"I DON'T KNOW HOW I WANT TO GO BUT I DO KNOW THAT I WANT TO BE THE ONE WHO DECIDES" – THE RIGHT TO DIE – THE HIGH COURT OF SOUTH AFRICA RULES IN

***Robert James Stransham-Ford and Minister of Justice and Correctional Services; The Minister of Health Professional Council of South Africa and the National Director of Public Prosecution* (3 June 2015)**

1 Introduction

The present case concerns the legality of assisted suicide and active euthanasia in South Africa. This particular issue has been a major point of contention, having been debated in South Africa and elsewhere for many years and is generally accepted to be unlawful. In November 1998, the South African Law Commission submitted a report to the then Minister of Health on this issue, entitled "Euthanasia and the Artificial Preservation of Life". At the time of its submission, the country was facing a number of imposing crises, including the HIV/AIDS epidemic. As a consequence of this, this report did not receive the necessary attention of either the Minister of Health or the legislature at the time. Sixteen years have since passed and in the interim South Africa became a democracy (in 1994). A Constitution was promulgated that *inter alia* guarantees fundamental human rights to all persons. However, the *status quo* on euthanasia and assisted suicide has remained unchanged in South Africa.

The advances made in medical science have resulted in patients living longer. For some, the advances in medical technology are welcomed in that they can prolong a meaningful life. For others, however, the prolonging of a poor quality of life is viewed as a burden rather than a benefit.

On an international level the importance placed on the autonomy of the mentally-sound patient's right to refuse any medical treatment that will unnecessarily prolong the agony of such patient, and also, for such a patient to receive assistance in ending his or her life at a point where his or her suffering has become so unbearable, has received more attention (at present there are 11 countries or States which recognise the right to assisted suicide and active euthanasia) ("Euthanasia and Assisted Suicide Laws around the World 2014" www.theguardian.com (accessed 2015-01-

15)). In South Africa, doctors are placed in a situation where they might wish to act in the best interest of the patient under their care, but at the same time there is no clarity as to their legal position and there is uncertainty as to the scope and content of the legal obligation to provide medical care. The basis for this uncertainty will be referred to within this case note. The potential of being exposed to civil claims and criminal prosecution should they decide to withhold life support to the patient or to provide drugs which may shorten the suffering of the patient, notwithstanding the fact that they are acting in accordance with the wishes of the patient, is real. Cases are dealt with on an *ad hoc* basis and with no national policy.

With the dawning of the constitutional era, a consideration and decision on the right of an individual to assisted suicide in light of the principles of the Bill of Rights contained in the Constitution of South Africa is long overdue. For this reason, the present case is of great significance. The matter concerned an urgent application requiring an immediate decision regarding the Applicant's request that a medical practitioner, registered in terms of the Health Professions Act 56 of 1974, terminate or enable the Applicant to terminate his life by the administration or provision of a lethal agent which would enable him to end his life. The application was opposed by the Minister of Justice and Correctional Services, the Minister of Health, the Health Professional Council of South Africa and the National Director of Public Prosecutions.

2 The facts

The Applicant in this matter was a 65-year-old male. He held a number of degrees, and had worked in many countries throughout the world. He had practised as an advocate for 35 years and was admitted as an advocate of the High Court of South Africa in 2001. In February 2013 the Applicant was diagnosed with *Adema carcinoma*, commonly known as prostate cancer. After undergoing an ultrasound in early 2015, it was determined that the cancer had metastasized in his lymph glands. Having suffered great pain, the Applicant had his lymph removed and it became apparent that the cancer had also spread to his lower spine, kidneys and lymph nodes. The Applicant tried various treatments without success. These treatments varied from dendritic cell therapy to traditional Chinese medicine, Vedic medicine, surgery, cannabis, the insertion of a renal stent, the insertion of a catheter fitter, morphine, Buscopan as well as a number of other pain inhibitors.

Since March this year, the applicant's quality of life deteriorated even more, and markedly so. The applicant knew and accepted that he was approaching death and stated in his founding affidavit that he suffered from *inter alia* severe pain, nausea, vomiting, stomach cramps, constipation, and disorientation, loss of weight and appetite, increased blood pressure and weakness and frailty which were related to the metastasis of his kidneys. He was bed-bound and relied heavily on pain medication, morphine in particular. He was reliant on others to perform normal daily activities such as brushing his teeth, and it was clear that his condition would only worsen with time. It is common cause that the Applicant's medical prognosis was dire and that there was no hope of recovery. The Applicant stated in his

Founding Affidavit that he understood and expected that he would become more confused as the disease spread with the prospect of hospitalisation being a reality. The disease was terminal, and relying on the medical diagnosis, the applicant had only a short time to live. This issue was not in dispute.

3 Arguments in support of the Applicant's case/ Applicant's case

According to the applicant, it was not death itself that he feared, but rather the suffering he would have to endure while dying. His medical condition was deteriorating daily. Relying on the provisions of the Constitution and specifically one's basic fundamental human rights as provided for in chapter two of the Bill of Rights the Applicant referred the Court to a number of relevant provisions. These included sections 1, 7, 8, 10, 12, and 39 of the Constitution.

Section 1 provides that

> "the Republic of South Africa is one, sovereign, democratic State founded on the following values:
>
> (a) Human dignity, the achievement of equality and their advancement of human rights and freedoms."

It is well recognised that the recognition and protection of the dignity of an individual is a central value, integral to the aims and objectives of the Constitution (*S v Makwanyane* 1995 (3) SA 391 (CC) par 329; and Ackermann *Human Dignity: Lodestar for Equality in South Africa* (2012), states that "human dignity, besides being a value and a right, is also categorised as imperative").

In addition hereto, section 7 provides:

> "(1) This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom.
>
> (2) The State must respect, protect, promote and fulfil the rights in the Bill of Rights."

It was the wish of the applicant that he be granted the right to terminate his life as alternative care did not satisfy his need and constitutional right to dignity. The applicant emphasised in his affidavit that he wished to die with dignity and personal integrity. It was his desire to be surrounded by loved ones while he was still capable of breathing on his own and being able to speak to and be aware of the presence of loved ones. In short, he wished to die with dignity. Counsel for the Applicant submitted to the Court that there was no dignity in suffering from severe pain throughout one's body, not being fully lucid due to the dulling effects of opiod medication, being unaware of those with you at you time of death, suffering from confusion, being unable to take care of your own hygiene and, potentially dying away from home. Counsel further submitted that by allowing an applicant to determine how he or she responds to a prognosis (such as in the case

before the Court) was to respect, protect, promote and advance an individual's right to subjective dignity and personal integrity and as such was respecting one's constitutional right to dignity.

The Applicant also referred to section 8 of the Constitution which provides that:

> "(3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a Court –
>
> (a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right."

The Applicant opined that palliative care did not satisfy his need and right to die with dignity whilst he was still *compos mentis* at the time of his death. Referring to the Animals Protection Act 71 of 1962, Applicant's Counsel submitted that it was legal (in fact it was an obligation) for the owner of a seriously injured or diseased animal to determine to end the suffering of said animal in their care where prolonging of such animal's life would amount to cruelty. The Applicant therefore questioned the fact as to why the law did not accord a human being the same dignity. There is evidence in foreign law that in the instance of on-going potential sustaining treatment, the patient has the choice to determine his or her own time of death.

The Applicant contended that the law needed to be developed on this particular matter and referred the Court to section 39 of the Constitution which provides:

> "(1) When interpreting the Bill of Rights, a Court, Tribunal or Forum –
>
> (a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
>
> (b) must consider International Law; and,
>
> (c) may consider foreign law.
>
> (2) When interpreting any legislation, and when developing the common or customary law, every Court, tribunal or forum *must* promote the spirit, purport and the objects of the Bill of Rights" (authors' own emphasis).

Referring to the judgment of the Constitutional Court in *Bel Porto School Governing Body v Premier Western Cape* (2002 (3) SA 265 CC 324) the Court noted that, when interpreting which remedy would be most appropriate to a particular issue, the remedies available are open-ended; in fact an open-ended list, the appropriateness of a which in a specific case is to be determined in a flexible and *ad hoc* manner. Given the supremacy of the Constitution it is therefore clear that this directive is a constitutional imperative, and the appropriateness is to be determined with this in mind.

With respect to the right to one's human dignity, the applicant relied on the provisions contained in section 10 of the Constitution which provides that "everyone has inherent dignity and the right to have their dignity respected and protected".

As far as the protection of one's right to freedom and security of the person is concerned, the Applicant referred the Court to section 12 which provides as follows:

"(1) Everyone has the right to freedom and security of the person, which includes the right –

(e) not to be treated or punished in a cruel, inhuman or degrading way.

(2) Everyone has the right to bodily and psychological integrity, which includes the right –

(b) to security in and control over their body."

The importance of the recognition and protection on one's dignity cannot be overemphasised. In the decision of *S v Makwanyane* (1995 (3) SA 391 (CC) par 329), the Court referred to one's dignity as the "touchstone of the new political order" and further that such recognition and protection is "fundamental to the new Constitution".

The order sought by the Applicant and which was before the Court was as follows:

(a) A declaration that the Applicant may request a medical practitioner, registered as such in terms of the Health Professions Act 56 of 1974, to end his life or to enable him to end his life by the administration or provision of some or other legal agent;

(b) A declaration that the medical practitioner who administers or provides some or other lethal agent to the Applicant, as contemplated above, shall not be held accountable and shall be free from any civil, criminal or disciplinary liability that may otherwise have arisen from:

(i) The administration or provision of some or other lethal agent to the Applicant;

(ii) The cessation of the Applicant's life as a result of the administration or provision of some or other lethal agent to the Applicant;

(c) To the extent required developing the common law, by declaring the conduct in prayers (a) and (b) above, lawful and constitutional in the circumstances in the matter before the Court.

In considering the Applicant's request, the Court had to answer the following questions:

(1) Is it conceivable that an individual's health could deteriorate to the extent that it would be deemed justifiable that such person could wish to end its life?

(2) Could such individual be legally permitted to end his life?

(3) Could a third party assist such person in ending his life?

(4) Could such third party be a medical practitioner?

(5) What safeguards need to be put in place so that no one could be held liable in any way for assisting such person in ending his life?

Considering the legal issue before him, Fabricius J, referred to the fact that a decision reliant on a legislative provision would have been preferable to the position in which he found himself, namely, that the matter on hand now stood to be determined in the absence of any legislative guidance.

4 Arguments in support of the respondents' case

The Health Professional Council of South Africa (as Third Respondent) obtained a medical report from one Dr De Muelenaere, who has practised as an oncologist for 26 years. Dr De Muelenaere stated that while he had sympathy for a patient in the condition of Mr Stransham-Ford, and that it was understandable that he might request the "easy way out", there are important moral, legal and ethical factors that ought to be addressed before a determination whether to grant the application in question could be made. Furthermore, consideration needs to be had to the alternatives to assisted suicide. These included palliative medical treatment which could improve the situation for the patient over a period of time. ("Palliative care" means the treatment and care of a terminally-ill patient with the object of relieving physical, emotional and psycho-social suffering and of maintaining personal hygiene.) Given the advances in the medical field, it has been suggested that most cancer patients die pain-free. Medical and other staff members at Hospice provided excellent in-house and home care for those who are terminally ill and the majority of medical-aid funds fund home nursing. Dr De Muelenaere concluded that he was of the opinion that assisted suicide was against current medical practice in South Africa. This approach is supported by the current legal position in South Africa, where in terms of the law, assisted suicide and active voluntary euthanasia are deemed thus unlawful (*S v Bellocq* 1975 (3) SA 538 (T) 538; *S v Marengo* 1991 2 SACR 43 (W) 47A–B; and finally *Ex Parte Minister of Justice: In re Grotjohn* 1970 (2) SA 355 (A)). Prior to the hearing of this application, the Court admitted Doctors for Life International and Cause for Justice as *amici curiae* and received affidavits from each. All arguments were considered, notwithstanding that certain arguments were inappropriate or paid little attention to the imperative provision of section 8(3) of the Bill of Rights. One of the arguments submitted by Cause for Justice was that the Applicant had only expressed his subjective view of human dignity and his medical condition. It was submitted that the question of dignity and the values of the Constitution ought to be determined objectively. Dr S Fourie on behalf of Doctors for Life International opined that "[a]ll those patients who die every year from advanced prostate cancer have similar symptoms and clinical situations as the Applicant".

It was further put to the Court by the Respondents that granting the Applicant's request for assisted suicide would result in an uncontrolled "ripple effect" and that the development of the common law on this matter would leave a void which would inevitably lead to abuse.

5 The decision

The Court *per* Fabricius J, decided the issue by stating the Applicant was a mentally competent adult who had freely and of his own accord, without any undue influence, approached the Court to attain legal authorisation in the act of assisted suicide. The applicant was terminally ill and his life was severely curtailed with an expectancy of a few weeks of life left. In light hereof, the Court held that the Applicant was entitled to be assisted by a willing and

qualified medical practitioner, to bring his life to an end. This could be achieved by either providing the Applicant with the necessary lethal medical agent to do so, or alternatively, the medical practitioner would administer the lethal agent himself. The Court held that no medical practitioner could be obliged to administer the lethal agent, and that the consent and willingness of the medical practitioner was integral to the decision and act. Where such medical practitioner acceded to assist with the suicide, such practitioner would in no way be subject to prosecution by the National Director of Public Prosecutions, nor would he be subject to disciplinary proceedings by the Health Professional Council of South Africa, and the act of the doctor shall not be considered unlawful.

The Court granted cancer patient and advocate Robin Stransham-Ford his request for a suicide under medical administration. The Court, however, said the order is only applicable to Stransham-Ford and will not automatically apply to every case. Each case should be decided on its own merits, and safeguards need to be put in place to protect the weak and vulnerable against improper application of the right to active euthanasia. The Court accepted that the Applicant was terminally ill with no foreseeable prospect of a cure. The Applicant was suffering and had requested that the Court condone his application to be granted the right to have a qualified medical doctor assist him in terminating his life by either the administration of a lethal agent, or in the alternative that he be provided with the necessary lethal agent which he could administer himself.

The Court expressly noted that any decision it made in no way had the effect that the draft "Bill on the End of Life" as contained in the report submitted by the South African Law Commission in 1998, was endorsed. In referring to the common-law crimes of murder and culpable homicide with respect specifically to assisted suicide, the Court stated that the absolute prohibition thereof resulted in and unjustifiably limited the Applicant's constitutional rights to human dignity and freedom to bodily and psychological integrity.

In its consideration, the Court considered the matter before it on the basis that the recognition and protection on one's dignity is not only a value and right provided for in terms of section 10 of the Constitution, but that it is also a "categorical imperative" of the Constitution. Human dignity has a wide meaning which covers a number of values (Currie and De Waal *Bill of Rights Handbook* 6ed (2013) 250), and when considering the value thereof, one must consider the "inherent human worth" of an individual (Ackermann *Human Dignity* 97). Given the medical condition and prognosis of the Applicant, the Court held that the complaint of the Applicant in light of his right to dignity was justifiable. The Court held the right of a patient who is facing death to die with dignity, is consistent with the values of an open and democratic society, and that a duty has been vested in the courts to interpret and uphold the provisions contained in the Constitution. The link between one's right to human dignity, privacy and freedom is so closely connected that the Court held that the Applicant was correct in relying on the inter-relationship between these rights. Individuals are recipients of such rights, not merely objects of statutory mechanisms, and it is in light hereof that the

Court looked at the Applicant's innate right to freedom and physical integrity, from which other rights, *inter alia* the right to bodily integrity, flow. The significance of one's human dignity is such that in fact it can be considered as a value that informs the interpretation of all other fundamental human rights (*Advance Mining Hydraulics (Pty) Ltd v Botes NO* 2000 (1) SA 815 TPD 823). The importance hereof is evident in sections. The Court confirmed the approach of O'Regan J, in *Makwanyane*, where the Court opined that the right to life – which is more than the mere right to existence but as envisaged in our Constitution, incorporates the right to experience humanity – which in turn is intertwined with the right to dignity. Where one does not have dignity, the right to life is substantially diminished (O'Regan J in *Makwanyane supra* stated that "without life, there cannot be dignity").

Referring to Carstens and Pearmain (*Foundational Principles of Medical Law* (2007) 210) the Court accepted that the underlying values, spirit and purport of the Constitution favour the introduction of voluntary active euthanasia in South Africa with the *proviso* that strict regulation of monitoring of such act be essential.

6 Comments

There is little doubt that the decision of Fabricius J, has far-reaching consequences for South African law. For some, such as Dignity SA, the decision is seen as a welcomed development in the law, as it "addresses a serious human-rights issue". For others, such as the National Prosecuting Authority, this decision has been viewed as an opening of the door to possible abuse without any legal ramifications. It is for this reason that in the opening remarks of his judgment, Fabricius J, states that the issue of assisted suicide is one which deserves broad discussion and which should in time be referred to the Constitutional Court.

As humans, we value our independence and freedom of choice. For this reason it can be said that humans fear dependence on others. "We want to write our own script and determine our own exit". We do not want to suffer the ultimate humiliation of total helplessness (Stott *Issues Facing Christians Today* 4ed (2006) 412). In the case above, the Applicant submitted that active voluntary euthanasia should be legalised in South Africa. This was also the recommendation of the South African Law Commission as reflected in its 1998 report entitled Euthanasia and the Artificial Preservation of Life. The Court ultimately agreed that while a person has the right to life, they also have the right to die with dignity.

6 1 The right to life v the right to die

The right to life is entrenched in section 11 of the Constitution of the Republic of South Africa, 1996. It is the right to life itself that is entrenched in section 11 and not the obligation to live.

The right to life was, however, not included in the Constitution merely to acknowledge one's right to exist. As O' Regan J, submitted in the landmark case of *Makwanyane* (*supra* par 325), the right to life is more than an

existence, it is the right to be treated with dignity and to live a life worth living.

Dying is a part of life (*Cruzan v Director, Missouri Department of Health* 497 US 261 (1990) 343). A dying person is, however, still a living person and is entitled to the rights of a living person, including dignity, bodily integrity and autonomy.

It follows then, as was submitted by the Applicant, that one also has the right to die with dignity and that the Court is obliged to advance, respect, protect and promote this right in accordance with sections 1, 7 and 8 of the Constitution. Furthermore, no one has the duty to live and can waive his or her right to life.

According to current law, a person may not be actively killed by a medical practitioner, but it is permissible for life sustaining treatment to be withdrawn even if this could ultimately result in the death of the patient (Currie and De Waal *Bill of Rights Handbook* 267). It has been argued however, that there is no difference between assisted suicide, where the patient is provided with a lethal agent or drug, or switching off a life-support machine (*Clarke v Hurst NO* 1992 (4) SA 630 (D)). In other words, there is no logical ethical distinction between withdrawing treatment and physician-assisted death.

Greater value has been attached to patient autonomy and dignity in recent years. As such, many countries, including South Africa, have identified the need to respect and protect a patient's decision to either refuse medical treatment or receive assistance to end their life.

While the need to respect patient autonomy has been acknowledged in South Africa, there is presently no legislation advising what procedure a patient is to follow when wanting to end his/her life (with assistance). Further compounding this problem, is the fact that the judgment of Fabricius J, was and is only applicable to the case of *Stransham-Ford*. No precedent was established by this judgment regarding the procedure to be followed in future cases except that each case must be decided on its own merits. It must therefore be assumed that until legislation is drafted and adopted, any person wishing to end his/her life, either by way of assisted suicide or voluntary active euthanasia, will need to bring an application in the High Court and ultimately allow the Court to decide whether to permit or refuse the request to die.

By restricting applications of this nature to the High Court, it has been suggested that the country's "poorer population's" constitutional right of access to the courts will be limited and thus infringed upon (as argued by the First Respondent). To prevent any discrimination against the poor and to reduce the number of applications being brought in the High Court, Professor Labuschagne of the University of Pretoria has proposed that any patient wanting to end his/her life by way of assisted suicide or active voluntary euthanasia should first meet the following criteria:

1. The patient must be suffering from a terminal disease or illness;
2. the suffering must be subjectively unbearable;

3. the patient must consent to the cessation of treatment or administering of euthanasia and
4. the above medical condition and facts must be certified by at least two medical practitioners.

Once it has been established that the patient is suffering from a terminal illness and wants to end his/her life, the High Court can then be approached to grant a declaratory order.

While many countries recognise the right to dignity and bodily autonomy, the acts of assisted suicide and euthanasia are still largely considered to be illegal. It is no different in the Netherlands (Dutch Penal Code Articles 293 and 294). However, as a result of various Dutch court cases, any medical practitioner acceding to a patient's request for help to die (in the Netherlands) will not be prosecuted, provided that the euthanasia or assisted suicide death is reported to the local prosecutor. The prosecutor must be satisfied that the patient on more than one occasion requested assistance to die, was in unbearable pain and that there was no alternative medical treatment available in order to avoid prosecution (Rotterdam court guidelines 1981). It can therefore be inferred that a terminally ill patient is not required to bring a court application in order to die with assistance. It is imperative to note that exemption from prosecution is only applicable to a medical practitioner and that any other person legitimately assisting a patient to die will be guilty of murder and subject to prosecution.

By comparison, in Canada both passive euthanasia and assisted suicide are legal, but active euthanasia remains unlawful and is deemed to be murder. Active euthanasia is the intentional killing of a person to relieve his or her pain whereas passive euthanasia is the withholding or withdrawing of life-preserving procedures. In the recent case of *Carter v Canada* (AG) (February 2015), the Supreme Court of Canada struck down the provisions prohibiting doctor-assisted suicide.

6 2 The artificial preservation of life where the patient is dead

In terms of South African law, a person is deemed to be clinically dead when there is an irreversible loss of spontaneous circulatory and respiratory functions or with irreversible brainstem death. Consensus has, however, never been reached in medical science as to precisely determining when the moment of death sets in.

6 2 1 When is it lawful to cease treatment?

At present, to disconnect the life-sustaining system of a patient who is clinically dead is not viewed as the cause of the patient's death. In other words, the disconnection of a respirator cannot be viewed as causing death, but rather the termination of a fruitless attempt at saving a person's life (*S v Williams* 1986 4 SA 1188 (A)). Death will have occurred at the time that the patient's relevant body functions has ceased. Any medical practitioner who

is convinced that a patient is clinically dead (in accordance with the relevant medically proscribed tests) and disconnects a respirator cannot be said to have acted unlawfully, and his actions cannot be viewed as mercy killing or euthanasia.

The discontinuation of life support where a patient is clinically dead therefore does not amount to assisted suicide or voluntary active euthanasia for purposes of the law.

6 3 Where the patient is competent to make a decision

6 3 1 Cessation of life-sustaining medical treatment and refusal of treatment

South African law recognises that a patient with the requisite mental capacity has the right to refuse medical treatment. This right of refusal can be directly linked to a person's right to bodily integrity and autonomy as guaranteed in the Constitution (s 12(2)). It is, however, a prerequisite that the patient be informed of the consequences of their decision to refuse medical treatment. In other words, the patient should be informed that his/her refusal, alternatively, discontinuation of medical treatment could hasten the moment of death.

In terms of section 129(2)(a) and (b) of the Children's Act 38 of 2005, children over the age of twelve and who have sufficient maturity and mental capacity to understand the benefits, risks and other implications of medical treatment, are entitled to consent to treatment without parental consent. It can therefore be argued that it would also be permissible for a child who meets the requirements of section 129(2)(a) and (b) of the Children's Act to refuse or discontinue medical treatment.

It is recommended that any medical practitioner who has a patient refusing or requesting the discontinuation of medical treatment should have the patient's diagnosis confirmed by another medical practitioner who is not directly involved in the treatment of the patient concerned, whereafter their findings regarding the condition of the patient are recorded in writing (South African Law Commission *Euthanasia and the Artificial Preservation of Life* Project 86 Discussion Paper 71 (1997) 23).

Any doctor or medical practitioner complying with the patient's request, and discontinuing medical treatment, cannot therefore not be seen to be acting unlawfully or *contra bonos mores* and should not be found liable where such action did have the effect of hastening death.

6 3 2 Assisted suicide and voluntary active euthanasia

The current position in South African law is that any person found assisting another person in the act of suicide is guilty of murder (see the cases of *R v Peverett* 1940 AD 213; *R v Nbakwa* 1956 (2) SA 557 (SR); and *S v Gordon* 1962 (4) SA 727 (N)). Several countries like Australia, Britain, Canada and the Netherlands have similar laws criminalising assisted suicide. However, in

the Netherlands, the Court has recognised the defence of necessity as justification for a medical practitioner's actions in cases of assisted suicide (see the *Alkmaar* case (NJ) 1958). "Necessity" refers to a patient's unbearable situation which induces the doctor to disregard the law (for a "higher good"). To rely on the defence of necessity, a doctor would need to prove the request for euthanasia came from the patient and that it was not forced. It must also be proved that the patient was suffering greatly and that there was no prospect of recovery. Furthermore, it must be proved that a second medical practitioner was consulted on the matter, and it was agreed that there was no possibility of recovering (Borst-Eilers "The Status of Physician Administered Active Euthanasia in the Netherlands", paper delivered at the Second International Conference on Health, Law and Ethics, London, July 1989).

Until the *Stransham-Ford* judgment, voluntary active euthanasia was unlawful in South Africa and any person assisting in the act of euthanasia could be convicted of murder (*S v Marengo supra*; and *S v Smorenburg* CPD June 1992 (unreported judgment)).

It is submitted that the current legal position prohibiting assisted suicide or voluntary active euthanasia was established during the pre-constitutional era in South Africa. The decision of Fabricius J, in the above case, can therefore be viewed as one that is keeping with the post-constitutional era, which requires the development of law to give effect to constitutional rights. Furthermore, as the authors Carstens and Permain submit, the underlying values of the Constitution support the introduction of voluntary active euthanasia in South Africa (Carstens and Permain *Foundational Principles of Medical Law* 210). The Australian Rights of the Terminally Ill Act (now overturned) provides a respectable frame of reference for the South African legislature to follow in developing the law.

6 3 3 Involuntary euthanasia

Involuntary euthanasia involves the death of a legally competent person at the hands of another. Unlike voluntary euthanasia, no request has been made by a patient for assistance to die. This is an abuse of power (in the medical field) and constitutes murder. As such, it can be said that no legal system would readily tolerate this type of conduct.

6 4 Where the patient is incompetent and has no prospect of recovery or improvement

Patients in a permanently comatose or vegetative state (as a result of a stroke, drowning or brain damage as a result of an accident) and for whom no hope of recovery or improvement exists, lack the necessary mental capacity to make decisions regarding their health and treatment. These patients are not brain dead but are in an irreversibly, unconscious state and are unable to request the cessation of medical treatment or ask for assistance to die. However, it may be that prior to becoming incompetent

such a patient signed an “advance directive” wherein he or she left directives and instructions regarding future medical treatment.

6 4 1 Cessation of treatment

An advance directive or living will is drafted by a patient while he/she still have the necessary mental competency to do so. In this directive, a patient may refuse any medical treatment which may be used to keep him/her alive artificially or authorise the administering of drugs which may hasten death. The object of this document is to provide a medical practitioner with guidelines as to how a patient is to be treated. It further absolves the practitioner from any criminal liability should he or she not administer drugs or withhold treatment which results in the death of the patient.

Although an advance directive is not a will, it can and should be viewed as a legitimate refusal of consent to treatment, and medical practitioners are obliged to comply with it (Strauss *Doctor, Patient and the Law* 3ed (1991) 344). Strauss is of the view that medical practitioners who refuse to comply with an advance directive could be held liable for failing to execute the wishes of the patient.

In the event that an advance directive has not been made and the patient is not mentally competent to make a decision, it must be asked whether life-sustaining treatment must be given indefinitely. The current legal position is that active euthanasia is unlawful, but cessation of treatment may be permissible under specific circumstances and subject to certain conditions. Life-sustaining treatment may therefore be withdrawn, where there is no prospect of the patient’s regaining consciousness or responding to treatment (*Clarke v Hurst NO supra*).

6 5 Need for legislation

The decision of Fabricius J, has been referred to as a brave, remarkable legal precedent, which was long overdue (Ganesh “Right-to-die Ruling Long Overdue” letter to the Editor 10 May 2015 *Sunday Times*). In light of this monumental decision, there is now, more than ever before, a need for legislation to be drafted which clearly regulates voluntary assisted euthanasia. Furthermore, the Hippocratic Oath, which all medical practitioners are bound by and which demands that they “neither prescribe nor administer a lethal dose of medicine to any patient even if asked …” needs to be reconsidered and amended.

The South African Law Commission’s proposed Draft Bill undeniably provides the legislature with a strong foundation on which to build and implement legislation regulating end-of-life decisions.

7 Conclusion

The Court conceded that the Applicant could choose to have an assisted death, without the threat of legal action against the doctor involved. In making such an order, the Court not only recognised and promoted the

Applicant's right to dignity (both to live and die with dignity) and bodily integrity but also fulfilled its constitutional mandate to develop the common law as required by section 39(2) of the Constitution.

The decision of Fabricius J, has been received with mixed emotions. While many in society believe that this has opened the door to abuse and created a void in the law, others have welcomed the decision. To acknowledge the varying opinions of society, the general public should be afforded the opportunity to submit comments on this topic to Government.

Even within the legal field, academics and lawyers alike are at either end of the spectrum over the decision. Prof Dan Ncayiyana believes that euthanasia should only be implemented in a secure environment. However, he does not believe that South Africa provides a secure environment for euthanasia as the country "lacks an ethos of respect for human life". Prof David McQuoid-Mason pointed out, however, that "Fabricius's ruling was careful not to make itself a general rule. It's not a blanket licence".

Since this ruling, at least three other people have approached Dignity SA to assist with similar applications. In time we shall undoubtedly see more terminally ill patients making application to the Court for an order to die.

More than a decade has passed since the South African Law Commission submitted its report on this issue, and South Africa can no longer ignore assisted suicide and euthanasia. There is now more than ever a need for legislation to be drafted, where the draft Bill, as provided by the South African Law Commission, provides a strong foundation on which to build.

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