr Clarke, became deeply comatose and went into a PVS and remained so for several years. Having approached the court, his wife was appointed curatrix to her husband with the power to authorise withholding or discontinuance of any life-sustaining treatment. Significantly, the court held that, in cases such as these, it would not be contrary to public policy if a court would make an evaluation of the quality of life of the patient to determine whether life-sustaining measures should be discontinued. This recognises that

4 Incompetence may be due to (1) being clinically dead in the sense of whole-brain death; (2) being in a permanent vegetative state (PVS), that is, totally and irreversibly non-conscious while the brain stem still functions; or (3) irreversibly lacking higher brain (cortical) function necessary for rational choice (being mentally incompetent) while still capable of awareness, discomfort, or pain (Landman, 2012:57-62).

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medical treatment is not about merely extending biological life in the total and irreversible absence of conscious life.

So, refraining from life-sustaining treatment of an incompetent individual is lawful provided the necessary clinical conditions obtain. This would include switching off machines; withholding or withdrawal of medication, procedures, or artificial nutrition and hydration; and issuing do-not-resuscitate (DNR) orders.

A decision about the continued life of an irreversibly incompetent individual involves judging the value of a life. If a medical intervention is unable to attain any worthwhile goal beyond mere biological functioning, then life-sustaining treatment is futile or pointless. Maintaining vital functions without the possibility of any conscious or subjective life – biology without biography – does not enable a life that is worth living, given the lives normal human beings live.

In sum, a doctor who ceases treatment of an incompetent patient, or any other medical intervention, that serves no therapeutic or palliative purpose does not commit an offence (Stransham-Ford, 2016:Para 33).

11.3.3 Surrogate decision-making

Crucial for end-of-life choices on behalf of incompetent individuals is a duly authorised surrogate, proxy, or substitute decision-maker who decides for the incompetent individual according to legally prescribed provisions. Surrogacy is also a key notion in advance directives (discussed in the next section). Medical practitioners and health care facilities are legally obliged to respect a surrogate's decision *as if* it is the incompetent patient's own competent expression of will. The surrogate *fully* assumes the decisional capacity of the patient. This is of great significance since some doctors all too often ignore – sometimes with poor communication and even arrogance – the legitimate pleas by surrogates, mostly close family, to cease treatment.

The National Health Act (RSA, 2003) explicitly recognises the legal authority of a surrogate decision-maker for an incompetent individual. Likewise, the SCA (Stransham-Ford, 2016:Para 31) confirmed the principle that treatment against one's will, or a substitute's will – treatment without informed consent – constitutes assault. Thus, medical practitioners should draw comfort from this protection against legal liability, even if a surrogate decides against life-sustaining treatment for a patient. In fact, on the contrary, overruling the surrogate may invite legal liability.

Ideally, a medical practitioner and surrogate should be *ad idem* about appropriate end-of-life treatment in the incompetent patient's best interest. Disagreements

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originate in inadequate understanding of their respective authority and powers, and this is in no small measure attributable to lack of dedicated legislation.

Should efforts at constructive communication and persuasion be unsuccessful, and a medical practitioner continues treatment against the surrogate's wishes, the surrogate can have their authority confirmed by means of a court order (Clarke, 1992). The SALC report (RSA, 1998:235) affirms the legal position that a medical practitioner shall not act in a manner that "would be contrary to the wishes of the interested family members of the patient, unless authorised by a court to do so".

Conversely, should a surrogate insist on futile treatment serving neither a therapeutic nor palliative purpose (Stransham-Ford, 2016:Para 33), while merely extending biological life in the irreversible absence of consciousness, the medical practitioner, after good-faith attempts at persuading the surrogate, would have the full backing of the law to override unilaterally the surrogate's decision.

The SCA (Stransham-Ford, 2016:Para 31) points out that all these common-law principles regarding refusal of life-sustaining treatment are recognised in the right to dignity given by section 10 of the Constitution (RSA, 1996) and the right to bodily integrity given by Section 12(2)(b). The only condition that refusal of treatment needs to meet is the required level of mental competence and legal capacity of the decsion-maker (principal or surrogate) (Stransham-Ford, 2016:Para 32). One should add that the person's decision should be made autonomously, free from coercion, pressure, or undue influence, and in terms of a stable set of personal values.

11.4 ADVANCE DIRECTIVES

A third category of end-of-life choices is advance directives, that is, instruments designed to assist medical practitioners and surrogates to decide for incompetent individuals. They are advance expressions of a competent person's preferences regarding future medical treatment should they ever become incapable of making their own decisions. They are documents drawn up, signed, attested by witnesses, and deposited for safekeeping in places where they can be accessed when needed. Still, verbal instructions may also constitute valid advance directives.

Although enjoying increasing popularity, advance directives have a precarious legal status in South Africa which undermines their credibility and effectiveness. They raise questions of interpretation, for example: What standards should guide a surrogate's decisions? For what reasons, if any, may a medical practitioner dishonour an advance directive? Is a medical practitioner immunised against

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criminal or civil liability for honouring an advance directive? What formalities, if any, do advance directives require?

The two kinds of advance directives recognised in dedicated legislation of other jurisdictions are a health care power of attorney and a living will.

11.4.1 Health care power of attorney

A health care power of attorney is a *substitute directive* where a competent person appoints or mandates a designated individual as their surrogate to make health care decisions on their behalf should they become incapacitated (Landman, 2012:64, 67-69). It confers *general* decision-making powers on the surrogate to make all health care decisions, including decisions about life-sustaining treatment. It may also contain *specific* instructions for prescribed circumstances, for example a DNR order, medication, procedures, nutrition and hydration, or any other form of life support.

A health care power of attorney is *durable* – it endures for life, unless revoked by its issuer while still competent. The surrogate (agent) fully steps into the patient's (principal's) shoes and makes *all* health care decisions on their behalf.

The term 'health care power of attorney' or a cognate does not appear in the National Health Act (RSA, 2003), but the Act provides for a person to *mandate in writing* another person of their choice to grant consent on their behalf should they become unable to do so (RSA, 2003:Sec 7(1)(a)). Such a mandate constitutes a health care power of attorney.

In the absence of a mandate, the Act (RSA, 2003:Sec 7(1)(b)) provides for a *family member* – such as a parent, spouse, sibling, or child – to *automatically* become the incompetent patient's surrogate, empowered to make all health care decisions on their behalf on the basis of recognised decision-making standards.[5]

The Act (RSA, 2003:Sec 7(1)(c)) also provides for the appointment of a surrogate by *court order*. This may be necessary in adverserial circumstances, for example when a medical practitioner refuses to act on a surrogate's instructions.

5 There is a descending hierarchy of decision-making standards applied according to a surrogate's familiarity with an incompetent patient's preferences while still competent: (1) The subjective standard is what a patient *actually* would have wanted; (2) the substituted-judgment standard is what a patient *probably* would have wanted, and (3) the best-interest standard calculates which option would have the *highest net benefit* for the patient. The SCA (Stransham-Ford, 2016:Para 32) refers to justifications for court orders regarding patients who are not clinically brain dead, but on a ventilator and unaware of their surroundings, ranging from "the concept of substituted judgment to the best interest of the patient".

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Should the surrogate be unavailable or uncontactable, the attending medical practitioner is legally entitled to decide about instituting or discontinuing life-sustaining treatment.

Although our legislation provides for issuing a health care power of attorney – in the form of a "mandate" – it lacks detail. Since the SALC report's draft bill on end-of-life decisions (RSA, 1998:224-237) was shelved, questions such as the following have been left hanging in the air: Would the "health service" (RSA, 2003:Sec 7(1)), about which the substitute can decide, include withholding or withdrawal of life-sustaining treatment? Is anyone – a medical practitioner or family member – empowered to override a surrogate's decision? If so, in what circumstances and on what grounds? What is to be done if the application of the Act means that there are two substitute decision-makers – for example, two children – insisting on different treatment pathways for their parent?

11.4.2 Living will

The living will is an advance directive that is increasingly embraced as people better understand what is at stake in end-of-life choices (Landman, 2012:63-64, 66-67). It is an *instruction directive* – a signed document attested by witnesses – with a *very specific focus* in which a competent person instructs medical practitioners and all others to *refrain* from life-sustaining interventions – which may be listed in the document – should they become irreversibly incompetent and thus unable to make their own choices.

In South Africa, the legal status or enforceability of a living will is unclear. This is extremely unsatisfactory, since so many people, often with the assistance of lawyers, draft living wills in good faith but only have a nebulous legal assurance that their wishes, as expressed in their living will, would be honoured.

A case could be made for a living will being implicit or embedded in the National Health Act (RSA, 2003:Sec 7(1)(e)), given the Act's insistence on informed consent as a requirement for medical treatment, even though a living will is not mentioned by name. This is not good enough. A living will should be explicitly legislated and issues surrounding it clarified – such as its purpose and scope, its format and minimum formalities, whether it may in any circumstances be overridden by family or medical practitioners, and whether someone acting in good faith in accordance with it is immune from criminal and civil liability.

Despite its legal hiatus, it would be cynical to disregard a living will's evidentiary value in ascertaining the wishes of an incompetent individual. Medical practitioners ignore a living will at their peril since a strong legal argument can be mustered, on the basis of recognised principles in our law, for taking a living will seriously.

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The SALC report's (RSA, 1998:233-235) proposed draft legislation on advance directives – both "a written power of attorney" (a health care power of attorney) and "a written directive" (living will) – has been shelved for 24 years.

Significantly, the SCA (Stransham-Ford, 2016:Para 32, footnote 30. Emphasis added.) says the following about "a living will or similar document or expression of wishes": "There is however much to be said for the position that *any* such prior instructions clearly expressed *should be heeded*." The SCA then backs this up with reference to legislation in the United Kingdom and the United States of America.

Indeed, several other jurisdictions have living-will legislation. There is no valid reason why we should lag behind (Landman & Henley, 2000). So, in 2018, an initiative by DignitySA and Ms Deidre Carter, MP, of the Congress of the People (Cope), assisted by Parliament's legal team, resulted in a private member's draft bill, the "National Health Amendment Bill" (RSA, 2018). It was an amendment to the National Health Act (RSA, 2003), explicitly recognising and regulating both forms of advance directives. The election of a new parliament and Covid-19 buried this initiative.

In sum, end-of-life choices involve (1) pain management that hastens death, (2) refusal of and refraining from life-sustaining treatment, and (3) advance directives. But in South Africa, lack of an unambiguous legal affirmation and protection of these legitimate medical practices encumber them with ignorance, misunderstanding, fear of legal liability, and even wilful dismissal. This has been an egregious neglect of moral obligation and legal duty by Parliament since 1998.

11.5 ASSISTED DYING : ASSISTED SUICIDE AND VOLUNTARY EUTHANASIA

Assisted dying – the fourth category of end-of-life choices – is a controversial option that evokes strong emotions and heated arguments. It occurs when a competent, terminally ill,[6] and suffering but autonomous person dies with the assistance, help, or aid of another person, at their voluntary request and for their own good. In the circumstances, the person who seeks assistance with dying considers death as desirable and preferable to continued life.

6 It could be argued persuasively that illness need not be terminal, for example, mental illness with competence intact, quadriplegia, or a 'completed' life. Thus, future legislation will have to consider whether terminal illness should be a necessary condition for assisted dying, in the process considering the constitutional equality rights of non-terminal persons, for example, quadriplegics.

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Assisted dying is an umbrella term for assisted suicide and voluntary euthanasia. With *assisted suicide*, the helper supplies the patient with means to commit suicide which the patient then self-administers, resulting in death. With *voluntary euthanasia*, the helper supplies as well as administers the means that leads to the patient's death.[7]

The theoretical debate about the *ethics of* assisted dying, important as it is, is interminable and unlikely to lead to moral consensus (Landman, 1997, 1998, 2022a). The more pressing societal debate, however, concerns the *ethics of decriminalising or legalising* assisted dying, that is, the ethics of public policy (Landman, 2000). It remains an ethical debate, though, since law is ultimately rooted in ethics. Earl Warren (1962), a former American chief justice, put it elegantly: "In civilized society, law floats in a sea of ethics". In South Africa, the Constitution's Bill of Rights (RSA, 1996:Ch 2) is an ethical document setting out the moral values and moral rights upon which we agreed to build a good and just society. So, it is an ethical imperative that our legal position on assisted dying should reflect the Constitution's Bill of Rights.

The unpalatable truth is that two arms of the state – the legislative and judicial – have ethical obligations in respect of decriminalising assisted dying which they have sidestepped for more than a quarter of a century. The Constitution (RSA, 1996) has made it possible – imperative – to re-evaluate the legal status of a range of practices in our society, and thus also our common law, and we have done so: Termination of pregnancy is legal, the death penalty and corporal punishment are illegal, same-sex marriages are legal, and unfair labour practices are illegal.

But assisted dying remains the stepchild. The 'last right' goes unrecognised, thus stripping the 'last rite' of solidarity, compassion, and dignity.

In this legal hiatus, there are nevertheless courageous medical practitioners who assist patients, in the appropriate circumstances, to commit suicide, and some even practise voluntary euthanasia when it is safe to do so. But this remains under the radar, for understandable reasons – it is extremely risky and personal and professional consequences can be dire.

7 Voluntary euthanasia or mercy killing has four main elements – terminal illness (see footnote 6), suffering, competence, and voluntariness. Interpretation of these elements may narrow or widen the definition of assisted dying. From the *perspective of the patient*, euthanasia can be *voluntary* (an expression of the patient's free will), *non-voluntary* (the patient's will is unknown or unknowable), or *involuntary* (contrary to the patient's will but nevertheless judged to be in the patient's interest or for the patient's own good – an option limited to highly unusual and tragic circumstances that can be disregarded in a medical setting). From the *perspective of the helper*, euthanasia can be *active* or *passive* (see footnote 2).

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In sharp contrast are doctors who would do everything medically possible to extend life without informed consent by either patient or surrogate, even in the face of protest by surrogates. They do so for a variety of reasons: Beliefs about what their professional values require, personal understanding of their legal obligations and duties, avoidance of legal liability for medical malpractice, religious convictions, or the pursuit of financial gain.

What exactly is the legal position regarding assisted dying in South Africa (Landman, 2022b)?

11.5.1 Common law and assisted dying

Our common law sets the currently applicable legal norm for assisted dying.

Before the advent of democracy in 1994, Dr Alby Hartmann, a general practitioner from Ceres, was found guilty of murder because he euthanised his octogenerian father who was dying of cancer (Hartmann, 1975).[8] He was sentenced to a year's imprisonment fully suspended from the rising of the court. Clearly, the court, in the person of Judge Louis van Winsen – 47 years ago already – found criminal punishment for merciful or compassionate killing in a medical context inappropriate. Dr Hartmann was, however, punished in his professional capacity and could not practise medicine again despite impassioned pleas by his patients.

The Hartmann case implicitly raised the issue of our common law that regards merciful killing in all conceivable circumstances as murder, effectively indistinguisable from murder with evil intent (*dolus*). After the adoption of the Constitution (RSA, 1996), there was a golden opportunity to review our legal position regarding assisted dying. President Nelson Mandela requested the SALC (RSA, 1998) to investigate all end-of-life decisions. A provisional report, published in 1997, solicited public comments, which were then incorporated in the final report of 1998. The report included a draft bill on all end-of-life choices. Regarding assisted dying, the commission proposed three alternative approaches for consideration. Since 1998, there have only been incidental hints about why the ANC government shelved the SALC report (RSA, 1998).[9]

8 Dr Hartmann's case (he was actually "Hartman") involved non-voluntary euthanasia since his father had not expressed any wish to be assisted with dying before he lost his ability to decide for himself (see footnote 7).

9 According to unconfirmed personal communication with a journalist who interviewed her, former Minister of Health Dr Manto Tshabalala-Msimang referred to assisted dying as "medicine for the rich". One of her successors, Dr Aaron Motsoaledi, said on an eNCA television show, *Judge for yourself* (10 May 2015), moderated by Judge Dennis Davis, that doctors should not kill and that "enough palliative care can help". In short, assistance with dying is claimed to be redundant in our constitutional dispensation.

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In 2015, in the North Gauteng High Court, Judge Hans Fabricius recognised the right of the applicant, Adv Robin Stransham-Ford, to be legally assisted with suicide without the helper attracting criminal or professional liability (Stransham-Ford, 2015). But Stransham-Ford died two hours before Judge Fabricius's ruling.

The Minister of Justice and Correctional Services, the Minister of Health, and others took the case on appeal to the SCA (Stransham-Ford, 2016) and the appeal was upheld in December 2016. As a result, Stransham-Ford could no longer be legally assisted with dying had he not been predeceased.

In 2019, Prof. Sean Davison (2019), co-founder of DignitySA – an NPO seeking to decriminalise assisted dying – was convicted in the Western Cape High Court on three counts of murder for assisting three individuals to commit suicide. He was sentenced to three years house arrest following a plea bargain, having faced a minimum of 14 years imprisonment.

In 2017, Mr Dieter Harck, who suffers from motor neurone disease, brought an action to the South Gauteng High Court. He requests the court to allow him to end his life, with the assistance of a willing doctor, when his disease reaches the inevitable stage where death is preferable to continued life. He argues that assisted dying should not be criminalised or regarded as professional misconduct. In addition, he approaches the court in the public interest to ensure that others would likewise be allowed to seek assistance with dying. In 2021, Harck testified and was cross-examined online due to the Covid-19 pandemic. Harck's case stalled in 2022 and may resume in 2023.

The Stransham-Ford (2016) appeal is the most informative court case on the legal status of assisted dying and related end-of-life choices. Having reaffirmed the legal position that neither suicide nor attempted suicide is an offence (Stransham-Ford, 2016:Para 30), the SCA explicitly addresses assisted dying as an end-of-life choice.

First, *voluntary euthanasia* – also referred to as "mercy killing" by the court – is murder. Informed consent is not a defence available to a person who brings about the death of the deceased (Stransham-Ford, 2016:Para 38). Neither does informed consent justify a guilty verdict on the lesser charge of culpable homicide (Stransham-Ford, 2016:Para 31). Thus, a medical practitioner who administers a lethal agent to a patient at the latter's request commits the crime of murder (Stransham-Ford, 2016:Para 40). The facts of a particular case will determine the sentence (Hartmann, 1975).

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Second, *assisted suicide* raises the question of the criminal liability of the medical practitioner who provides or prescribes the means with which the patient commits suicide. In answer, the SCA argued that in the Grotjohn (1970) case

> […] the court did not decide that a criminal offence is committed *whenever* a person encourages, helps or enables someone to commit suicide or to attempt to do so. Whether they will depend on the facts of the case and issues of intention (mens rea), unlawfulness and causation. It follows that it cannot be said that in the current state of our law PAS [physician-assisted suicide] is in *all* circumstances unlawful. (Stransham-Ford, 2016:Para 54. Emphasis added.)

Thus, it needs to be established, on the basis of the facts in the circumstances of a particular case, whether a helper or encourager is liable for the crime of murder. In particular, a court would have to determine the *causal chain* that led to the death of the patient. For the helper to be found not guilty, the patient's act of suicide (such as voluntarily ingesting a substance) must be *completely independent* of, or *separate* from, the antecedent act of the helper (supplying the substance) (Stransham-Ford, 2016:Para 49). Thus, causation, as one constituent element of a crime, given the specific circumstances of a case, *may* be absent despite the fact that the helper had supplied the means that the patient thereafter self-administered to commit suicide. For example, a medical practitioner prescribes a month's supply of a legal substance for treating an illness and the patient ingests all 30 tablets at once and dies as a consequence.

Our common law regarding assisted dying can therefore be summarised as follows: Assisting suicide (depending on the facts of each case) and voluntary euthanasia (always) are crimes of murder.

11.5.2 The Constitution and assisted dying

But our common law must harmonise with our Constitution (RSA, 1996). Our constitutional rights in all probability embed a right to assisted dying that departs from our common law. There appears to be a formidable and untenable tension that needs to be removed by developing the common law in light of the Constitution's Bill of Rights.

Constitutional rights underpinning the establishment of a right to assisted dying are the rights to (1) dignity (RSA, 1996:Sec 10); (2) freedom and security of the person (RSA, 1996:Sec 12(1)), which includes the right not to be treated or punished in a cruel, inhuman, or degrading way (RSA, 1996:Sec 12(1)(e)); and (3) bodily and psychological integrity (RSA, 1996:Sec 12(2)), which includes

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the right to security of and control over one's body (RSA, 1996:Sec 12(2)(b)). Personal autonomy is the thread that runs through all these constitutional rights.

In addition, assisted dying calls for an interpretation of the right to life (RSA, 1996:Sec 11) that reconciles it with the right to dignity (RSA, 1996:Sec 10). In this regard, Judge Kate O'Regan made some instructive observations in the Constitutional Court (Makwanyane, 1995):

> The right to life incorporates the right to dignity; they are intertwined; the right to life is more than a right to mere existence because it is the right to be treated as a human being and with dignity; without dignity, a human life is substantially diminished; without life, there cannot be dignity.

Thus, recognising the right to life does not entail that preserving merely biological life, irreversibly devoid of quality and dignity, is a constitutional imperative.

Our right to life does not entail a duty to live. We can waive a right. It should be no different with the right to life.

The action by Dieter Harck in the South Gauteng High Court – an initiative by a terminally ill person with *pro bono* legal representation – is currently the only attempt to reconsider our common law. So, the recognition of a constitutional right to assisted dying hinges on a lone private initiative while terminally ill people are denied their constitutional rights to, among others, dignity, freedom and security of the person, and bodily integrity, including control over one's body.

11.5.3 Decriminalising assisted dying: Harmonising the Constitution and common law

What, then, is to be done about current apathy towards constitutional recognition of a right to assisted dying? There are two routes ahead – directly via Parliament or indirectly via the courts. But whichever one we follow, Parliament holds the key to decriminalising assisted dying.

According to the SCA, the proper approach to constitutional litigation in our courts should be followed (Stransham-Ford, 2016:Para 95). A court can only consider the constitutionality of assisted dying once an appropriate case is brought before it. In the Stransham-Ford (2016) appeal case, the SCA found that the North Gauteng High Court (Stransham-Ford, 2015) had erred in respect of both the facts and the law. In future, any party – a terminally ill patient or an organisation like DignitySA – could pursue litigation in the public interest with the benefit of "*full* argument and time to reflect" (Stransham-Ford, 2016:Para 76. Emphasis added.).

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Significantly, the SCA gave future initiatives – as well as the current one by Dieter Harck – a significant boost when it predicted that "[w]hen an appropriate case comes before our courts *the common law will no doubt evolve* in the light of the considerations outlined there and the developments in other countries" (Stransham-Ford, 2016:Para 101. Emphasis added).

Any court considering the decriminalisation of assisted dying will have to pay particular attention to section 39(2) of the Constitution (RSA, 1996), which requires that in the development of the common law the court must strive to give effect to the nature, purport, and objects of the Bill of Rights (Stransham-Ford, 2016:Para 55).

Significantly, the SCA considered the well-known case of Carter (2012) that resulted in decriminalising assisted dying in Canada. The court suggests, in the form of a question, that common law crimes of murder and culpable homicide should be developed, by redefining one or more of their constituent elements to exclude assisted dying, and illustrates how decriminalisation could be achieved:

> Assuming the basis for any judgment was a finding that a constitutionally protected right had been infringed, would the more appropriate remedy be that adopted by the Canadian Supreme Court of a *declaration of incompatibility* [between the common law and the Constitution] *joined with a suspension of the order* [pertaining to a possible future case before the court] *to enable parliament to remedy the deficiency*? (Stransham-Ford, 2016:Para 73. Emphasis added.)

The SCA sees this as an "extremely important possibility" (Stransham-Ford, 2016:Para 73) and it would include "a fair public hearing" (Stransham-Ford, 2016:Para 74), as with parliamentary hearings preceding termination of pregnancy legislation. Development of the common law could be premised on a different view of causation, intention (*mens rea*), or unlawfulness (Stransham-Ford, 2016:Para 56) and may involve a defence of necessity or a defence of consent (Stransham-Ford, 2016:Para 61). In some other jurisdictions, this is exactly what happened. The SCA points out that the possibility of a special defence for medical practitioners and carers would have to be explored (Stransham-Ford, 2016:Para 56).

The SCA regards "the legislature [as] the proper engine for legal development" (Stransham-Ford, 2016:Para 73). A court can only respond to an appropriate case brought before it. And should that happen, the court would probably refer the case to Parliament to enact the necessary legislation. This would respect the separation of powers of the legislature and judiciary. Parliament, not the courts, makes laws. Thus, a court can alert Parliament to inconsistencies in our law and

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impress upon it its duty to remove the tension between our commonm law and Constitution by decriminalising assisted dying.

So, we are at the mercy of that dysfunctional institution of ours – Parliament. There is no effective alternative to putting assisted dying on the agenda of our elected representatives other than via the courts. Civil society has negligible powers of persuasion. The prospects are dim indeed, judging by the past 26 years. Prof. Pieter Carstens (Ho, 2020), a constitutional law expert, states bluntly that our constitutional right to assisted dying faces "the hypocrisy and lack of courage to act by lawmakers and government".

Given this damning critique, could a case be made for a more activist approach by the SCA towards the recognition of a constitutional right to assisted dying? Arguably, in the Stransham-Ford appeal (2016), despite the flaws in the case brought before it from the North Gauteng High Court (Stransham-Ford, 2015), the SCA could have alerted lawmakers to pressing constitutional issues such as compromised autonomy, dignity, and bodily integrity that accompany non-recognition of a constitutional right to assisted dying. The SCA could have pointed out the significant practical obstacles unique to decriminalising assisted dying and that recognition of a constitutional right is left to chance, monetary resources, and political vicissitudes.

Arguably, an appeal to the Constitutional Court against Stransham-Ford (2016) could have yielded a different result, particularly if the Constitutional Court saw its role as more activist. But the losing party (the estate Stransham-Ford), having already received a cost order, lacked the resources to appeal.

Unfortunately, the SCA's references to medical evidence for the alleged effectiveness of treating physical pain are highly problematic, feeding into the pernicious misconception *that palliative care renders assisted dying redundant* (Stransham-Ford, 2016:Paras 35, 88).

Exerting control over and manipulating another's body, wilfully disregarding their autonomous preferences, through palliative sedation and, as a last resort, terminal sedation, means foisting upon them treatment that denies their constitutional rights, among others, to autonomy, dignity, and bodily integrity, including control over one's body. Overriding autonomous preferences in circumstances of end-of-life suffering constitutes a formidable harm. Hence, unwanted and inappropriate palliative care to ease physical suffering cannot make assisted dying redundant. On the contrary, having some control over one's physical and monetary assets after death while being denied control over one's body in life is, at the very least, an indefensible inconsistency.

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It is perverse to make the recognition of a constitutional right to assisted dying dependent on the initiative of a terminally ill person who must *also* be able to access the necessary financial resources, while the state (the ministers who routinely oppose such cases) has endless access to taxpayer-generated legal resources.

It was quite different with termination of pregnancy. A cynic could point out, with some justification, that this discrepancy is attributable to women constituting more than half of all eligible voters while the dying do not constitute a useful voting block. Evidently, for our lawmakers, women's rights weigh heavier than the rights of the terminally ill. Moreover, terminally ill litigants, like Stransham-Ford who died two hours before Judge Fabricius's ruling, cannot reasonably be expected to continue living while the legal process grinds on through several courts.

Assisted dying is a subject about which we gain true understanding only when we or family members wish to opt for a final liberation from intractable and unbearable end-of-life suffering in our own chosen way and not according to the dictates of others. But then it is too late. Still, extensive anecdotal evidence suggests that assisted dying is gaining significant popular support.

11.6 CONCLUSION

End-of-life choices break down into four clusters – pain management that hastens death, refusal of and refraining from life-sustaining treatment, advance directives, and assisted dying as both assisted suicide and voluntary euthanasia. All of these should be clear, legitimate, and accessible end-of-life options for terminally ill persons.

The first three are standard-of-care medical practices that are unconscionably encumbered by legal uncertainty. No wonder that medical practitioners sometimes fail to act in ways that properly recognise patient rights, and that patients and their families do not know their own rights.

And the fourth – assisted dying – constitutes the common-law crime of murder. As such, in all likelihood, it contradicts rights in the Constitution's Bill of Rights, which is an ethical document that sets out the moral values and moral rights upon which we agreed to build a good and just society. So, although assisted dying is on firm ethical ground, what matters in practice is the public-policy ethical imperative to decriminalise or legalise it.

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