

SOUTH AFRICAN LAW COMMISSION

DISCUSSION PAPER 71

Project 86

**EUTHANASIA AND THE ARTIFICIAL
PRESERVATION OF LIFE**

Closing date for comments:

30 June 1997

ISBN: 0-621-17724-5

INTRODUCTION

The South African Law Commission was established by the South African Law Commission Act, 1973 (Act 19 of 1973).

The members of the Commission are -

The Honourable Mr Justice I Mahomed (Chairperson)

The Honourable Mr Justice P J J Olivier (Vice-Chairperson)

The Honourable Madam Justice Y Mokgoro

Prof R T Nhlapo

Adv J J Gauntlett SC

Mr P Mojapelo

Ms Z Seedat

The Secretary is Mr W Henegan. The Commission's offices are on the 8th floor, 228 Visagie Street, Pretoria. Correspondence should be addressed to:

The Secretary
South African Law Commission
Private Bag X668
PRETORIA
0001

Telephone: (012) 322-6440

Telefax: (012) 320-0936

E-mail: salawcom@cis.co.za

URL: <http://www.law.wits.ac.za/salc/salc.html>

PREFACE

This Discussion Paper (which reflects information accumulated up to the end of January 1997) has been prepared to elicit responses and to serve as a basis for the Commission's deliberations, taking into account any responses received. The views, conclusions and recommendations in this paper are accordingly not to be regarded as the Commission's final views. The paper is published in full so as to provide persons and bodies wishing to comment or to make suggestions relating to the reform of this particular branch of the law with sufficient background information to enable them to place focused submissions before the Commission.

For the convenience of the reader a summary of issues discussed and requests for comment appear on the next page.

The Commission will assume that respondents agree to the Commission quoting from or referring to comments and attributing comments to respondents, unless representations are marked confidential. Respondents should be aware that the Commission may in any event be required to release information contained in representations under the Constitution of the Republic of South Africa, Act 108 of 1996.

Respondents are requested to submit **written** comments, representations or requests to the Commission by 30 June 1997 at the address appearing on the previous page. The researcher will endeavour to assist you with particular difficulties you may have. Comment already forwarded to the Commission should not be repeated; in such event respondents should merely indicate that they abide by their previous comment, if this is the position.

The researcher allocated to this project, who may be contacted for further information, is Mrs AM Louw. The project leader responsible for the project is the Honourable Mr Justice P J J Olivier.

SUMMARY

The advances made in medical science and especially the application of medical technology have resulted in patients living longer. For many patients this signifies a welcome prolongation of meaningful life, but for others the result is a poor quality of life which inevitably raises the question whether treatment is a benefit or a burden.

At present the position in our law is that the termination of a person's life is unlawful, even if the motive for such conduct is to end the person's unbearable suffering, and this is the case even where the suffering person has expressed the wish to die or has even begged to be killed.

In most Western countries increased importance is, however, being attached to patient autonomy. The need has therefore arisen to consider the protection of a mentally competent, but terminally ill patient's right to refuse medical treatment and to receive assistance, should he or she so require, in ending his or her unbearable suffering, by the administering or supplying of a lethal substance to the patient. The position of the incompetent patient, as well as the patient who is clinically dead, has to be clarified as well.

The Commission is consequently considering proposals for possible law reform with regard to the following matters:

- * The circumstances in which it would be lawful for a medical practitioner to cease or authorise the cessation of all further life-sustaining treatment of a patient whose life functions are being maintained artificially while the person has no spontaneous respiratory and circulatory functions or his or her brainstem does not register any impulse.

- * The right of a mentally competent person to refuse any life-sustaining treatment with regard to any specific illness from which he or she may be suffering, even though such refusal may cause the death or hasten the death of such a person.

- * The right of a medical practitioner responsible for the treatment of a terminally ill patient to alleviate pain and distress in accordance with responsible medical practice, by increasing the dosage of medication to be given to the patient, with the object of relieving the pain and distress of the patient and with no intention to kill, even if the secondary effect of this action may be to shorten the patient's life.
- * Whether it would be lawful for a medical practitioner to give effect to the well-informed considered request of a terminally ill, but mentally competent, patient to make an end to the patient's unbearable suffering or to enable the patient to make an end to his or her unbearable suffering by administering or providing a lethal agent.
- * The recognition of a written directive regarding the cessation of medical treatment in cases of terminal illness.
- * Recognition of a power of attorney authorising a person to make decisions concerning the medical treatment of the principal in the event of his terminal illness. The continuing validity of a power of attorney after the principal has become mentally incompetent.
- * Those instances in which the chief medical practitioner of a hospital or clinic may, in the absence of a directive of the patient or his agent decide to discontinue the treatment of the terminally ill patient.
- * The circumstances in which a court may order the cessation of medical treatment or the performance of any medical procedure which would have the effect of terminating a patient's life.

For the purposes of focussing attention on the various problem areas and to elicit discussion and debate, a draft bill, not necessarily reflecting the views of the Commission, is published for comment.

CONTENTS	PAGE
INTRODUCTION	(iii)
PREFACE	(v)
SUMMARY	(vii)
LIST OF SOURCES	(xii)
TABLE OF CASES	(xviii)
CHAPTER 1	1
Origin of the investigation	1
CHAPTER 2	4
The artificial preservation of life where the patient is clinically dead	4
CHAPTER 3	10
Cases where the patient is competent to make decisions.	10
(i) Cessation of life-sustaining medical treatment	12
(ii) Assisted suicide	20

(iii)	Voluntary active euthanasia	28
(iv)	Involuntary active euthanasia	48
CHAPTER 4		49
	The incompetent patient who has no prospect of recovery or improvement	49
(i)	Cessation of life-sustaining medical treatment	50
A)	There is an advance directive (living will) or power of attorney	50
(a)	Comparative law	52
*USA		52
*Australia		55
*Canada		61
Alberta		61
Saskatchewan		63
Newfoundland		64
Manitoba		68
*United Kingdom		69
(b)	The legal position in South Africa	71
(c)	Conclusion	73
B)	There is no advance directive (living will) or	78

	power of attorney	
	(a) Comparative law	79
	*USA	79
	*United Kingdom	82
87	(b) The position in South Africa	
	(c) Conclusion	89
92	(ii) Involuntary active euthanasia	
CHAPTER 5		95
	A draft bill on the rights of the terminally ill	95
ANNEXURE A		96

LIST OF SOURCES

Alberta Law Reform Institute **Advance directives and substitute decision-making in personal health care**_ Report for discussion No 11 November 1991.

Alberta Law Reform Institute and The Health Law Institute **_Advance directives and substitute decision-making in personal health care** Joint Report No 64 March 1993.

Australian Medical Association media release March 25 1997.

Barnard, C N "A human cardiac transplant: an interim report of a successful operation performed at Groote Schuur Hospital, Cape Town" 1967 **S A Medical Journal** 1271.

Benatar, S R "Dying and 'euthanasia'" 1992 **SA Medical Journal** 35.

Bix, B "Physician assisted suicide and the United States Constitution" 1995 **Modern Law Review** 404.

Boister, N " Causation at the death" 1993 **THRHR** 516.

British House of Lords **Report of the Select Committee on medical ethics**_ 31 January 1994.

British Medical Association **_Treatment of patients in persistent vegetative state** September 1992.

Burrows, R "Removal of life support in intensive care units" 1994 **Medicine and Law** 489.

De Klerk, A "Transplantation of human tissue and organs in South African law" 1992 **TRW** 112.

Departement van Justisie en Welzijn, Volkgezondheid & Cultuur **Gezamenlijk persbericht** No 2775 11 August 1993.

Dorfling, D__F **"Genadedood" in die strafreg - 'n regsfilosofiese en regsvergelykende perspektief** (unpublished thesis submitted in partial fulfilment of the degree Magister Legum) Faculty of Law, Rand Afrikaans University 1991.

Dörfling, D F "Eutanasie: die reg van die **curator personae** om verdere behandeling van 'n pasiënt te verbied - 'n nuwe regverdigingsgrond in die Suid-Afrikaanse reg" 1993 **TSAR** 345.

Doyle, D, Harris G & Mac Donald N (eds) **Oxford textbook of palliative medicine** London Oxford University Press 1993.

Dreyer, L "Redelike dokter versus redelike pasiënt" 1995 **THRHR** 532.

Dworkin, R **Life's dominium: an argument about abortion and euthanasia** London Harper Collins 1993.

Dyer, C (ed) **Doctors, patients and the law** Oxford Blackwell 1992.

Earle, M "'Informed consent': is there room for the reasonable patient in South African law?" 1995 **SALJ** 629.

Eekelaar, J "White coats or flak jackets? Doctors, children and the courts - again" 1993 **Law Quarterly Review** 182.

Finnis, J M "**Bland**: Crossing at the Rubicon?" 1993 **Law Quarterly Review** 329.

Griffiths, J "Assisted suicide in the Netherlands: the **Chabot** case" 1995 **Modern Law Review** 232.

Griffiths, J "Assisted suicide in the Netherlands: postscript to **Chabot**" 1995 **Modern Law Review** 895.

Hu, P "The acceptability of active euthanasia in China" 1993 **Medicine and Law** 47.

Hunt, T M A & Milton, J R L **South African criminal law and procedure Vol 2** 2nd edition Cape Town Juta 1982.

Kapp, MB "'Ageism' and right to die litigation" 1994 **Medicine and Law** 69.

Kennedy, I & Grubb, A **Medical law: text and materials** London Butterworths 1989.

Keown, J "The law and practice of euthanasia in the Netherlands" 1992 **The Law Quarterly Review** 51.

Keown, J "Physician assisted suicide and the Dutch Supreme Court" 1995 **Law Quarterly Review** 394.

Labuschagne, J M T "Dekriminalisasie van eutanase" 1988 **THRHR** 167.

Labuschagné, J M T " Aktiewe eutanase en professionele hulpverlening by selfdoding van 'n psigiatrisiese pasiënt" 1995 **SALJ** 227.

Law Commission **Mentally incapacitated adults and decision making: an overview** Consultation Paper No.119 London HMSO 1991.

Law Commission **Mentally incapacitated adults and decisionmaking: a new jurisdiction** Consultation Paper No 128 London HMSO 1993.

Law Reform Commission of Canada **_Report on euthanasia, aiding suicide and cessation of treatment** 1983.

Law Reform Commission of Saskatchewan **Proposals for an advance health care directives act** December 1991.

Law Reform Commission of Western Australia **Report on medical treatment for the dying** 1991.

Leenen, H J J "The definition of euthanasia" 1984 **Medicine and Law** 333.

Leenen, H J J "Supreme Court's decisions on euthanasia in the Netherlands" 1986 **Medicine and Law** 349.

Leenen, H J J "Dying with dignity: developments in the field of euthanasia in the Netherlands" 1989 **Medicine and Law** 517.

Leonard-Taitz, J "Euthanasia, the right to die and the law in South Africa" 1992 **Medicine and Law** 597.

Lowe, N & Juss, S "Medical treatment - pragmatism and the search for principle" 1993 **Modern Law Review** 865.

Lupton, M L "**Clarke v Hurst NO, Brain NO & Attorney-general, Natal**" 1992 **SACJ** 342.

Manitoba Law Reform Commission **Report on self-determination in health care (living wills and health care proxies)** Report No 74 1991.

Mason, J K & McCall Smith, R A **Law and medical ethics** 3rd edition London Butterworths, 1991.

Ministry of Justice, the Netherlands **Newsletter** February 1993.

Newfoundland Law Reform Commission **Advance health care directives and attorneys for health care** Discussion Paper No 6 1992.

Plachta, M “The right to die in Canadian legislation, case law and legal doctrine” 1994 **Medicine and law** 639.

Pozgar, G D **Legal aspects of health care administration** 4th edition Maryland Aspen Publishers 1990.

Pretoria News, 7 January 1997, 7.

Roberts, S E “When not to prolong life” 1990 **Law Quarterly Review** 218.

Rougé, D Telmon, N, Albarède, J-L & Arbus, L “Questions raised by artificial prolongation of life of the aged patient” 1994 **Medicine and law** 269.

Roy Morgan Gallup Research Report February 18, 1997.

Stern, K “Competence to refuse life sustaining medical treatment” 1994 **Law Quarterly Review** 541.

Strauss, S A **Doctor, patient and the law** 3rd edition Pretoria J L van Schaik Publishers 1991.

Strauss, S A "Toestemming deur 'n jeugdige" 1964 **THRHR** 116.

Strauss, S A “Bodily injury and the defence of consent” 1964 **SALJ** 179.

Strauss, S A “Onvrywillige genadedood: ’n belangrike Transvaalse beslissing” 1969 **THRHR** 385.

Telegraaf 12 May 1993.

The Australian March 26 1997,12.

Trindade, F A "Disclosure of risks in proposed medical treatment" 1993 **Law Quarterly Review** 352.

Van den Heever, P "The patient's right to know: informed consent in South African medical law" 1995 **De Rebus** 53.

Van der Merwe, N J & Olivier, P J J **Die onregmatige daad in die Suid-Afrikaanse reg** 6th edition Pretoria Van der Walt and Son 1989.

Van der Wal, G & Dillmann, R J M "Euthanasia in the Netherlands" 1994 **British Medical Journal** 1346.

Van Oosten, F F W "Aandadigheid aan selfmoord in die Suid-Afrikaanse reg" 1985 **TSAR**_189.

Van Oosten, F F W "**Castell v De Greef** and the doctrine of informed consent: medical paternalism ousted in favopur of patient autonomy" 1995 **De Jure** 164.

Weinfeld, J "Active voluntary euthanasia - should it be legalised?" 1985 **Medicine and law** 101.

TABLE OF CASES

SOUTH AFRICA

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

Esterhuizen v Administrator, Transvaal 1957 3 SA 710 (T).

Ex parte Die Minister van Justisie: In re S v Grotjohn 1970 2 SA 355 (A).

Lange v Lange 1945 AD 332.

R v Davidow 1955 WLD unreported.

R v Makali 1950 1 SA 340 (N).

R v McCoy 1953 2 SA 4 (SR).

R v Nbakwa 1956 2 SA 557 (SR).

R v Peverett 1940 AD 213.

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

S v Gordon 1962 4 SA 727 (N).

S v Hartmann 1975 3 SA 532 (C).

S v Hibbert 1979 4 SA 717 (D).

S v Marengo 1990 WLD unreported.

S v McBride 1979 4 SA 313 (W).

S v Smorenburg 1992 CPD unreported.

S v Williams 1986 4 SA 1188 (A).

USA

Cruzan v Director Missouri Department of Health (1990) 497 US 261; 111 L Ed 2d 224; 110 S Ct 2841.

In re Claire Conroy 98 NJ 321; 486 A 2d 1209 NJ 1985.

In re Hilda M Peter 108 NJ 365; 529 A 2d 419 NJ 1987.

In re Nancy Ellen Jobes 108 NJ 394; 529 A 2d 434 NJ 1987.

In re Quinlan 81 NJ 10; 355 A 2d 647 (NJ 1976).

John F Kennedy Memorial Hospital Inc v Bludworth 452 So 2d 921 (Fla 1984).

UNITED KINGDOM

Airedale NHS Trust v Bland [1993] 1 All ER 821.

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118; [1957] 1 WLR 582.

Gillick v West Norfolk and Wisbeck Area Health Authority and another [1985] 3 All ER 402.

F v West Berkshire Health Authority [1989] 2 All ER 545, [1990] 2 AC 1.

In re B (a minor) (wardship: sterilization) [1987] 2 All ER 206; [1988] AC 199.

In re B (a minor) (wardship: medical treatment) [1990] 3 All ER 927; [1981] 1 WLR 1421.

In re C (a minor)(wardship: medical treatment) [1989] 3 WLR 240.

In re J (a minor) [1990] 3 All ER 930.

In re R [1991] 4 All ER 177.

In re S (Adult: Refusal of treatment) [1992] 3 WLR 806.

In re T(adult): Refusal of treatment [1992] 4 All ER 649; [1992] 3 WLR 782.

In re W [1993] Fam Court 64.

Sidaway v Bethlehem Royal Hospital Governors [1985] 1 All ER 643.

AUSTRALIA

Wake and Gondarra v Northern Territory of Australia July 1996, Supreme Court of the Northern Territory, as yet unreported.

CHAPTER 1

ORIGIN OF THE INVESTIGATION

1.1 The South African Voluntary Euthanasia Society (SAVES), which has since changed its name to SAVES The Living Will Society, suggested in a letter to the Commission, dated 14 October 1991, that the Commission should consider legislation regarding a document known as a "Living Will". This proposal was subsequently substantiated in a memorandum dated 27 December 1991, which contained more detailed information about the Society and its objectives as well as references to applicable overseas legislation, articles and newspaper reports.

1.2 On 27 January 1992, at a meeting of the Working Committee, the Commission approved the proposal submitted by SAVES as a research project. However, it was decided that issues relating to the termination of life should, for the sake of completeness, also be investigated under the heading "Euthanasia and the artificial preservation of life".

1.3 In 1994 the Commission published a working paper on euthanasia and the artificial preservation of life.¹ Working Paper 53 contained a draft bill which elicited a live and varied response. Submissions ranged from passionate calls for the legalisation of euthanasia to outright condemnation of any act associated therewith. The submissions received, the discussions that followed, the points raised at two workshops,² the participation of the general public, all assisted the Commission in its

1 SA Law Commission **Euthanasia and the artificial preservation of life** Working paper 53 March 1994 (hereinafter referred to as Working paper 53).

2 On 22 June 1994 and 18 October 1996.

task. All points of criticism and suggestions for improvement were duly considered. We take this opportunity to thank all who responded to Working Paper 53 and the Commission's request for submissions.

1.4 The subject under discussion readily lends itself to theorisation and moralising. Our research has however indicated that it is especially in this field that a sober and practical approach will be most fruitful.³

1.5 Our research has also shown that the subject under discussion lends itself to confusion with regard to the terminology used. An analysis of the situation brought us to the conclusion that there are basically three categories within which the preservation of life and questions relating to actions that hasten death should be discussed, namely:

- (a) The artificial preservation of life after clinical death has set in;
- (b) the preservation of the life of a competent but terminally ill patient;
- (c) the preservation of the life of an incompetent, terminally ill patient.

1.6 The rules of law relating to each category in question will be stated, followed by a discussion in every case.

1.7 Since the question of euthanasia has never been put before the South African public in its entirety, which this working paper sets out to do, the Commission states the issues objectively and neutrally and does not propose specific measures at this stage. The object of this paper is to elicit public response. Merely for the purposes of focussing attention on the various problem areas and to evoke discussion and debate, a draft bill, not necessarily reflecting the views of the Commission, is published for comment as Annexure A.

³ An excellent example of such an approach is found in the **Report of the Select Committee on medical ethics** of the British House of Lords, published on 31 January 1994 (hereinafter referred to as Report of the Select Committee).

1.8 The Commission will only in its final report suggest measures of law reform to Parliament in so far as these may appear to be necessary and advisable.

1.9 During the course of 1996 the magazines You and Huisgenoot invited their readers to contact the Project Leader in connection with their personal experiences and opinions regarding the cessation of life of family members or themselves. Close to a hundred letters were received by the Project leader. We wish to express our gratitude to You and Huisgenoot for their co-operation. Copies of this Discussion paper will be forwarded to the respondents and we invite their further comments.

CHAPTER 2

THE ARTIFICIAL PRESERVATION OF LIFE WHERE THE PATIENT IS CLINICALLY DEAD

2.1 People, especially moralists and persons with strong religious beliefs, often speculate in a metaphysical way about the concepts "life" and "death". Quite often qualities are attributed to the concept of "life" that gives it an esoteric meaning, for example that life should be equated with a decent existence or one associated with consciousness, and on this basis conclusions are then drawn. The jurist must however inevitably follow a more sober, certain and accordingly more clinical approach - just like the medical scientist.

2.2 No consensus has however been reached in medical science on the question as to precisely when it is that death sets in¹. With the first heart-transplant operation, Professor Chris Barnard and his team used the following test: the absence of heart activity for five minutes, measured by an electrocardiograph, the absence of spontaneous respiration and the absence of reflexes.²

2.3 However, consensus is apparently now developing to the effect that irrespective of whether other criteria apply, death definitely sets in with the death of the brainstem, that is to say when no response is ascertainable on the electro-encephalograph.

1 Strauss, S A **Doctor, patient and the law** 3rd ed Pretoria J L van Schaik Publishers 1991 321 (hereinafter referred to as "Strauss **Doctor, patient and the law**"); Benatar, S R "Dying and 'euthanasia'" 1992 **SA Medical Journal** 35.

2 Barnard, C N "A human cardiac transplant: an interim report of a successful operation performed at Groote Schuur Hospital, Cape Town" 1967 **S A Medical Journal** 1271.

2.4 The previously mentioned report of the British House of Lords³ outlines the developments regarding medical science in this field. The report indicates that since 1980 there has been broad agreement by the medical profession that brain death equals death, though the criteria for diagnosis and the existence of legal definitions of brain death still vary between countries. The definition of brain death in the United States of America for instance requires "... the confirmed death of the whole brain as indicated by clinical tests and a flat waveform on the electro-encephalogram". In the United Kingdom the position is different: "...the definition requires clinical evidence confirming death of the brainstem which supports vital organs such as the heart and lungs".

2.5 In our law the generally accepted test is still the irreversible loss of spontaneous circulatory and respiratory functions. The establishment of such irreversible loss depends on clinical diagnosis and proof. Although the legislator had the opportunity to authoritatively prescribe a test, it chose not to do so. The now repealed Anatomical Donations and Post Mortem Examinations Act⁴ contained no criteria for the establishment of death. Section 3(2) of this Act *inter alia* stipulated that for purposes of tissue-removal the death of a person had to be established by at least two medical practitioners, one of whom shall have been practising for at least five years after the date on which he was registered as a medical practitioner. Establishment of the death of a person with the object of tissue removal in terms of this Act was therefore left entirely in the hands of the doctors. This approach has also been followed in the current Human Tissue Act.⁵

3 **Report of the Select Committee** Appendix 5 at 70.

4 Act 24 of 1970. This Act was repealed by the Human Tissue Act 65 of 1983. See further De Klerk, A "Transplantation of human tissue and organs in South African law" 1992 **TRW** 112.

5 Act 65 of 1983.

2.6 In so far as case law is concerned, the position has not been cleared up either. In **S v Williams**⁶ the accused shot the deceased in the neck with the result that his jugular vein and carotid artery were severed. Medical help was summoned quickly and the patient, who had lost a great deal of blood and was unconscious, was connected to a respirator. The jugular vein and carotid artery were ligatured. After one day it was found that according to medical evidence the left side of the brain was dead and a day later no brain activity could be discerned. The brain stem was also dead. He was, however, kept 'alive' by artificial respiration for forty-eight hours, after which the respirator was disconnected on the instructions of the neurosurgeon, after consultation with two other neurosurgeons. Ten minutes later no heartbeat could be found.

2.7 The question was whether the accused had in fact caused the death of the deceased. The trial court regarded the moment of death as being of cardinal importance. Accordingly it found that death set in with the death of the brain stem, in other words at the moment when brain activity (including activity of the brain stem) ceased.

2.8 On appeal it was submitted that the trial court had incorrectly held that a person is legally dead when death of the brain-stem occurs, even though the person's heartbeat and respiration have not yet ceased. According to this submission the accused was still alive when the respirator was disconnected and it was therefore the disconnection of the respirator that caused his death.

2.9 The Appellate Division did not consider it necessary to decide whether the medical approach concerning the moment of death, as reflected in the trial court's verdict, should be accepted in law as the moment of death. The Appellate Division dealt with this question on the basis of what was described as probably the traditional public policy on this question, namely that death occurs with the cessation of a person's respiration and heartbeat.⁷ With respect, the mere question as to the existence in a

6 1986 4 SA 1188 (A).

7 Supra at 1194 E-F.

patient of respiration and heartbeat cannot be a complete description of a clinical test for death. Many people experience cardiac arrest and respiratory failure for a few seconds or minutes after which normal functions are resumed. The traditional test referred to **independent** respiratory and circulatory functions.

2.10 It would appear unnecessary for present purposes to choose or to justify one or the other of these tests. It is enough to accept that death occurs with irreversible cessation of spontaneous circulatory and respiratory functions or with irreversible brainstem-death. Whether one or the other has occurred is a question of fact and depends on clinical proof.

2.11 Quite often a person who is already dead according to the above-mentioned tests is kept 'alive' artificially by a ventilator, that is to say, he or she is ventilated and the circulatory functions are kept going. If it could however be proved that brain-stem death has occurred, such a person would, in our opinion, already be legally dead. Alternatively, if no apparatus is available to prove brain-stem death, we agree with the opinion of Dorfling:⁸

A person will be considered dead if in the announced opinion of a physician based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

2.12 For the purposes of our investigation the central question is: Suppose it can be proved that a person is clinically dead according to the above-mentioned tests, but he or she is being kept 'alive' by a heartlung-machine or ventilator. Is the medical practitioner entitled to disconnect the life-sustaining system?

8 Dörfling, D F "**Genadedood**" in die strafreg - 'n regsfilosofiese en regsvergelykende perspektief (Unpublished thesis submitted in partial fulfilment of the degree Magister Legum) Faculty of Law Rand Afrikaans University 1991 at 157 (hereinafter referred to as "Dörfling").

2.13 According to the present legal rules, the answer to this question is an unqualified "yes". There is no rule in our law which requires any person to artificially bestow certain signs of life on a person who is already dead. The respiration and heartbeat that seemingly exist are artificial and do not represent life. To disconnect the life-sustaining system would therefore not be to cause death.

2.14 In **S v Williams**⁹ the Appellate Division came to the same conclusion. The court held that the disconnection of the respirator could not be seen as the act that caused death, but that it was merely the termination of a fruitless attempt to save the person's life. This is not what killed him. It is the action of the accused that caused his death.

2.15 The disconnection of the respirator in the case currently under discussion is therefore not an action which can be described as mercy killing or euthanasia.

2.16 Logically it follows that where the medical practitioner responsible for the treatment of the patient concerned is convinced that the patient is clinically dead according to any of the tests described above, the disconnection of the respirator will neither be unlawful for the purposes of criminal law nor for the purposes of private law.

2.17 The only problem which needs to be addressed in this instance is whether the present legal position should be formalised in legislation. The advantage of legislation could only be to remove legal uncertainty. In our view, the law is clear, but are doctors, patients and the families of patients sufficiently aware of the legal position? If not, does the remedy lie in legislation or, rather, in extra-legal education? **The guidance of our readers is sought on this question.**

2.18 Should legislative enactment be deemed necessary, it may read as follows:

Conduct of a medical practitioner in the event of clinical death

9 Supra.

2. (1) *For the purposes of this Act, a person is considered to be dead when two medical practitioners agree and confirm in writing that a person is clinically dead according to the following criteria for determining death, namely -*
 - (a) *the irreversible absence of spontaneous respiratory and circulatory functions; or*
 - (b) *the persistent clinical absence of brain-stem function.*
- (2) *In the event of a person being considered to be dead according to the provisions of sub-section (1), the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of treatment.*

CHAPTER 3

CASES WHERE THE PATIENT IS COMPETENT TO MAKE DECISIONS

3.1 This chapter deals with those instances where the patient is in possession of all his or her faculties, and therefore legally and mentally competent to make certain requests of the medical practitioner which, if acceded to, would amount to the hastening of the death of the patient concerned. The question is whether agreement to such requests would be unlawful or lawful and if any legal reform is necessary.

3.2 Before this problem can be dealt with, clarity has to be obtained with regard to the terms "legal competency" and "mental competency".

3.3 In general a person will be regarded as legally competent if he or she has the ability to enter into a legal transaction and therefore take part in commerce and law. The essence of the term "legal competency" lies in the fact that a person should be able to understand the nature and implications of the legal transaction concerned. He or she therefore understands its nature and implications and consents to it while he or she is not being influenced by mental illness or any other factor that could seriously impair his or her capacity to understand the nature and consequences of the action.¹

1 **Lange v Lange** 1945 AD 332.

3.4 The situation sketched in 3.1 deals not only with the competence, in general, to conclude a legal transaction, but it deals specifically with the legal act which is known as **consent to injury**. A prerequisite for the validity of this consent is that the consenting person should be mentally competent. This means that persons under twenty-one years of age and who do not therefore have unlimited contractual capacity in the eyes of the law, may still be mentally competent to consent to injury. As it is the bodily integrity of a person that is at issue here, the writers agree that for this kind of consent the co-operation of a minor's parent or guardian is not a prerequisite, as long as it is certain that the minor is mentally competent.²

3.5 Whether the consenting person is mentally competent or not is a question of fact on which it is unnecessary now to dwell.

3.6 A prerequisite for valid consent to injury is that the consent has to be voluntary consent³ and that the consenting person has to have had full knowledge of the extent of his or her rights and of the nature of the injury.⁴

3.7 A further requirement is that the consent to injury is considered valid only if it is not **contra bonos mores**. In our law it is for instance accepted that a person cannot consent to serious bodily mutilation.⁵ This requirement should however be approached with caution as consent to serious bodily mutilation is not in all cases considered **contra bonos mores**. Say, for instance, that in light of medical considerations it is found that

2 Strauss, S A "Toestemming deur 'n jeugdige" 1964 **THRHR** 116 at 123; Van der Merwe, N J en Olivier, P J J **Die onregmatige daad in die Suid-Afrikaanse reg** 6th edition Pretoria Van der Walt & Son 1989 at 91-92.

3 **R v McCoy** 1953 2 SA 4 (SR).

4 **Esterhuizen v Administrator, Transvaal** 1957 3 SA 710 (T). See also Van den Heever, P "The patient's right to know: informed consent in South African medical law" 1995 **De Rebus** 53; Van Oosten, F F W "Castell v De Greef and the doctrine of informed consent: medical paternalism ousted in favour of patient autonomy" 1995 **De Jure** 164; Earle, M "Informed consent': is there room for the reasonable patient in South African law?" 1995 **SALJ** 629; Deyer, L "Redelike dokter versus redelike pasient" 1995 **THRHR** 532; Burrows, R "Removal of life support in intensive care units" 1994 **Medicine and Law** 489; Stern, K "Competence to refuse life-sustaining medical treatment" 1994 **Law Quarterly Review** 541.

5 **R v McCoy** supra.

the amputation of a leg is inevitable. The patient's consent to the amputation, that is to say the serious bodily mutilation, would certainly not be seen as invalid.⁶

3.8 The consent of a mentally competent patient can be relevant in the following situations:

(i) Cessation of life-sustaining medical treatment

3.9 The case under discussion here is that of a mentally competent patient who is terminally ill and for whom no effective medical treatment exists. One thinks here of a patient with terminal cancer, Aids sufferers and persons with chronic and untreatable diseases, for instance motor-neuron disease and others. Generally these patients' lives are prolonged, in comparison with the natural condition, by for example intravenous or nasogastric feeding, the administering of antibiotics to avoid or fight secondary infections and the administering of oxygen when necessary.

3.10 It can happen that such a patient may find the situation unbearable as a result of pain and suffering or because of the indignity of the situation. He or she then requests the cessation of the life-prolonging treatment but with the continuation of palliative care.

⁶ See also Strauss, S A "Bodily injury and the defense of consent" 1964 **SALJ** 179 at 332.

3.11 Palliative care⁷ can be described as medical intervention not intended to cure but to alleviate the suffering, including the emotional suffering, of the patient. It is concerned with the quality of life when, in the course of an illness, death becomes inevitable. With palliative care many patients can be kept comfortable until the moment of death.

3.12 The question is therefore: suppose a patient who has the necessary mental capacity and who realises the nature, extent and consequences of a request for the cessation of life-sustaining treatment, still persists in his request: will compliance with that request be **contra bonos mores** or should effect be given to it?

7 Browde, S "There would be little need for euthanasia if doctors understood how to deliver a 'good death'
The Sunday Independent 8 December 1996.

3.13 In English law the rule is acknowledged that an adult patient who has the necessary mental capacity and who has been fully informed of the consequences of his or her decision, has the right to refuse any treatment, even if such refusal would hasten death. The House of Lords' "**Report of the Select Committee on medical ethics**"⁸ states that a patient who is mentally competent and fully informed of the consequences may refuse any form of medical treatment. Reference is made to two court judgements: in the case **Sidaway v Bethlehem Royal Hospital Governors**⁹ Lord Scarman said that "... a doctor who operates without the consent of the patient is... guilty of the civil wrong of trespass to the person; he is also guilty of the criminal offence of assault". From this it follows that a patient who has the necessary mental capacity may refuse medical treatment and that no medical treatment may be forced on such a person against his or her will. In **In re T(adult: refusal of treatment)**¹⁰ the Court of Appeal again affirmed this right of the patient.

3.14 The same report¹¹ recalls that the British Department of Health has positively acknowledged this right. Their contribution in this regard reads as follows:

A patient who has the necessary mental capacity and has been properly informed of the nature of his condition and the implications of the treatment proposed is entitled to accept or decline that treatment as he sees fit.... The patient's right to self-determination regarding the treatment he will accept is paramount. The BMA (British Medical Association) said 'ultimately the individual's right to self determination decides whether or not treatment can be

8 Op cit, par 41.

9 [1985] 1 All ER 643. See also Trindade, F A "Disclosure of risks in proposed medical treatment" 1993 **Law Quarterly Review** 352.

10 [1992] 3 WLR 782.

11 **Report of the Select Committee** par 42 and further.

given... the decisions of a competent patient regarding non-treatment must be respected'.

3.15 The report further states that the medical practitioner has to tread carefully with regard to the question whether consent has been given in a specific case. The report states that the British Alzheimer's Disease Society led evidence to the effect that practitioners often assume that patients are behaving irrationally and are thus incapable of giving informed consent. The British Department of Health recommends that should a medical practitioner have any doubt as to whether valid consent has been given, a second medical opinion on that question should be sought and the matter should further be discussed with other members of the health care team and with the patient's relatives and friends who could cast light on whether the decision was in keeping with the patient's previous wishes.¹²

3.16 The report also states that a too-ready acceptance of the validity of the patient's wishes may cause a problem. The medical practitioner has to be very careful to make sure that the patient's request is not influenced by an undiagnosed depressive illness which, if successfully treated, might affect his or her attitude.¹³

3.17 The report also refers to the fact that a great deal of dissatisfaction exists with regard to the judgment of the High Court in the case of **In re S (Adult: Refusal of treatment)**¹⁴ in which the court forced the woman in question, against her wishes, to have a Caesarean section performed. The woman refused the operation on religious grounds, although she had been advised that both she and the fetus would die without it. The court forced her to undergo the operation and she survived, but the child didn't. Apparently the case was heard as a matter of urgency and the judgement given on

12 Op cit par 44.

13 Op cit par 45.

14 [1992] 3 WLR 806.

short notice. A number of witnesses expressed their dissatisfaction with this judgment.¹⁵

15 **Report of the Select Committee** para 46.

3.18 In the case of children, the position in English law is that parents or competent guardians can consent to the treatment of the child if it is in its best interest.¹⁶ Under the Family Law Reform Act of 1969 minors aged sixteen and seventeen are presumed to be competent to consent to treatment unless there is a reason to suppose that they are not. Even children under the age of sixteen may consent to treatment if they have "sufficient understanding and intelligence.... to understand fully what is proposed".¹⁷

3.19 However, it is important to note that the right of minors to refuse consent has not been upheld by the courts. In two cases the courts have given consent for treatment of competent minors who had refused treatment.¹⁸

3.20 It is not evident that South African law differs substantially from English law in this regard. In our opinion it is clear that the right to refuse medical treatment where the patient has the necessary mental capacity is also acknowledged in our law. It would also be a prerequisite here for the patient to be informed fully with regard to the consequences of his or her refusal, to understand the nature of the consequences and to give the instructions for the life-prolonging treatment to be discontinued. It would seem that the legal position is that our courts would acknowledge the medical practitioner's obligation to comply with such a request and that, in doing so, he or she would not act unlawfully, either according to criminal law or in terms of private law, even if such an action would have the effect of hastening death.

3.21 With reference to the submissions received by the Commission and the discussions during the workshops held on 22 June 1994 and 18 October 1996, it seems that South African medical practitioners would in general comply with the request of a

16 See also Roberts, S E "When not to prolong life" 1990 **Law Quarterly Review** 218 for a discussion of **In re C (a minor) (wardship: medical treatment)** [1989] 3 WLR 240 (CA) and **In re B (a minor)** [1981] 1 WLR 1421 (CA). See further Lowe, N & Juss, S "Medical treatment - pragmatism and the search for principle" 1993 **Modern Law Review** 865; Eekelaar, J "White coats or flak jackets? Doctors, children and the courts - again" 1993 **Law Quarterly Review** 182.

17 **Gillick v West Norfolk and Wisbeck Area Health Authority and another** [1985] 3 All ER 402.

18 **Re R** [1991] 4 All ER 177 and **Re W** [1993] Fam Court 64.

mentally competent patient for the discontinuance of life-prolonging treatment and the provision of palliative care only. Some medical practitioners, however, seem to be under the misconception that it is their duty to prolong life at all cost, notwithstanding the quality thereof. They may influence the patient, his or her family and next of kin to continue with the life-prolonging treatment. Every patient is of course free to discharge his or her medical practitioner and to appoint another practitioner in his or her place, but indications are that very few patients have the perseverance to follow this route.

3.22 The Commission is prima facie of the view that the cessation of treatment as discussed above is legally supportable, **but would like the guidance of our readers on this aspect.**

3.23 Some people may argue that it seems necessary, possibly for the sake of caution, but also in order to remove any uncertainty, to confirm the right of the mentally competent patient by way of legislation to refuse life-sustaining treatment.

3.24 The legislative enactment might read as follows:

Mentally competent person may refuse treatment

3. (1) *Every person above the age of 18 years and of sound mind is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.*

(2) *Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in subsection (1) is, that such a person's refusal is based on the free and carefully considered exercising of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.*

3.25 A further complication that was brought to our attention, and which was also discussed in the abovementioned Report of the British House of Lords¹⁹ with regard to the cases now being discussed, is the so-called double effect. It is true that patients often request the discontinuance of life-prolonging treatment in circumstances as set out above and that medical practitioners comply with this request. The request is furthermore for the provision of palliative care only, which includes the administering of pain-killing drugs.

19 Op cit par 242 and further.

3.26 A guideline for behaviour by a medical practitioner in respect of a terminally ill patient who is enduring pain is to be found in the World Medical Association's Declaration of Venice of October 1983. The declaration affirms the doctor's duty to heal and, if possible, to relieve suffering. Furthermore, the following rules are set out:²⁰

The physician may relieve suffering of a terminally ill patient by withholding treatment with the consent of the patient or his immediate family if unable to express his will. Withholding of treatment does not free the physician from his obligation to assist the dying person and give him the necessary medicaments to mitigate the terminal phase of his illness.

3.27 The effect of large dosages of pain-killers is, however, that it may hasten death. It is apparently the position in our medical practice, as in England, that medical practitioners fail to supply sufficient pain-killers to ensure effective relief of pain for the patient, as they are afraid that they may be criminally prosecuted on account of the fact that such large dosages of pain-killers may hasten death and that they may therefore be held criminally liable.

3.28 Authority exists in our law to the effect that the hastening of a person's death, if it was done unlawfully and with the necessary intention, would constitute murder.²¹ It can also be argued that the medical practitioner, even though he may have had a pure motive, had **dolus eventualis** under those circumstances.

3.29 Professor Strauss²² nevertheless feels that administering drugs to a terminally ill patient would be lawful, even if it has the secondary effect of hastening death, if the

20 Declaration of Venice, October 1983 15.

21 **R v Makali** 1950 1 SA 340 (N) at 344.

22 Strauss **Doctor, patient and the law** 345.

doctor acted in good faith and used the normal drugs in reasonable quantities with the object of relieving pain and without the intention of causing death.

3.30 Professor Strauss refers to a paper by Professor H J J Leenen from Amsterdam in which, amongst other things, he said.²³

The administration of the pain-alleviating method can be qualified as an act with double effect. It must not be defined according to its side-effect, the unavoidable shortening of life, but according to its aim, which is to combat the pain of which the patient is suffering. Many medical acts and drugs have side-effects, but nobody will define them from the viewpoint of these side-effects. The same is true for pain-killing.

3.31 This is also the position as set out in the Report of the British House of Lords where it was stated that it was common practice and unexceptional for doctors to prescribe sufficient drugs to control the pain of a patient adequately even though a probable consequence may be the shortening of the patient's life.²⁴ The report rejected the charge of medical hypocrisy in that the so-called double effect was being used as a cloak for what in effect amounted to widespread euthanasia. They did however acknowledge the fact that the doctor's intention, and the evaluation of the pain and distress suffered by the patient, are of crucial significance in judging the double effect. They referred to the fact that juries are however asked everyday to assess intention in all sorts of cases and could also do so in respect of double effect if in a particular case there was any reason to suspect that the doctor's prime intention was to kill the patient rather than to relieve suffering.²⁵

3.32 Should legislative enactment of this principle be deemed necessary, it might read as follows:

23 As quoted by Strauss **Doctor, patient and the law** 346, since published as "The Definition of Euthanasia" 1984 (3) **Medicine and Law** 333.

24 **Report of the Select Committee**, par 73, 20.

25 Op cit, par 243, 50.

Conduct of medical practitioner in relieving distress

4. (1) *Should it be clear to a medical practitioner responsible for the treatment of a patient that the patient is suffering from a terminal illness and that such a patient's pain and distress cannot satisfactorily be alleviated by ordinary palliative treatment, he or she may, in accordance with responsible medical practice-*

(a) *with the object to provide relief of severe pain and distress; and*

(b) *with no intention to kill*

increase the dosage of medication (whether analgesics or sedatives) to be given to the patient, even if the secondary effect of this action may be to shorten the life of the patient.

(2) *No medical practitioner shall treat a patient as contemplated in subsection (1) unless the condition of the patient concerned has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition in view of his or her expertise with regard to the illness with which he or she is affected and on account of his examination of the patient concerned.*

(3) (a) *A medical practitioner who treats a patient as contemplated in subsection (1) shall record in writing his findings regarding the condition of the patient and his conduct in treating the patient.*

(b) *A medical practitioner as contemplated in subsection (2) shall record in writing his findings regarding the condition of the patient concerned.*

3.33 The next two cases to be discussed relate to the relatively small percentage of mentally competent patients who are terminally ill, for whom no effective medical treatment is available and for whom the palliative medical skills are not adequate. They

may be subject to unbearable pain or discomfort despite all the known techniques and not prepared to continue living under such circumstances.

(ii) Assisted suicide

3.34 In this case the patient does not only require, as has been set out in paragraph (i) discussed above, that life-prolonging medical treatment should be discontinued. He or she wants something more: the patient may for example request that lethal drugs be made available to take him or herself; or the patient may request to be supplied with a hipodermic needle containing a lethal drug in order to give him or herself an injection.

3.35 In our law the position is that the person who knowingly supplies a drug to a patient for use in a suicide is guilty of aiding and abetting a suicide and can accordingly be found guilty of murder. An example in point is that of **R v Peverett**.²⁶ In this case the accused, Peverett, concluded a suicide pact with his mistress, one Saunders. Peverett connected the exhaust pipe of the car with the interior of the car and the two of them sat in the car with the doors and windows closed while the engine was running. They were both later found in an unconscious state but survived the attempted suicide. Peverett was found guilty of the attempted murder of Saunders. Watermeyer JA held as follows:²⁷

In the present case it is clear that the accused contemplated and expected that as a consequence of his acts Mrs. Saunders would breathe the poisoned gas and die. In the eye of the law, therefore, he intended to kill her, however little he may have desired her death.

The Appeal Court confirmed the conviction of attempted murder.

26 1940 AD 213.

27 Supra at 219.

3.36 In a decision by the then South Rhodesian court, **R v Nbakwa**,²⁸ the facts were that Nbakwa, a man who lived according to the traditions of his tribe, suspected and accused his mother of the death of his child. His mother then requested him to kill her. Nbakwa went to the hut where his mother was lying ill, tied a rope to a rafter in the hut and tied a noose in the other end. He then told her to hang herself. She asked him to lift her up and asked for something to stand on. He helped her to get up and then put a block of wood under the rope. He then looked on while she hanged herself by kicking away the block of wood. Nbakwa was acquitted on a charge of murder. The rationale of the judgement was that there was no chain of causation between Nbakwa's act and the subsequent death of the mother. She caused her own death. Beadle J stated as follows:²⁹

The accused did not actually kill the deceased himself, but if his acts could be construed as an attempt to do so he could be legally convicted of attempted murder, since on an indictment for murder a verdict of attempted murder is a competent one. I will first consider, therefore, whether these particulars disclose on the part of the accused an attempt to murder the deceased. In my view the acts of the accused on this occasion do not go far enough to constitute an attempt; they go no further than what are commonly called acts of preparation. The accused provided a means for causing death and he persuaded the woman to kill herself, but the actual act which caused the death of the woman was the act of the woman herself. There was, to use a common legal expression, a **novus actus interveniens** between the actions of the accused and the death of the deceased which in my view broke the chain of causation between the act of the accused and the death of the deceased..... The direct cause of death was not the action of the accused. I come to the conclusion, therefore, that the accused's acts did not go far enough to constitute an attempt to murder; at most his acts went no further than acts of preparation.

3.37 In South Africa the school of thought in **R v Nbakwa**³⁰ was followed in **S v Gordon**.³¹ Gordon and a girlfriend concluded a suicide pact. Gordon obtained some lethal drug and both took some of it. The girlfriend died, but Gordon lived. He was

28 1956 (2) SA 557 (SR).

29 Supra at 559 A-E.

30 Supra.

31 1962 4 SA 727 (N).

charged with murder. Henning J distinguished the said case from **R v Peverett**³² as follows:³³

Now it will be observed that in that case the accused completed every necessary act to bring about the death of himself and Mrs Saunders, the starting of the engine being the final act. In the present case it is an accepted fact that the deceased took the tablets herself and that was the final act which brought about her death.

32 Supra.

33 Op cit at 730 B-C.

3.38 Henning J found that Gordon was not guilty of the murder. He stated as follows:³⁴

To my mind, the mere fact that he provided the tablets knowing that the deceased would take them and would probably die cannot be said to constitute, in law, the killing of the deceased. The cause of her death was her own voluntary and independent act in swallowing the tablets. He undoubtedly aided and abetted her to commit suicide, but that is not an offence. The fact that he intended her to die is indisputable, but his own acts calculated to bring that result about fall short of a killing or an attempted killing by him of the deceased. One might say that the accused, as it were, provided the deceased with a loaded pistol to enable her to shoot herself. She took the pistol, aimed it at herself and pulled the trigger. It is not a case of **qui facit per alium facit per se**.

3.39 When the matter came before the Appeal Court for the first time, in **Ex parte Die Minister van Justisie: In re S v Grotjohn**³⁵, the court was of the opinion that the school of thought as stated in **Rv Nbakwa**³⁶ and **S v Gordon**³⁷ was not unqualifiedly correct. Chief Justice Steyn held as follows:³⁸

Of 'n persoon wat 'n ander aanmoedig, help of in staat stel om selfmoord te pleeg, 'n misdaad begaan, sal afhang van die feite van die besondere geval. Met die oog op die gewysdes wat aanleiding tot die vrae gegee het, is dit egter nodig om op die voorgrond te stel dat die blote feit dat die laaste handeling die selfmoordenaar se eie, vrywillige, nie-misdadige handeling is, nie sonder meer meebring dat bedoelde persoon aan geen misdaad skuldig kan wees nie. Die antwoord op die tweede vraag hang eweseer van die feitelike omstandighede af. Na gelang daarvan kan die misdaad moord, poging tot moord of strafbare manslag wees.

34 Op cit at 731 B-D.

35 1970 2 SA 355 (A).

36 Supra.

37 Supra.

38 Op cit at 365 H.

3.40 The warning in **Ex parte Minister van Justisie : In re S v Grotjohn**³⁹ apparently brought new insight to the trial courts, as can be seen in **S v Hibbert**⁴⁰ where Hibbert handed his depressed wife a fire-arm after she had expressed the desire to commit suicide. He was convicted of murder after his wife used the fire-arm he had given her to commit suicide. Shearer J explained as follows:⁴¹

Now in the present case the accused set in motion a chain of events which ended in the deceased pressing the trigger of a fire-arm which she had been given by the accused and thus causing her death. The successive words and actions of the accused were designed to place her in possession of that fire-arm and were accompanied by the obvious hazard that the deceased might be persuaded to inflict upon herself an injury which could result in her death. The accused's conduct fell short only of the final act of pulling the trigger. It seems to me that the act of pulling the trigger to which all other conduct conduced, cannot in any sense be described as independent of the course of conduct. That being so, we conclude that there was, in the proper sense of that expression, no **actus novus interveniens** which broke the chain of causation set in motion and continued by the series of acts of the accused which I have mentioned. The accused must, as we have found, have appreciated that injury and possibly death could result from his actions. That being so there is present the necessary intention to bring home a charge of murder. We find therefore that the accused occasioned the death of the deceased by his conduct; that he had the necessary intention and is therefore guilty as charged of murder.

Hibbert was sentenced to four years' imprisonment all of which was conditionally suspended for five years.⁴²

39 Supra.

40 1979 4 SA 717 (D).

41 Op cit at 722 E-H.

42 See also Van Oosten, F F W "Aandadigheid aan selfmoord in die Suid-Afrikaanse reg" 1985 **TSAR** 189 at 194; Labuschagne, J M T "Dekriminalisasie van eutanاسie" 1988 **THRHR** 167 especially at 171-174; Hunt, T M A and Milton, J R L **South African criminal law and procedure Vol 2** 2nd edition Cape Town Juta 1982 at 369-371.

3.41 In the Western world aiding, abetting and assisting suicide is generally punishable.⁴³ According to section 2(a) of the **British Suicide Act**, 1961 aiding, abetting and assisting suicide is punishable with imprisonment of up to fourteen years.

3.42 Section 241 of the **Canadian Penal Code** reads as follows:

Everyone who
 (a) counsels a person to commit suicide or
 (b) aids or abets a person to commit suicide,
whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

The Law Reform Commission of Canada published a report in 1983⁴⁴ in which it did not recommend the decriminalisation of the aiding of suicide.

3.43 In Australia the **Criminal Code** also states that it is a crime to aid another in committing suicide. According to a report of the Law Reform Commission of Western Australia⁴⁵ it would, in that country, be a crime for a doctor to place poison in the hand of a patient knowing that it would cause his death. This would amount to aiding suicide.⁴⁶

43 See in general Hu, P "The acceptability of active euthanasia in China" 1993 **Medicine and Law** 47; Bix, B "Physician assisted suicide and the United States Constitution" 1995 **Modern Law Review** 404.

44 Law Reform Commission of Canada **Report on euthanasia, aiding suicide and cessation of treatment** 1983.

45 Law Reform Commission of Western Australia **Report on medical treatment for the dying** 1991 (hereinafter referred to as **Western Australia Report**).

46 See below for a discussion of the current position in Northern Australia.

3.44 Section 294 of the Dutch **Criminal Code** reads as follows:

[H]ij die opzetlijk een ander tot zelfmoord aanzet, hem daarbij behulpzaam is of hem de middelen daartoe verschaft, wordt, indien de zelfmoord volgt gestraft met gevangenisstraf van ten hoogste drie jaren of geld boete van de vierde categorie.

3.45 This section should be read with section 293 of the Dutch **Criminal Code** that reads as follows:

Hij die een of ander op zijn uitdrukkelijk en ernstig verlangen van het leven berooft, wordt gestraft met gevangenisstraf van hoogstens twaalf jaren.

3.46 Notwithstanding the express prohibitions found in sections 293 and 294 of the Dutch Criminal Code, the criminal courts in the Netherlands have since 1973 shown an inclination in suitable cases to accept necessity as a defence for contraventions of said sections.⁴⁷

3.47 An example of this can be found in the well-known Alkmaar case⁴⁸ in which the Dutch Supreme Court held, on appeal, that a doctor, who had applied active euthanasia at the request of an elderly woman suffering from several painful diseases, had acted lawfully. The accused relied on the defence of **force majeure** as a result of medical necessity.

3.48 Section 40 of the Dutch Criminal Code states that when a person commits a crime as a result of "overmacht" he is not criminally liable. "Overmacht" takes two forms, namely psychological **force majeure** and necessity. Necessity is regarded here

47 See Griffiths, J "Assisted suicide in the Netherlands: the **Chabot** case" 1995 **Modern Law Review** 232; Griffiths, J "Assisted suicide in the Netherlands: postscript to **Chabot**" 1995 **Modern Law Review** 895; Keown, J "Physician assisted suicide and the Dutch Supreme Court" 1995 **Law Quarterly Review** 394.

48 (NJ) (1985) No. 106, 451 as discussed by Leenen, H J J "Supreme Court's decisions on euthanasia in the Netherlands" 1986 **Medicine and Law** 349. See also Labuschagné, J M T "Aktiewe eutanاسie en professionele hulpverlening by selfdoding van 'n psigiatriese pasiënt" 1995 **SALJ** 227.

as a ground of justification (although, in the Netherlands, it can be used as a ground for the exclusion of culpability as well) and is found where two interests are weighed up against each other and the interest sacrificed weighs less than the interest protected. It is furthermore required that it should not be possible to attain the object aimed at in a less punishable manner.⁴⁹

3.49 Necessity in this case therefore refers to the patient's unbearable situation which induces the doctor to disregard the law (for a so-called "higher good"). The question of whether necessity exists is answered according to responsible medical opinion measured against the existing standard of medical ethics.

49 Dörfling 20.

3.50 In 1989 the criteria laid down by the criminal courts in the Netherlands to determine whether the defence of necessity applied in a given case were summarised as follows by Mrs Borst-Eilers,⁵⁰ Vice-President of the Health Council:

- (a) The request for euthanasia must come only from the patient and must be entirely free and voluntary;
- (b) it must be a well-considered, durable and persistent request;
- (c) the patient must be experiencing intolerable suffering with no prospect of improvement;
- (d) euthanasia must be a last resort;
- (e) euthanasia must be performed by a physician;
- (f) the physician must consult with a second independent physician who has experience in this field.

3.51 In medical circles the Royal Dutch Medical Association (KNMG), to which 60 per cent of Dutch doctors belong, has played a significant role since 1973. In 1984 a report was published that led in 1988 to a publication entitled **Guidelines for Euthanasia**, setting out guidelines that closely correspond to the above criteria as developed by the courts over the years.

50 Borst-Eilers, E "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) as quoted by Keown, J "The law and practice of euthanasia in the Netherlands" 1992 **The Law Quarterly Review** 51 at 56.

3.52 In November 1990 the Minister of Justice and the KNMG agreed that a doctor, after practising euthanasia, would have to submit a report to the 'gemeentelijke lijkschouwer' (coroner), who would in turn inform the public prosecutor. The prosecutor would ask the police to investigate the matter only if the **Guidelines for Euthanasia** had not been complied with. The final decision whether to prosecute would be taken by the "Procureurs-Generaal", but in practice they simply approve the decision of the prosecutor.⁵¹ In 1992, 1 300 such reports were received.⁵²

3.53 Because medical practice and court decisions were no longer in accordance with the spirit of the legislation and different courts applied different criteria, the Dutch Government decided in 1982 to establish a State Committee to investigate euthanasia. In 1985 the Committee recommended that sections 293 and 294 be amended in order to allow a doctor to apply euthanasia in specific instances. Because of the opposition of the Christian Democrats, the Bill was not passed, but in December 1987 a compromise was reached by the opposing parties.⁵³

3.54 The compromise provided that sections 293 and 294 would remain unchanged, but that the position in practice, as set out above, would be given legal foundation. In September 1991 the findings of an independent commission consisting of jurists and doctors led to the introduction of a proposed Bill⁵⁴ in this regard, which was accepted in the Second Chamber of Parliament but rejected in the First Chamber because provision was made for both voluntary and non-voluntary euthanasia (i.e. incompetent persons, for example comatose patients).⁵⁵ In the Netherlands non-voluntary euthanasia is still regarded as murder.

51 Keown 60.

52 Ministry of Justice, the Netherlands **Newsletter** February 1993.

53 Leenen, H J J "Dying with dignity: developments in the field of euthanasia in the Netherlands" 1989 **Medicine and Law** 517 at 523.

54 Wijziging van de Wet op de Lijkbezorging No 22572.

55 **Telegraaf**, 12 May 1993.

3.55 The Bill was amended and stated that under no circumstances would the verifying of the doctor's actions be excluded. Even euthanasia at a patient's express request, practised according to the prescribed criteria, would therefore not automatically be exempted from punishment. It furthermore provided that non-voluntary euthanasia would as a rule be regarded as punishable.

3.56 In order to make a sensible decision with regard to the legal position in the case under discussion, it is necessary to look at the third possible category of the cases under discussion, namely where the patient desires active euthanasia.

(iii) Voluntary active euthanasia

3.57 The example that is usually used to illustrate what is referred to as "voluntary active euthanasia" is that of a terminally ill person who requests the termination of his or her life as he or she is experiencing unbearable pain and where the doctor then administers a lethal injection.

3.58 In South Africa such an act would undoubtedly be unlawful and the person giving the assistance could be convicted of murder. We discuss the following cases.

S v Davidow⁵⁶

3.59 The accused was charged with the murder of his mother, who was suffering from a terminal illness accompanied by severe pain. The accused did everything in his power to obtain the best possible medical treatment for his mother. Her condition was, however, incurable and was deteriorating. She was very depressed and expressed the wish to be relieved of her suffering. The accused was extremely concerned about his mother's condition. Finally he asked a friend to give his mother a lethal injection. The friend refused. Eventually the accused, who was in a state of emotional turmoil, shot and killed his mother in her hospital bed. The accused was eventually found not guilty since he was not accountable for his actions as a result of his emotional state during the

56 1955 WLD unreported.

perpetration of the deed. There was, however, no question as to the unlawfulness of the act.

S v De Bellocq⁵⁷

57 1975 3 SA 538 (T).

3.60 The accused, a young married woman, gave birth to a premature baby. After a few weeks it appeared that the baby was suffering from a disease known as toxoplasmosis, was an idiot and would never be able to live a normal life. The accused was a medical student and realised the extent of the problem. On the spur of the moment she drowned the baby in the bath. She was eventually found guilty of murder. On account of the overwhelming extenuating circumstances, she was however sentenced in terms of section 349 of the old Criminal Procedure Act⁵⁸. This section provided that the accused could be discharged on her own recognisance provided that she would appear and be sentenced if called upon by the court.

S v Hartmann⁵⁹

3.61 The elderly father of the accused, a medical practitioner, suffered from cancer. The accused had treated his father for a considerable period. The condition of the father deteriorated and he was on the point of death. Morphine was administered to ease the pain. Eventually the practitioner injected his father with a lethal dose of pentothal, which immediately caused his death. The accused was convicted of murder. He was sentenced to one year's imprisonment. He was detained until the rising of the court and the balance of the sentence was suspended for one year. The Medical and Dental Council took disciplinary action by suspending him temporarily.

S v McBride⁶⁰

58 Act 56 of 1955.

59 1975 3 SA 532 (C).

60 1979 4 SA 313 (W).

3.62 The accused and his wife were under the impression that the wife suffered from cancer. Her health deteriorated. Their financial position, likewise, deteriorated. The accused decided to take his wife's life and then his own. He shot and killed his wife, but his own life was saved through the intervention of others. He was accused of murdering his wife but the charge was dismissed on the grounds of criminal incapacity.

S v Marengo⁶¹

3.63 The accused shot and killed her 81-year old father, who suffered from cancer. She pleaded guilty to a charge of murder and stated that she could no longer endure her father's suffering. She was convicted of murder and sentenced to three years' imprisonment suspended for five years.

S v Smorenburg⁶²

3.64 The accused was a nursing sister. She attempted on two occasions to end the lives of terminally ill patients by injecting them with insulin in order to end their suffering. She was found guilty of attempted murder on both counts and was sentenced to three months' imprisonment suspended in its entirety.

3.65 All of the above-mentioned cases deal with active euthanasia. In each case the accused actively contributed to the death of the deceased. In each case the motive for the act was to end the suffering or useless existence of the deceased. However, in no case could the act be regarded as lawful. The courts, at best, reflected the sense of justice of the community regarding the blameworthiness of the accused by imposing very light sentences.

61 WLD October 1990 unreported.

62 CPD June 1992 unreported.

3.66 The attitude of the South African judiciary reflects the Anglo-American view. In Britain, Australia and Canada and in most of the states of the USA active assistance in terminating life is unlawful and is regarded as murder. In the previously mentioned **Report of the Select Committee**⁶³ the position in Britain was again revised, but the commissioners recommended that the legal position should not be amended.

3.67 We have already referred to the position in the Netherlands under section 293. Although active life-terminating assistance (euthanasia) is punishable, the defense of necessity is accepted as a ground for justification if the conditions referred to above have been adhered to.

3.68 In the Netherlands a nationwide survey⁶⁴ found that about one third of persistent, explicit requests for euthanasia were agreed to. In the remaining two thirds, either alternatives were found which made the patient's life bearable again, or the patient died naturally before any action was taken. Of all deaths in the Netherlands, 1,8 per cent (that is two thousand three hundred cases annually) were the result of voluntary euthanasia. There were a further four hundred cases (0,3 per cent of all deaths) of assisted suicide. According to the survey there was an increase in the number of cases of voluntary euthanasia. Of the doctors interviewed for the study, fifty four per cent said that they had practised voluntary euthanasia or had assisted a suicide; many said that they would be reluctant to do so again, and then only in the face of unbearable suffering and if there was no alternative.

63 Op cit para 259-260.

64 **Report of the Select Committee** par 121.

3.69 The latest development in the field of ‘physician-assisted termination of life’ flowed from the pen of the legislature of the Northern Territory of Australia, which enacted the **Rights of the Terminally III Act** in 1996. This Act drew world-wide attention,⁶⁵ both critical and supportive. In March 1997 the Act however became void as the federal government (Senate) voted by a narrow margin of thirty eight votes to thirty four to overturn it by passing the **Euthanasia Laws Bill 1996** (the Andrews’ Private Members Bill). The vote set the scene for continuing controversy over the rights of states and territories to make their own laws and the constitutional powers of the Commonwealth to veto these laws.⁶⁶ Although the Australian Medical Association welcomed this new development it is being suggested that Parliament’s will on the matter runs counter to the current views of most Australians.⁶⁷ Doctors from both sides of the euthanasia lobby are however united in their calling for better funding for and access to palliative care services.⁶⁸ Although the act has been overturned it is, for the sake of completeness, of more than passing interest to refer briefly to its provisions.

3.70 The **Rights of the Terminally III Act** provided that a patient who, in the course of terminal illness, is experiencing pain, suffering and or distress to an unacceptable extent, may request his or her medical practitioner to assist in terminating his or her life.⁶⁹

3.71 A medical practitioner who receives such a request from a patient may, subject to section 8, assist the patient to terminate his or her life if the medical practitioner is

65 **Wake and Gondarra v Northern Territory of Australia**, judgment delivered in July 1996, as yet unreported; See also “Renewed protest over Australia’s euthanasia laws” **Pretoria News** 7 January 1997,7.

66 **The Australian** March 26 1997,12; State legislation unlike territory legislation is unassailable.

67 **Roy Morgan Gallup Research Report** 18 February 1997; **The Australian** March 26 1997,12;

68 Comments made by Dr Robert Marr, national spokesperson for the Coalition for Voluntary Euthanasia , as reported in **The Sydney Morning Herald**, March 26, 1997 and Dr Keith Woollard, President of AMA, **Australian Medical Association media release** 25 March 1997.

69 Section 4.

satisfied that the conditions of section 7 have been met. The medical practitioner may also deny the request for such assistance.⁷⁰

3.72 Before turning to sections 7 and 8, some of the terminology used in sections 4 and 5 needs clarification:

The Act defines “assist” to include the prescription of a substance and the giving of a substance to the patient for self-administration and the administration of the substance to the patient. The Act therefore covers both active voluntary euthanasia and assisted suicide.

“Terminal illness” is defined as an illness which, in reasonable medical judgment will, in the normal course and without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient.

3.73 We now return to the conditions laid down by section 7 under which a medical practitioner may render the aforesaid assistance. Section 7 reads as follows:

7. CONDITIONS UNDER WHICH MEDICAL PRACTITIONER MAY ASSIST

(1). A medical practitioner may assist a patient to end his or her life only if all of the following conditions are met:

- (a) The patient has attained the age of 18 years;
- (b) The medical practitioner is satisfied, on reasonable grounds, that -
 - (i) The patient is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient;
 - (ii) In reasonable medical judgment, there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and
 - (iii) Any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object of allowing the patient to die a comfortable death;

70 Section 5.

- (c) Two other persons, neither of whom is a relative or employee of, or a member of the same medical practice as the first medical practitioner or each other -
 - (i) One of whom is a medical practitioner who holds prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering; and
 - (ii) The other who is a qualified psychiatrist, have examined the patient and have -
 - (iii) In the case of the medical practitioner referred to in subparagraph (i), confirmed -
 - (a) The first medical practitioner's opinion as to the existence and seriousness of the illness;
 - (b) That the patient is likely to die as a result of the illness; and
 - (c) The first medical practitioner's prognosis; and
 - (iv) In the case of the qualified psychiatrist referred to in subparagraph (ii) - that the patient is not suffering from a treatable clinical depression in respect of the illness;
- (d) The illness is causing the patient severe pain or suffering;
- (e) The medical practitioner has informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available to the patient;
- (f) After being informed as referred to in paragraph (e), the patient indicates to the medical practitioner that the patient has decided to end his or her life;
- (g) The medical practitioner is satisfied that the patient has considered the possible implications of the patient's decision to his or her family;
- (h) The medical practitioner is satisfied, on reasonable grounds, that the patient is of sound mind and that the patient's decision to end his or her life has been made freely, voluntarily and after due consideration;
- (i) The patient, or a person acting on the patient's behalf in accordance with section 9, has, not earlier than 7 days after the patient has indicated to his or her medical practitioner as referred to in paragraph (f), signed that part

of the certificate of request required to be completed by or on behalf of the patient;

- (j) The medical practitioner has witnessed the patient's signature on the certificate of request or that of the person who signed on behalf of the patient, and has completed and signed the relevant declaration on the certificate;
 - (k) The certificate of request has been signed in the presence of the patient and the first medical practitioner by another medical practitioner (who may be the medical practitioner referred to in paragraph (c)(i) or any other medical practitioner) after that medical practitioner has discussed the case with the first medical practitioner and the patient and is satisfied, on reasonable grounds, that the certificate is in order, that the patient is of sound mind and the patient's decision to end his or her life has been made freely, voluntarily and after due consideration, and that the above conditions have been complied with;
 - (l) Where, in accordance with subsection (4), an interpreter is required to be present at the signing of the certificate of request, the certificate of request has been signed by the interpreter confirming the patient's understanding of the request for assistance;
 - (m) The medical practitioner has no reason to believe that he or she, the countersigning medical practitioner or a close relative or associate of either of them, will gain a financial or other advantage (other than a reasonable payment for medical services) directly or indirectly as a result of the death of the patient;
 - (n) Not less than 48 hours has elapsed since the signing of the completed certificate of request;
 - (o) At no time before assisting the patient to end his or her life had the patient given to the medical practitioner an indication that it was no longer the patient's wish to end his or her life;
 - (p) The medical practitioner himself or herself provides the assistance and/or is and remains present while the assistance is given and until the death of the patient.
- (2) In assisting a patient under this Act a medical practitioner shall be guided by appropriate medical standards and such guidelines, if any, as are prescribed, and shall consider the appropriate pharmaceutical information about any substance reasonably available for use in the circumstances.
- (3) Where a patient's medical practitioner has no special qualifications in the field of palliative care, the information to be provided to the patient on the availability of palliative care shall be given by a medical practitioner (who may be

the medical practitioner referred to in subsection (1)(c)(i) or any other medical practitioner) who has such special qualifications in the field of palliative care as are prescribed.

(4) A medical practitioner shall not assist a patient under this Act where the medical practitioner or any other medical practitioner or qualified psychiatrist who is required under subsection (1) or (3) to communicate with the patient does not share the same first language as the patient, unless there is present at the time of that communication and at the time the certificate of request is signed by or on behalf of the patient, an interpreter who holds a prescribed professional qualification for interpreters in the first language of the patient.

3.74 Section 8 of the Act provides a further safeguard. It reads as follows:

8. PALLIATIVE CARE

(1) A medical practitioner shall not assist a patient under this Act if, in his or her opinion and after considering the advice of the medical practitioner referred to in section 7(1)(c)(i), there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient.

(2) Where a patient has requested assistance under this Act and has subsequently been provided with palliative care that brings about the remission of the patient's pain or suffering, the medical practitioner shall not, in pursuance of the patient's original request for assistance, assist the patient under this Act. If subsequently the palliative care ceases to alleviate the patient's pain and suffering to levels acceptable to the patient, the medical practitioner may continue to assist the patient under this Act only if the patient indicates to the medical practitioner the patient's wish to proceed in pursuance of the request.

3.75 Section 10 of the Act further provides that a patient may rescind a request for assistance under this Act at any time and in any manner. In such an event the medical practitioner concerned shall destroy the original certificate of request.

3.76 The Act lastly deals with a number of administrative matters, which are not relevant for the purposes of our discussion.

Discussion

3.77 In the discussion above, a distinction is made between cases of assisted suicide (par. (ii)), and cases where the patient requires active assistance in ending his or her life and where the final act is performed by the person granting the request. (par. (iii))

3.78 The first question to be discussed is whether any real distinction, whether moral or legal, can be drawn between the two sets of cases. Is it not true that in both cases the person to whom the request was directed performed the act, and was the intention in both cases not to cause death? Both cases presently under discussion are legally speaking versions of active euthanasia and should be dealt with accordingly. Should legal reform be necessary, it would be imperative to state clearly that both instances should be determined in the way which will be decided upon. It is the principle of assistance in the ending of life, or voluntary euthanasia, which is under discussion here.

3.79 The central question in the present case is therefore whether our community would consider a request for euthanasia as reasonable or unreasonable where the consent is given by a mentally competent person with full knowledge and understanding of the extent, nature and consequences of his or her consent.

3.80 The arguments for and against voluntary active euthanasia have often been debated and are generally known. A reasonably extensive summary of the argument against voluntary euthanasia can be found in the previously mentioned report of the British House of Lords of 1994. We take the liberty to quote fully the relevant section of the report as well as the justification for the decision taken by the committee.⁷¹

236. The right to refuse medical treatment is far removed from the right to request assistance in dying. We spent a long time considering the very strongly held and sincerely expressed views of those witnesses who advocated voluntary euthanasia. Many of us have had experience of relatives or friends whose dying days or weeks were less than peaceful or uplifting, or whose final stages of life were so disfigured that the loved one seemed already lost to us, or who were

71 **Report of the Select Committee** par 236 and further. See also Kapp, M B "‘Ageism’ and the right to die litigation" 1994 **Medicine and law** 69; Rougé, D Telmon, N, Albarède, J-L & Arbus, L "Questions raised by artificial prolongation of life of the aged patient" 1994 **Medicine and law** 269.

simply weary of life. Our thinking must inevitably be coloured by such experience. The accounts we received from individual members of the public about such experiences were particularly moving, as were the letters from those who themselves longed for the release of an early death. Our thinking must also be coloured by the wish of every individual for a peaceful and easy death, without prolonged suffering, and by a reluctance to contemplate the possibility of severe dementia or dependence. We gave much thought too to Professor Dworkin's opinion that, for those without religious belief, the individual is best able to decide what manner of death is fitting to the life which has been lived.

237. Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.

238. One reason for this conclusion is that we do not think it possible to set secure limits on voluntary euthanasia. Some witnesses told us that to legalise voluntary euthanasia was a discrete step which need have no other consequences. But as we said in our introduction, issues of life and death do not lend themselves to clear definition, and without that it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused. Moreover to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation. These dangers are such that we believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address. Fear of what some witnesses referred to as a "slippery slope" could in itself be damaging.

239. We are also concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. We accept that, for the most part, request resulting from such pressure of from remediable depressive illness would be identified as such by doctors and managed appropriately. Nevertheless we believe that the message which society send to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.

240. Some of those who advocated voluntary euthanasia did so because they feared that lives were being prolonged by aggressive medical treatment beyond the point at which the individual felt that continued life was no longer a benefit but a burden. But, in the light of the consensus which is steadily emerging over the circumstances in which life-prolonging treatment may be withdrawn or not initiated, we consider that such fears may increasingly be allayed. We welcome moves by the medical professional bodies to ensure more senior oversight of practice in casualty departments, as a step towards discouraging inappropriately aggressive treatment by less experienced practitioners.

241. Furthermore, there is good evidence that, through the outstanding achievements of those who work in the field of palliative care, the pain and distress of terminal illness can be adequately relieved in the vast majority of cases. Such care is available not only within hospices: thanks to the increasing dissemination of best practice by means of home-care teams and training for general practitioners, palliative care is becoming more widely available in the health service, in hospitals and in the community, although much remains to be done. With the necessary political will such care could be made available to all who could benefit from it. We strongly commend the development and growth of palliative care services.

242. In the small and diminishing number of cases in which pain and distress cannot be satisfactorily controlled, we are satisfied that the professional judgment of the health-care team can be exercised to enable increasing doses of medication (whether of analgesics or sedatives) to be given in order to provide relief, even if this shortens life. The adequate relief of pain and suffering in terminally ill patients depends on doctors being able to do all that is necessary and possible. In many cases this will mean the use of opiates or sedative drugs in increasing doses. In some cases patients may in consequence die sooner than they would otherwise have done but this is not in our view a reason for withholding treatment that would give relief, as long as the doctor acts in accordance with responsible medical practice with the objective of relieving pain or distress, and with no intention to kill.

243. Some witnesses suggested that the double effect of some therapeutic drugs when given in large doses was being used as a cloak for what in effect amounted to widespread euthanasia, and suggested that this implied medical hypocrisy. We reject that charge while acknowledging that the doctor's intention, and evaluation of the pain and distress suffered by the patient, are of crucial significance in judging double effect. If the intention is the relief of severe pain or distress, and the treatment given is appropriate to that end, then the possible double effect should be no obstacle to such treatment being given. Some may suggest that intention is not readily ascertainable. But juries are asked every day to assess intention in all sorts of cases, and could do so in respect of double effect if in a particular instance there was any reason to suspect that the doctor's primary intention was to kill the patient rather than to relieve pain and suffering. They would no doubt consider the actions of the doctor, how they compared with

usual medical practice directed towards the relief of pain and distress, and all the circumstances of the case. We have confidence in the ability of the medical profession to discern when the administration of drugs has been inappropriate or excessive. An additional safeguard is that increased emphasis on team work makes it improbable that doctors could deliberately and recklessly shorten the lives of their patients without their actions arousing suspicion.

244. We could add that the effects of opiates (the drugs most commonly involved in double effect) and of some other pain-relieving and sedative drugs are so uncertain that the outcome of a particular dose can never be predicted with total confidence. The body weight, metabolism, habituation and general condition of the individual patient all affect the response. There have been cases where an error in dispensing resulted in the administration of a dose which seemed likely to be lethal, yet the patient flourished. A doctor called to testify in the case of Dr Bodkin Adams asserted that a particular dose must certainly kill, only to be told that the patient had previously been given that dose and had survived. The primary effect (relief of pain and distress) can be predicted with reasonable confidence but there can be no certainty that the secondary effect (shortening of life) will result. Decisions about dosage are not easy, but the practice of medicine is all about the weighing of risks and benefits.

3.81 In contrast with the conclusion drawn by the said committee of the House of Lords, Professor Labuschagne of the University of Pretoria is an outspoken champion of the decriminalisation of voluntary euthanasia.⁷² He discusses the arguments against euthanasia under the following headings and comments as follows:

1. Religious-moral arguments.

Labuschagne points out that the religious and moral objections to euthanasia are based on diverse religious and moral convictions. He identifies with the writer Williams who argues that religious arguments against euthanasia are in themselves not enough. People who do not share particular convictions should not be bound by them. A rule should therefore be necessary for the "worldly welfare of society generally" before it can lay claim to judicial status. He also holds that a deregulating process on a wide front is taking place in the criminal law.

72 Labuschagne, J M T "Dekriminalisatie van eutanase," 1988 **THRHR** 167. See also Weinfeld, J "Active voluntary euthanasia - should it be legalised" 1985 **Medicine and law** 101, 108 and further.

Labuschagne discusses the religious-moral arguments in more depth under the following headings:

(a) God has allocated a specific time of death to every person

He says that it is sometimes argued that God in his Providence has allocated a specific time of death to every person and that man is not supposed to interfere with that. Labuschagne however holds that if this argument is to be taken seriously, the question can then be asked why lives are prolonged artificially by medicine. Medical science is inherently an interference with the processes of nature. He associates himself with the writer Fletcher⁷³ who indicated that things like sterilisation, artificial insemination and birth control "...are all medically discovered ways of fulfilling and protecting human values and hopes in spite of nature's failures and foolishnesses. Death control, like birth control, is a matter of human dignity."

(b) The prohibition against killing

Labuschagne mentions the fact that it is sometimes argued that euthanasia is incompatible with the sixth commandment which forbids killing. He however points out that the killing of a person may be lawful in certain circumstances, for example when acting in self-defence. The question is therefore not simply whether a fellow human being has been killed, but rather whether the killing was justified. That is the question that has to be answered.

(c) Suffering has a purpose

73 Op cit 168.

The argument is sometimes used, according to Labuschagne, that man should suffer, as suffering has a divine purpose. According to him the opposite principle would be love for one's neighbour, which has as its purpose the lessening or the elimination of human suffering. He associates himself⁷⁴ with the writer Mathews where he says:

Nothing could be more distressing than to observe the general degeneration of a fine and firm character into something which we hardly recognize as our friend, as the result of physical causes and of the means adopted to assuage intolerable pain. It is contended that the endurance of suffering may be a means of grace and no Christian would deny this, but I would urge that, in the case of man whose existence is a continuous drugged dream, this cannot be alleged.

2. Diagnostic and prognostic mistakes.

According to Labuschagne a further argument against euthanasia is that doctors are bound to make diagnostic or prognostic mistakes and that people sometimes recover from illness against all expectation. However, Labuschagne notes that in the proposals for the decriminalisation of euthanasia it is almost without exception accepted that the opinion of only one expert medical practitioner will not suffice. It should be the unanimous decision of more than one medical practitioner, in other words a panel. The fact that mistakes will nevertheless still occur, cannot be denied. Mistakes are typical of the human phenomenon and are found everywhere. Only if man should succeed in obliterating himself, would human mistakes cease. In such a case the need for euthanasia would however also cease. According to him the said argument therefore contributes nothing to the euthanasia debate.

3. No illness is incurable.

Labuschagne notes that it is sometimes argued that no illness is inherently incurable: as long as there is life, there is hope. It is argued that medical science may in future find a

74 Ibid.

cure for a certain illness. Against this Labuschagne holds that a person should judge a situation as it stands. He associates himself with Mathews where he says:

We cannot regulate our conduct at all unless we assume that we must be guided by the knowledge we have. We take for granted that known causes will be followed by known effects in the overwhelming majority of cases. Any other assumption would strike at the roots of sanity.

4. The thin-end-of-the-wedge argument.

It is sometimes argued, according to Labuschagne, that voluntary euthanasia is only the thin end of the wedge and that it could diminish the value attached to life. Legalisation of voluntary euthanasia could open the door to abuse and even foul play. Labuschagne however refutes this argument by saying that it could also be applicable to any other human action. To use an analogy: freedom of speech should be forbidden as it could lead to slander. Nobody can take such an argument seriously.

5. Medical-ethical arguments.

According to Labuschagne the following sub-divisions of this argument can be distinguished:

(a) The Oath of Hippocrates is violated

It is sometimes submitted that euthanasia is in conflict with the Oath of Hippocrates that doctors have to take before practising medicine. Labuschagne however, asks the question, whether it is meaningful to be bound to an oath that is over two thousand years old. If so, the oath should be adapted. In any case, the Oath of Hippocrates should be interpreted progressively, as the duty of the medical practitioner is not only to cure illness, but also to eliminate suffering.

(b) Trust in medical science is violated

According to Labuschagne, it is sometimes submitted that legalising euthanasia (especially active euthanasia) would violate the trust of the population in the medical practitioner and in medical science. It is alleged that patients would see medical practitioners as executioners and not as doctors. In answer to this argument Labuschagne notes that the patient's consent is a requirement in all cases and that mechanisms have been built into the euthanasia process to prevent abuse.

(c) Euthanasia assists organ transplants

The argument is sometimes raised that the legitimisation of euthanasia will enable doctors to obtain prime human organs on order, so to speak. Although Labuschagné concedes that organ transplants might benefit should euthanasia be legitimised, he nevertheless argues that this should never be used as justification for euthanasia.⁷⁵

(d) The problem of consent

Labuschagne explains that the problem in this case is that the consent to euthanasia given by the patient while he is in pain, suffering and facing death, and accordingly in a state of anxiety and depression, may be questionable. Can it really be regarded as voluntary? There is a difference between the desire to die and a request to be killed. A British study showed that requests to be killed should not always be taken seriously as they are often intended as cries for help and attention. Although Labuschagne concedes that as factors like pain, illness, drugs and a range of other circumstances may have an effect on a person's mental state, the patient should be evaluated throughout. There should be compulsory consultation between and supervision by experts. The doctor should inform his or her patient as to the diagnosis and prognosis of the illness. This should however only be done should the patient request the information. The information needn't be given all at once. Consent given after having obtained sufficient information is known as informed consent. According to

75 Op cit 189.

Labuschagne, the latter is based on human individuality, dignity and autonomy and forms one of the fundamental tenets of euthanasia.

3.82 Labuschagne⁷⁶ is of the opinion that voluntary euthanasia should be legalised. He proposes legislation that would legalise cessation of treatment as well as active euthanasia and suggests the following criteria:

- (a) The patient must be suffering from a **terminal** illness;
- (b) the suffering must be subjectively **unbearable**;
- (c) the patient must **consent** to the cessation of treatment or administering of euthanasia;
- (d) the above-mentioned condition and facts must be **certified** by at least two medical practitioners.

3.83 Labuschagne is also of the opinion that it would be preferable, in order to eliminate any question of criminal liability, to approach the Supreme Court, if possible before performing the act of euthanasia, in order to obtain a declaratory order that all conditions have been met.

3.84 It is therefore clear that Labuschagne wants to control euthanasia and wants to make it permissible only in cases where the necessary certificate has been issued by at least two medical practitioners. It can be assumed that he also intends the act of euthanasia to be performed by a medical practitioner only. This does not however mean that non-medical euthanasia would always be inadmissible. The common law principles with regard to necessity would be applicable in appropriate cases to justify non-medical euthanasia. Labuschagne refers to two hypothetical examples in this regard:

76 Op cit 190.

- (a) The driver A of a motorvehicle is trapped in his burning car. He requests B to kill him as he does not want to burn to death. B takes his revolver and kills A.
- (b) C, a soldier, lies on the battle-field, seriously wounded. While the enemy draws nearer he asks his friend D to kill him in order to escape a torturous death at the hands of the enemy. D kills him.

Labuschagne is of the opinion that neither B nor D is criminally liable. Both have acted in what is legally known as necessity.

3.85 Labuschagne finally states that his recommendations are based on respect for human dignity and compassion for fellow human beings who have been exposed to great suffering and affliction. The accent therefore falls on the sacredness of the quality of life rather than the sacredness of life per se. He associates himself with Fletcher:⁷⁷

[I]t is harder morally to justify letting somebody die a slow and ugly death dehumanised than it is to justify helping to avoid it.

3.86 He also quotes from Dowling, evidently with approval:⁷⁸

By the bed of an actual sufferer the proportions of the problem are seen quite differently. It becomes no longer a question of the sanctity of 'life' and the need to prolong suffering existing just as long as it is technically possible, but a case in which the compelling demands of compassion and dignity combine to impose merciful death as the only natural solution.

3.87 We feel that we have stated all the arguments for and against euthanasia with the necessary thoroughness. The decision as to whether active voluntary euthanasia

77 Op cit 191.

78 Op cit 191.

and assisted suicide should be allowed is after all one of policy. **We seek the guidance of our readers on this question.**

3.88 Finally, the question should also be asked whether the legalisation of euthanasia would not be in conflict with the right to life as it is currently entrenched in section 11 of the Constitution⁷⁹. Some say no. In the first place they argue that it is the right to life which is entrenched, not the obligation to live. Apart from that they argue that the right to life in the present context should be weighed up against other fundamental rights such as, amongst others, the right to human dignity. Thirdly, they argue that the right to life, should it be applicable in the said case, would in any case be limited by section 36 of the Constitution which permits legislation that is reasonable and justifiable in an open and democratic society. **What do our readers consider to be the correct view?**

3.89 While the Commission is **prima facie** of the view that legal provision should be made to regulate cessation of life-sustaining treatment, the Commission has not taken up any position as regards voluntary euthanasia and assisted suicide, whether for or against. **We require the guidance of our readers in this respect as well.**

3.90 If voluntary euthanasia and assisted suicide should be included as acceptable end of life decisions, **we would also like our readers to inform us what safeguards should be provided for.** Should the request be acceded to only in the case of terminally ill patients? Is the opinion of a single medical practitioner sufficient? Must the request be in writing and attested by independent witnesses?

3.91 Should it be necessary to introduce legislation in this regard, we propose the following clause:

Cessation of life

79 Act 108 of 1996. For more on 'the right to die', see Plachta, M "The right to die in Canadian legislation, case law and legal doctrine" 1994 **Medicine and law** 639; Leonard -Taitz, J "Euthanasia, the right to die and the law in South Africa" 1992 **Medicine and Law** 597.

5. (1) *Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall not give effect to the request unless he or she is convinced that-*
- (a) *the patient is suffering from a terminal illness;*
 - (b) *the patient is subject to extreme suffering;*
 - (c) *the patient is over the age of 18 years and mentally competent;*
 - (d) *the patient has been adequately informed as to the illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;*
 - (e) *the request of the patient is based on an informed and well considered decision;*
 - (f) *the patient has had the opportunity to re-evaluate his or her request, but that he or she has persisted; and*
 - (g) *euthanasia is the only way for the patient to be released from his or her suffering.*
- (2) *No medical practitioner to whom the request to make an end to a patient's suffering is addressed as contemplated in subsection (1), shall give effect to such a request, even though he or she may be convinced of the facts as stated in that subsection, unless he or she has conferred with an independent medical practitioner who is knowledgeable with regard to the terminal illness from which the patient is suffering and who has personally checked the patient's medical*

history and examined the patient and who has confirmed the facts as contemplated in subsection (1)(a), (b) and (g).

(3) A medical practitioner who gives effect to a request as contemplated in subsection (1), shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner with whom he or she has conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).

(4) The termination of a patient's life on his or her request in order to release him or her from suffering may not be effected by any person other than a medical practitioner.

(5) A medical practitioner who gives effect to a patient's request to be released from suffering as contemplated in this section shall not suffer any civil, criminal or disciplinary accountability with regard to such an act provided that all due procedural measures have been complied with.

(6) No medical practitioner is obliged to give effect to a patient's request to assist with the termination of the patient's life.

(iv) Involuntary euthanasia

3.92 For the sake of completeness the case of involuntary euthanasia has to be discussed as well. This involves those cases where a person, acting in sympathy and compassion for a legally competent person, performs euthanasia either by an omission or by a positive act. In these instances there is no request for euthanasia by the patient.

3.93 No legal system would tolerate this kind of conduct, especially because of the possible abuse which may occur if it were to be accepted. We therefore feel that no legal reform is necessary in this area. **Do our readers agree with this viewpoint?**

CHAPTER 4

THE INCOMPETENT PATIENT WHO HAS NO PROSPECT OF RECOVERY OR IMPROVEMENT

4.1 This Chapter deals with the situation of mentally incompetent or permanently comatose persons **for whom no hope of recovery or improvement exists** who cannot take their own decisions and cannot therefore request cessation of treatment, assistance with suicide or active voluntary euthanasia. Some of these patients can be referred to as being in a permanently vegetative state. They are not brain dead, but they are in an irreversibly, unconscious state. To keep the patient alive, he or she has to be fed artificially, and ventilated, if necessary. Some of the life functions have to be aided.

4.2 The factors that cause this condition are numerous: quite often it is the result of brain injury or asphyxiation as a result of which the blood supply and therefore also the supply of oxygen to the brain is shut off for such a long period that it results in irreversible brain damage. The condition is often the result of a serious stroke, but it can also be the result of brain damage during the birth process, with the result that the child born is in an unconscious, irreversibly vegetative condition for the rest of his or her life.

4.3 In discussing cessation of life-sustaining medical treatment two situations need to be considered separately. The one is where the patient concerned has indicated, before becoming incompetent, in a written and signed document, called a “living will” or “advance directive”¹ or in a power of attorney, his or her wishes regarding life

1 This is the preferred term. The term “living will” can create the impression that one is dealing with a valid will, which is not the case.

sustaining treatment. The other situation is where the patient has not indicated his or her wishes before becoming incompetent.

(i) Cessation of life-sustaining medical treatment

A. There is an advance directive (living will) or power of attorney

4.4 A so-called advance directive (living will) is drafted by a competent person who foresees the possibility that he or she may at some future date, as a result of physical or mental ability, be unable to make rational decisions as to his or her medical treatment and care. In this document the drafter therefore endeavours to make certain requests or issue directives to the people who would be responsible for his or her medical treatment. The underlying principle is that a patient has the right to refuse specific treatment, even life-sustaining treatment, and that medical staff are obliged to honour the wishes of a mentally competent patient. When a patient is no longer able to make decisions regarding his or her treatment and care, doctors are dependent on prior consent, directives by an agent or their own judgment, with due observance of the ethical code that binds them. The object of the advance directive (living will) is therefore to give guidelines to medical practitioners as to their conduct in circumstances where the patient is unable to do so himself or herself. It is a particular object of this document to absolve medical practitioners from liability should the treatment or the withholding of such treatment hasten the death of the patient.

4.5 The validity of the consent given and the directions set out in the document is, however, not without its problems. We must therefore determine whether the validity of advance directives (living wills) should be recognised by statute and, if so, what precautionary measures should be taken, if any.

4.6 The main clause of the English version of the Living Will, as made available by the South African Living Will Society to its members for signing, reads as follows:

If the time comes when I can no longer take part in decisions for my own future let this declaration stand as the testament to my wishes. If there is no

reasonable prospect of my recovery from physical illness or impairment expected to cause me severe distress or to render me incapable of rational existence, I request that I be allowed to die and not be kept alive by artificial means and that I receive whatever quantity of drugs may be required to keep me free from pain or distress even if the moment of death is hastened.

4.7 As Professor Strauss² rightly observes, the advance directive (living will) is not a will in the technical, testamentary sense of the word. It is merely a standing request to medical staff to act in a specific manner in specific circumstances. Professor Strauss is of the opinion that, as far as the request not to be kept alive by artificial means is concerned, it constitutes a legitimate refusal of consent to treatment and that medical practitioners are accordingly obliged to comply with it. In respect of a clause in an advance directive (living will) that authorises the administering of drugs, even if its secondary effect is to hasten death, Professor Strauss³ feels that complying with such a request would be lawful if the doctor acted in good faith and used the normal drugs in reasonable quantities with the object of relieving pain and not of causing death.⁴

4.8 Various legal systems also use a power of attorney to enable a principal to entrust an agent with the decision-making power regarding the principal's medical treatment and care. The agent is usually a family member or confidant of the principal. The circumstances in which the proxy will come into force are set out in the power of attorney. This happens should the principal no longer be able to make decisions or give instructions to medical practitioners as a result of an illness. Such a power of attorney may also embody the wishes of the principal not to be kept alive artificially in specific circumstances. A power of attorney may therefore often include a so-called "advance directive" or a "health care directive", which corresponds with the usual terms found in an advance directive (living will).

4.9 In our law a power of attorney lapses when the principal becomes mentally incompetent. An agent would therefore not be able to make decisions as to, for

2 Strauss **Doctor, patient and the law** 344.

3 Strauss **Doctor, patient and the law** 345.

4 See Ch 3, par 3.25 and further for a discussion of the so-called "double effect".

example, the performance of an operation or the discontinuation of artificial respiration or feeding on behalf of a person who is permanently unconscious. Legislation would be necessary to permit this.

4.10 During 1988 the Commission investigated the desirability of making provision for an enduring power of attorney in certain circumstances.⁵ The investigation was concerned with decision-making in respect of a mentally incompetent person's property and not his or her person. The Commission proposed two Bills - one to make provision for enduring powers of attorney under certain circumstances and the other to make provision for a simpler, less expensive way of appointing a curator in respect of the property of a mentally incompetent person. Only the latter recommendation was accepted. This led to the **Mentally Ill Person's Legal Interests Amendment Act, 1990**.⁶ It was said that the reason why the first-mentioned Bill was not promoted was because its application would have been very limited and that the legislature does not cater for exceptions.

(a) Comparative law

4.11 We shall now briefly discuss the main developments regarding advance directives (living wills) in comparative perspective.

* **The United States of America**

5 South African Law Commission Report **Enduring Powers of Attorney and the Appointment of Curators to Mentally Incapacitated Persons** October 1988.

6 Act 108 of 1990.

4.12 California was the first state to accept legislation with regard to the advance directive (living will) by enacting the **Natural Death Act, 1976**.⁷ Subsequently most states have adopted similar legislation.

4.13 It has been found that the requirements for a valid advance directive (living will) differ from one state to another. In general all the states provide for a written document signed by the drafter or by someone on his or her behalf, as well as at least two witnesses. In some states people with an interest in the case are excluded as competent witnesses and a few other states provide for the document to be drafted by an attorney. In California an advance directive (living will) lapses automatically after five years.

4.14 In 1985 the National Conference of Commissioners of Uniform State Laws suggested a uniform enactment with regard to advance directives (living wills) through the **Uniform Rights of the Terminally Ill Act**. The most important feature of this Act is that it is confined to terminal illnesses. Section 1(9) of the Uniform Act defines a terminal condition as:

[A]n incurable or irreversible condition that, without the administration of life sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.

4.15 Section 1(4) of the Uniform Act defines life-sustaining treatment as:

[A]ny medical procedure or intervention that ... will serve only to prolong the process of dying.

7 Pozgar, G D **Legal aspects of health care administration** 4 th edition Maryland Aspen Publishers 1990 195 (hereinafter referred to as "Pozgar **Health care administration**").

4.16 In the case **John F Kennedy Memorial Hospital Inc v Bludworth**⁸ the Supreme Court of Florida had to decide the following legal question:

In the case of a comatose and terminally ill individual who has executed a so-called “Living” or “mercy” will, is it necessary that a court appointed guardian of his person obtain the approval of a court of competent jurisdiction before terminating extraordinary life support systems in order for consenting family members, the attending physicians, and the hospital and its administrators to be relieved of civil and criminal liability?

8 452 So 2d 921 (Fla 1984) on 922.

4.17 The court held that such approval is not necessary. The court investigated the right of terminally ill patients to refuse to be kept alive artificially and found, on the basis of quoted authority, that such a right was not only recognised in the state of Florida, but also in other states of the USA. The court subsequently considered the question of who may exercise the right when a person is unable to do it himself or herself as a result of his or her comatose state. In this regard the majority of the court held as follows:⁹

We hold that the right of a patient, who is in an irreversible comatose and essentially vegetative state, to refuse extraordinary life-sustaining measures, may be exercised either by his or her close family members or by a guardian of the person of the patient appointed by the court. If there are close family members such as the patient's spouse, adult children, or parents, who are willing to exercise this right on behalf of the patient, there is no requirement that a guardian be judicially appointed. However, before either a close family member or legal guardian may exercise the patient's right, the primary treating physician must certify that the patient is in a permanent vegetative state and that there is no reasonable prospect that the patient will regain cognitive brain function and that his existence is being sustained only through the use of extraordinary life sustaining measures. This certification should be concurred in by at least two other physicians with specialities relevant to the patient's condition.

4.18 Regarding the way in which a family member exercises the right on behalf of the patient, the court was of the opinion that conduct is based on the doctrine of "substituted judgment". In this respect the court observed as follows:¹⁰

Under this doctrine close family members or legal guardians substitute their judgment for what they believe the terminally ill incompetent persons, if competent, would have done under these circumstances. If such a person, while competent, had executed a so-called "living" or "mercy" will, that will would be persuasive evidence of that incompetent person's intention and it should be given great weight by the person or persons who substitute their judgment on behalf of the terminally ill incompetent.

4.19 It is worth noting that in this case the advance directive (living will) was only regarded as persuasive evidence of the wishes of the person concerned that should

9 **John F Kennedy Memorial Hospital Inc v Bludworth** 452 So 2d 921 (Fla 1984) at 926.

10 Op cit 926.

carry considerable weight with the decision-maker. However, it appears that the advance directive (living will) in itself could not authorise the discontinuance of artificial life-support systems even when the point had been reached where no recovery was possible. Consent was still required either from the family, the curator or the court.

4.20 The **Patient Self-Determination Act, 1990**¹¹ was enacted on 1 December 1991. It provides that, on admission, hospital staff should specifically enquire from patients whether they wish to fill in a form stipulating which treatment they prefer or refuse and whether they wish to appoint a family member or friend to make decisions on their behalf if circumstances may arise in which they are unable to communicate their wishes themselves. The form is completed voluntarily and is regarded as valid and binding. This Act is a federal Act and is accordingly applicable to all the states in America.

4.21 In addition to advance directive (living will) legislation, some states have also made statutory provision for the appointment of agents by way of enduring powers of attorney, in terms of which decisions can be made on behalf of incompetent patients in respect of their medical treatment.

4.22 The advance directive (living will) legislation has been criticised. The writer George D Pozgar holds the following opinion:¹²

Although many interest groups hailed the enactments of natural death or living will acts as providing the solution to the difficult problems inherent in euthanasia situations, the statutes present inadequacies that must be addressed. A person drafting a living will when healthy and mentally competent cannot predict how he or she will feel at the time of a terminal illness. Moreover, unless the document is updated regularly, how can it be ascertained that the document actually reflects what the patient wishes? If a proxy is used and that proxy is a close family member, there could be danger of a conflict of interest, emotionally or legally. Guidelines must be unified and tightened in order to offer better guidance to physicians and courts.

11 This Act was enacted as sections 4206 and 4751 of the **Omnibus Budget Reconciliation Act** of 1990.

12 Pozgar **Health care administration** 196.

* **Australia**

4.23 The question regarding the refusal of consent to medical treatment and the artificial support of life is dealt with differently in the different states of Australia.¹³ Mainly two approaches are adopted by the different states. Firstly, some states such as South Australia and the Northern Territory give effect to the advance directive (living will) by way of legislation. Secondly, some states such as Victoria and Western Australia make use of substituted decision-making by an agent appointed according to an enduring power of attorney or a curator appointed by the court.

4.24 In South Australia the **Natural Death Act, 1983** recognises the advance directive (living will).¹⁴ In broad outline the **Natural Death Act, 1988** of the Northern Territory is modelled on the South Australian legislation. Under this Act a person of sound mind above the age of 18 years who desires not to be subjected to life-prolonging treatment in the event of a terminal illness, may make a directive to that effect in the prescribed form. The directive must be witnessed by two persons. A doctor responsible for the patient's treatment is obliged to act in accordance with the directive unless he or she has reason to believe that the patient has revoked it or was not, at the time of giving the directive, capable of understanding its nature and consequences.

4.25 In the state of Victoria a completely different approach has been adopted by the enactment of the **Medical Treatment Act, 1988**.¹⁵ This Act is premised on the basis that a patient's wishes with regard to the refusal of medical treatment should be

13 Western Australia Report 7-8.

14 Western Australia Report 8.

15 Western Australia Report 21.

complied with. If a patient is unable to make a decision an authorised agent or appointed curator should be able to make the decision on the patient's behalf. The Act is formalistic and prescribes even the finest detail. It begins with a preamble setting out the need for the statutory enactment. This is followed by a statement of purpose.

4.26 For our purposes section 5(1) of the Act is important. It reads as follows:

Refusal of treatment certificate

5. (1) If a medical practitioner and another person are each satisfied -
- (a) that a patient has clearly expressed or indicated a decision -
 - (i) to refuse medical treatment generally; or
 - (ii) to refuse medical treatment of a particular kind -
- for a current condition; and
- (b) that the patient's decision is made voluntarily and without inducement or compulsion; and
 - (c) that the patient has been informed about the nature of his or her condition to an extent which is reasonably sufficient to enable the patient to make a decision about whether or not to refuse medical treatment generally or of a particular kind (as the case requires) for that condition and that the patient has appeared to understand that information; and
 - (d) that the patient is of sound mind and has attained the age of 18 years-
- the medical practitioner and the other person may together witness a refusal of treatment certificate.

The form of the refusal of treatment-certificate is prescribed in the Act.

4.27 A person may also appoint an agent by way of an enduring power of attorney to make decisions on his or her behalf as to his or her medical treatment, if that person is no longer able to do so. An agent thus appointed or duly appointed guardian of the patient may refuse consent to medical treatment on behalf of the patient if the medical treatment would cause unreasonable distress to the patient or if there are reasonable grounds for believing that the patient, if competent, would have considered the treatment unwarranted.¹⁶ As in the case where the decision is made by the patient himself or herself, a medical practitioner and another person must jointly sign a

16 Sections 5B(1) and (2).

certificate of refusal of treatment in respect of the refusal by the agent or guardian, if they are satisfied that the agent or guardian has been informed of the nature of the patient's current condition and that they understand the implications of such refusal. A refusal of treatment certificate in the prescribed form must be completed by the medical practitioner, the other person and the agent or guardian.

4.28 An enduring power of attorney is not revoked by the subsequent incapacity of the principal but can be revoked by the principal himself or herself. The Guardianship and Administration Board may suspend or revoke an enduring power of attorney in specific circumstances.¹⁷ One of these circumstances would be if the Board was satisfied that refusal of medical treatment was not in the best interests of the patient.¹⁸

4.29 The presentation of the refusal of treatment certificate serves as evidence of the patient's refusal of treatment and a medical practitioner who acts in good faith and who refuses to administer or continue medical treatment in reliance on such certificate is not guilty of misconduct or liable in any criminal or civil proceedings.¹⁹

4.30 The Law Reform Commission of Western Australia investigated the reform of civil and criminal law in this regard. It was mandated to:²⁰

To review the criminal and civil law so far as it relates to the obligations to provide medical or life supporting treatment to persons suffering conditions which are terminal or recovery from which is unlikely, and, in particular, to consider whether medical practitioners or others should be permitted or required to act upon directions by such persons against artificial prolongation of life.

4.31 The Law Reform Commission's report was submitted in February 1991. Its point of departure was:²¹

17 Section 5C.

18 Section 5C(3).

19 Section 9.

20 Western Australia Report 1.

21 Western Australia Report 9.

.... that persons have a right to self determination. This includes the right to choose whether or not to be treated, or to continue to be treated, and the right to determine the course of future treatment if their mental or physical condition makes them unable to exercise their right of choice at the time.

4.32 The Law Reform Commission was not in favour of a person stipulating his or her wishes in respect of future medical treatment by way of an advance directive (living will). It preferred an enduring power of attorney whereby an agent could be appointed to make decisions on behalf of the principal regarding his or her treatment according to the requirements that exist at that time.

4.33 The Law Reform Commission advanced the following reasons why it found the advance directive (living will) to be unacceptable:²²

- * The drafter of the document issues directives as to his or her medical treatment without knowing the precise circumstances that will exist when the will is required to be activated.
- * It normally cannot be expected that a person who is healthy when he makes a decision as to the withholding of life-sustaining treatment will take into account all the factors that would have influenced his or her decision if it was made at a time of actual illness or injury.
- * In most cases the advance directive (living will) is either too specific, thereby failing to cover all circumstances, or too general, thereby causing problems of interpretation, or too discretionary, thereby differing little from a power of attorney.

22 Western Australia Report 12 - 13.

- * There are furthermore problems regarding the question of when the advance directive (living will) should come into force. What should be the criteria and who will decide whether the criteria have been met?

- * There are also problems concerning the communication of the information to the attending doctor. Should he or she accept the authenticity of the document at face value? How would he or she be able to ascertain whether the document had been revoked in the mean time?

4.34 The Law Reform Commission favours a system similar to the one entrenched by legislation in the state of Victoria. This entails the competence to appoint an agent, by way of an enduring power of attorney, to make decisions regarding the medical treatment of the principal. The power of attorney takes effect only if the principal becomes incompetent. In cases where no agent has been appointed or where the appointed agent may be unwilling or unable to act, a guardian must be appointed for the incompetent person.²³

4.35 The decision by the agent or guardian should be based on the decision that the patient would probably have taken in the circumstances, had he or she been able to do so. Where such substituted judgment is inappropriate, the decision should be based on what a reasonable person would probably conceive to be in the best interests of the patient, considering the circumstances.

4.36 The decision made by an agent or guardian on behalf of the incompetent person should be subject to review at the insistence of any interested party.²⁴ If an agent or guardian makes a decision in good faith, he or she should not be civilly or criminally liable for that decision. Certain formalities are prescribed to ensure the legality of an enduring power of attorney.

23 Western Australia Report 15.

24 Western Australia Report 20.

4.37 In order to facilitate proof of refusal of medical treatment, the Law Reform Commission suggests that use should also be made of the refusal of treatment certificate, as is the case in Victoria. Unlike Victoria, it is suggested that such refusal should also apply to palliative care,²⁵ which is defined as:²⁶

the provision of reasonable medical procedures for relief of pain, suffering and discomfort; or the reasonable provision of food and water.

4.38 Finally, it is recommended that a doctor should escape liability if, in reliance on a refusal of treatment certificate, he or she refuses to perform medical treatment. No liability should furthermore result where a medical practitioner administers drugs for the purpose of controlling or eliminating pain and suffering even if the treatment shortens the patient's life, provided that the doctor acted with the consent of the patient, his or her agent or guardian or that the treatment was reasonable in the circumstances of the case.

* **Canada**

° **Alberta**

25 Western Australia Report 23.

26 Section 3 of the (Victoria) Medical Treatment Act, 1988.

4.39 At present there is no advance directive (living will) legislation in Canada, although several attempts have been made to effect a statutory arrangement.²⁷

4.40 In its initial report²⁸ for discussion the Alberta Law Reform Institute recommended that the advance directive (living will) should not be used exclusively. In the report the problems that were foreseen with this document were stated as follows:²⁹

The living will concept has a number of inherent problems, the most significant of which is that it involves the individual having to anticipate what medical condition he or she may be faced with in the future, and what treatment options may be available at that time. This inevitably leads to difficulties of interpretation. ... Most standardized or prescribed forms of living will attempt to overcome the problem of anticipation by resorting to generalized and imprecise language, employing such terms as “heroic measures” and “extraordinary treatment”. However, this merely exacerbates the problem, because these terms are capable of a wide range of interpretations. In the end, the attending physician may find that the living will is simply too vague and ambiguous to provide any useful guidance as to the patient’s wishes.

27 Alberta Law Reform Institute and The Health Law Institute **Advance directives and substitute decision-making in personal healthcare** Joint Report No. 64 March 1993 (hereinafter referred to as “Joint Report”).

28 Alberta Law Reform Institute **Advance directives and substitute decision-making in personal healthcare** Report for discussion No. 11 November 1991 (hereinafter referred to as “Alberta Report”).

29 Alberta Report 30.

4.41 The principal recommendation in the Alberta Report and the Joint Report was that legislation be introduced to give legal effect to health care directives. The Alberta Law Reform Institute and the Health Law Institute argued that a health care directive would enable individuals to exercise control over future health care decisions in a number of ways.³⁰ First, it could be used to appoint someone as a health care agent, who would have legal authority to make health care decisions on behalf of the individual in the event of his or her becoming incapable of making these decisions personally. Second, the health care directive could identify anyone whom the individual does not wish to act as his or her health care proxy. Third, it could be used to provide instructions and information concerning future health care decisions; for example, instructions as to what types of medical treatment the individual would not want in certain circumstances. If these advance instructions were unambiguous and relevant to the health care decision being considered, they would be legally binding and would have to be followed.³¹

4.42 The Alberta Law Reform Institute identified a need to create a system of substitute decision-making for those patients who have no guardian and who have not appointed a health care agent.³² It recommended that this be done by way of a statutory list of proxy decision-makers. In the event of a patient being mentally incapable of making a health care decision, the first available person on the statutory list

30 Joint Report 7.

31 Joint Report 7 - 8.

32 Alberta Report 58 - 65.

would have the legal authority to make the decision on the patient's behalf. It was recommended that the statutory list be as follows.³³

- (a) A guardian appointed under the Dependent Adults Act (or the equivalent legislation) with authority to make health care decisions on behalf of the patient;
- (b) a health care agent appointed by the patient pursuant to a health care directive;
- (c) the patient's spouse or partner;
- (d) the patient's children;
- (e) the patient's parents;
- (f) the patient's siblings;
- (g) the patient's grandchildren;
- (h) the patient's grandparents;
- (i) the patient's uncle and aunt;
- (j) the patient's nephew and niece;
- (k) any other relative of the patient;
- (l) the patient's health care practitioner.

33 Joint Report 9.

4.43 Another key recommendation of the Alberta Law Reform Institute concerned the criteria for substitute decision-making.³⁴ As we have seen,³⁵ the view was taken that if the patient's health care directive contains instructions which are unambiguous and relevant, these should be legally binding. What happens if there are no such instructions? In the Alberta Report it was proposed that, where possible, proxies should apply a substituted judgment test - that is, they should decide according to what they believe the patient would have decided if competent, rather than according to what they consider to be in the patient's best interests. This view was affirmed in the Joint Report.³⁶

° **Saskatchewan**

34 Alberta Report 65 - 70.

35 See paragraph 4. 73 above.

36 Op cit 10.

4.44 In December 1991 the Law Reform Commission of Saskatchewan published a report recommending the enactment of legislation giving legal effect to advance health care directives.³⁷ However, the Saskatchewan recommendations are much narrower in scope than those of other Canadian provincial law reform agencies. In particular, the Saskatchewan Commission took the position that advance directives (living wills) should be limited to cases of “last illness”. Thus, the Commission recommended that an advance directive (living will) should be given recognition “if it is intended to take effect when the maker is suffering from a condition that is terminal, or will result in a significant diminished quality of life.”³⁸

4.45 It is further important to take note of the following conclusion of the Saskatchewan Commission:³⁹

But whether the Living Will is drafted in broad or narrow terms, in detail or in generalities , it can take effect in Canada only as a manifestation of a refusal to consent to medical treatment ... At present, most physicians are more apt to regard a living will as a “guide or a framework for patient management” than as a legally binding document. Under current practice in Saskatchewan hospitals, when an advance directive is known to attending physicians, a psychological assessment of the patient and involvement of family members is often given equal weight with the patient’s expressed wishes in determining a course of action.

° **Newfoundland**

37 Law Reform Commission of Saskatchewan **Proposals for an advance health care directives act** December 1991 16 (hereinafter referred to as “Saskatchewan Report”).

38 Saskatchewan Report 29.

39 Saskatchewan Report 20.

4.46 In January 1992 the Newfoundland Law Reform Commission published a discussion paper on advance directives and attorneys for health care.⁴⁰ Its recommendations on health care directives are very similar to that of the Alberta Law Reform Institute and the Health Law Institute⁴¹ and to those of the Manitoba Law Reform Commission.⁴² The basic position adopted by the Newfoundland Discussion Paper is that individuals should be able to use a health care directive to appoint a health care proxy, and also to provide information and instructions which would be binding on the proxy. As with the Manitoba Report, the focus of the Newfoundland Discussion Paper is limited to health care directives. It does not consider the additional issue of whether there should be a statutory list of proxy decision-makers, so as to deal with the situation where the patient has not appointed a health care agent.

4.47 Against this background, we take a detailed look at some of the recommendations made in the Newfoundland Discussion Paper. Firstly, the Newfoundland Law Reform Commission submitted that the Canadian Criminal Code should be amended to make it clear that criminal law imposes no duty on a medical practitioner to initiate or maintain medical treatment contrary to the instructions of the patient.⁴³ Legislation should furthermore be enacted to recognise the patient's common law right to refuse medical treatment by granting a competent individual the opportunity to give advance instructions regarding his or her medical treatment and/or to delegate decision-making powers to his or her nominated agent.

4.48 It is further recommended that it should be possible for an individual to use a health care directive or to authorise an attorney to make health care decisions on that person's behalf. A health care decision should include the giving, refusal or withdrawing

40 Newfoundland Law Reform Commission **Advance health care directives and attorneys for health care** Discussion Paper No. 6, 1992 (hereinafter referred to as "Newfoundland Discussion Paper").

41 Joint Report 12.

42 See paragraphs 4.90 *et seq* below.

43 Newfoundland Discussion Paper 101.

of consent to any and all types of medical care, treatment, diagnostic procedures, palliative care, medication as well as non-medical matters which are necessarily incidental to medical care. This should include life-prolonging treatment, psychiatric treatment, the administration of nutrition and hydration and admission to medical or psychiatric treatment facilities or removal from such institutions.⁴⁴

44 Newfoundland Discussion Paper 101.

4.49 The Newfoundland Law Reform Commission further recommends that a health care directive should be in writing and signed by the person making it.⁴⁵ Neither the agent appointed in that health care directive nor the spouse of that agent should be qualified to witness the execution of the directive. A signed, handwritten health care directive of the maker should be valid without any necessity of witnessing, but where the maker signs it with a mark other than his or her signature the execution should be attested by two witnesses.⁴⁶

4.50 It is also recommended that health care facilities (such as hospitals) should be required to enquire, upon admission, whether the patient has made or revoked a directive and to request a copy of the directive, if any.⁴⁷

4.51 The Newfoundland Law Reform Commission believes, however, that the responsibility for communicating the contents of a health care directive should remain with maker.⁴⁸ Where the patient is incapable (unconscious) the medical practitioner should be required to ensure whether such a directive exists or whether an authorised agent has been appointed to attend to the patient's interests. These requirements should also be applicable in emergency situations.

4.52 It is recommended that a health care provider who has been furnished with a copy of a directive should be required to include it in the patient's medical record in such a way that it is brought to the attention of other members of the medical staff.⁴⁹

45 Op cit 102.

46 Op cit 101.

47 Op cit 103.

48 Ibid.

49 Ibid.

4.53 Such a directive should only become effective upon a determination that the maker is not mentally capable of making or communicating with respect to medical treatment.⁵⁰

50 Newfoundland Discussion Paper 103.

4.54 The legislation should specify that a person who is mentally capable of taking a decision with respect to treatment is also able to understand the information that is relevant to the decision and is able to appreciate the reasonable foreseeable consequences of such a decision. The legislation should specify that a principal who has drawn up a valid health care directive is presumed to be capable of doing so unless the contrary is proved.⁵¹

4.55 The Newfoundland Law Reform Commission feels it should be possible to revoke a health care directive by -

- (i) a subsequent validly executed health care directive;
- (ii) a declaration in writing that revokes the directive and that is executed in the same manner as a directive;
- (iii) the burning, tearing up or other destruction of the directive by the principal (or by some person in his or her presence and by his or her direction) with the intention of revoking the directive.⁵²

4.56 It is recommended that a medical practitioner who fails to comply with the valid instructions of a health care agent should be subject to the charges of battery and negligence and to administering treatment without the patient's consent.⁵³

51 Ibid.

52 Op cit 104 - 105.

53 Op cit 106.

4.57 Any person who, without the principal's consent, wilfully conceals, cancels, alters, falsifies or forges a health care directive or any amendment or revocation of such directive or who wilfully withholds any personal knowledge thereof, should be guilty of an offence and liable for damages in a civil action.⁵⁴

4.58 Lastly, the Newfoundland Law Reform Commission recommends that the statutory provisions concerning such directives should be accompanied by a educational campaign to ensure that the general public is aware of the availability of the mechanisms. Health care facilities and professional medical associations should also be encouraged to provide educational support to their members and staff regarding health care directives.⁵⁵

° **Manitoba**

4.59 After due research the Manitoba Law Reform Commission brought out a report in June 1991 entitled **Self-determination in health care (living wills and health care proxies)**. Extensive legislation was suggested in the report in order to make provision for health care directives. Again the point of departure was that individuals should have a free choice in making provision for:⁵⁶

... health care directives in which they can set out their wishes respecting future health care and can appoint health care proxies to make future decisions on their behalf. The decision contained in health care directives or made by health care

54 Newfoundland Discussion Paper 107.

55 Ibid.

56 Manitoba Law Reform Commission **Report on self-determination in health care (living wills and health care proxies)** Report No. 74 1991 40 (hereinafter referred to as "Manitoba Report").

proxies should be legally binding; the failure to respect them should have the same consequences as the failure to respect a direction concerning current medical treatment. No one should incur liability simply because they honestly gave or followed such a decision. Finally, the making of health care directives should entail only as much formality as is manifestly necessary to protect the maker from fraud and undue influence.

4.60 In the report the following warning was however issued regarding the use of health care directives:⁵⁷

Persons considering the use of a health care directive should not, of course, overlook its possible drawbacks. Personal circumstances and medical technology change and a direction given today may not reflect a maker's wishes ten or twenty years later; a maker who fails to review and update a health care directive may face very serious and unwanted consequences indeed. A vague or imprecise health care directive may also pose problems: the making of a health care directive that refuses "heroic treatment" may give psychological comfort to a maker, yet prove meaningless to physicians. Makers must be made aware that they should avoid ambiguous language in their health care directives and that the assistance of a physician in making one may be helpful; where precision is not possible, the appointment of a health care proxy should be seriously considered.

4.61 The recommendations of the Manitoba Law Reform Commission have now been embodied in the **Health Care Directives Act**.⁵⁸ The Act received Royal Assent in June 1992, but has not yet been proclaimed in force.⁵⁹

57 Manitoba Report 40.

58 S. M. 1992, c 33 as quoted in the Alberta Report 11.

59 Alberta Joint Report 11.

* **United Kingdom**

4.62 In the United Kingdom there is at present little doubt as to the legal right of a patient of sound mind to refuse medical treatment.⁶⁰

⁶⁰ **Airedale NHS Trust v Bland** [1993] 1 All ER 821; Dyer, C (ed) **Doctors, patients and the law** Oxford Blackwell 1992 115.

4.63 The effect of advance directives (living wills) or the appointment of an agent has, however, not been expressly tested by the English courts and no legislation in this regard has yet been proposed. However, in the **Report of the Select Committee**⁶¹ the following recommendations are made with regard to advance directives (living wills) and powers of attorney:

- 296. We recommend the development of advance directives, but conclude that legislation for advance directives generally is unnecessary.
- 297. We recommend that a code of practice on advanced directives should be developed.
- 298. We do not favour the more widespread development of a system of proxy decision-making.

4.64 The English **Enduring Powers of Attorney Act, 1985**, does not provide for medical control of an incompetent patient (unlike recent similar legislation in the USA and Australia). Neither does the Scottish legislation on this point, the **Law Reform (Miscellaneous Provisions) Scotland) Act, 1990**, bring any relief.

4.65 The usefulness of advance directives (living wills) is, however, acknowledged by writers,⁶² but eventually it will depend on the extent to which the courts are prepared to recognise the previously expressed wishes of the patient as indicative of his or her intention at the time when the medical decision has to be made. Until the validity of

61 Op cit 58.

62 Mason, J K and McCall Smith, R A **Law and medical ethics** 3 rd edition London Butterworths 1991 339 (hereinafter "Mason and McCall Smith").

advance declarations is settled in English law by court decision or statute, doctors are advised by legal scholars to treat such declarations with caution.⁶³ This is not to say that advance declarations should not be taken into account in determining treatment, but the overriding consideration must be what is in the best interest of the patient.⁶⁴

63 Dyer, C (ed) **Doctors, patients and the law** Oxford Blackwell 1992 116.

64 Mason and McCall Smith 340.

4.66 The English Law Commission⁶⁵ published a discussion paper in 1991 providing an overview of the entire field of mentally incapacitated adults, without making specific recommendations, with the object of providing a basis for discussion and possible legislation. This process has, however, not yet been finalised.⁶⁶

4.67 As far as the English courts are concerned, attention can be drawn to the recent **Airedale NHS Trust v Bland**-case⁶⁷ in which the court on several occasions⁶⁸ referred approvingly to the usefulness of such an advance directive (living will). This was done despite the fact that consent as such was not raised. Lord Goff,⁶⁹ for instance, held that a patient's right to refuse medical treatment could be extended to incompetent patients in cases where they had expressed their wishes at an earlier date. He warned, however, that special care should be taken to ensure that such consent is still applicable at the time when the medical decision has to be taken.

4.68 Certain writers argue that certainty as to the legal position will only be attained through legislation. In this regard it is recommended that the advance directive (living

65 Law Commission Consultation Paper No. 119 **Mentally incapacitated adults and decision-making: an overview** London HMSO 1991.

66 See also Law Commission Consultation Paper No. 128 **Mentally incapacitated adults and decision-making: a new jurisdiction** London HMSO 1993.

67 **Airedale NHS Trust v Bland** [1993] 1 All ER 821.

68 Op cit 843 a-b, 852 j, 866 e-f.

69 Op cit 866 e-f.

will) should be a combination of the written instructions regarding medical treatment and the appointment of an agent.⁷⁰

(b) The legal position in South Africa

4.69 Professor Strauss⁷¹ defines a “Living Will” as follows:

Legally it is a declaration in which a person **in anticipando** by way of an advance directive refuses medical attention in the form of being kept alive by artificial means.

4.70 In principle every person of sound mind is legally entitled to refuse medical treatment. In this sense it can be said that the individual has a right to die. The refusal of treatment should however be clearly stated. Professor Strauss argues that if a person in a specific situation is entitled to refuse specific medical treatment at that moment, there is no reason why he would not be entitled at an earlier stage to express a standing refusal of specific treatment. This argument would of course also apply to refusal of any treatment at all. Professor Strauss is of the opinion that medical practitioners would be obliged to give effect to such explicit statements and that they could even expose themselves to liability should they disregard the patient's wishes.

70 Kennedy, I & Grubb, A **Medical law: text and materials** London Butterworths 1989 1154.

71 Strauss **Doctor, patient and the law** 344.

4.71 On the other hand, Mr Dörfling⁷² is of the opinion that there should be a weighing up between the right of members of the community to refuse treatment, or the so-called right to die, and the medical practitioners's moral duty to treat.

4.72 Mr Dörfling foresees the following problems regarding the use of the advance directive (living will) if it is not regulated by statute:

- (a) It is doubtful whether it could be expected of medical staff to comply with the living will - their moral and ethical codes could compel them to act.
- (b) It is not certain whether a medical practitioner who complies with the living will could be subject to criminal or even civil prosecution.
- (c) There is no criminal sanction for the abuse of such a living will through destruction, concealment or fraud, for instance.
- (d) The question remains as to whether the cessation of life-supporting treatment is punishable.

4.73 Mr Dörfling mentions that the legal persuasions of the community as well as medical and ethical standards change continually and that the law would therefore have to adapt continually. He also foresees problems concerning the possible revocation of the document at a later stage.

72 Dörfling 195.

4.74 There is at present no judgment on record in which the matter of the advance directive(living will) has specifically been discussed although it was stated in **Clarke v Hurst NO**⁷³ that effect should be given to a patient's wishes as expressed when he was in good health. In this case the court decided the question of whether the patient's artificial feeding should be discontinued with reference to the convictions of the community as interpreted by the court. The patient's wishes as set out in his "Living Will" were not used as the only criterion. Nevertheless the court remarked as follows:⁷⁴

It is indeed difficult to appreciate a situation, save where the patient is suffering unbearable pain or is in a vegetative state, where it would be in his best interests not to exist at all. The patient in the present case has, however, passed beyond the point where he could be said to have an interest in the matter. But just as a living person has an interest in the disposal of his body, so **I think the patient's wishes as expressed when he was in good health should be given effect.** (Our emphasis)

(c) Conclusion

4.75 When a purpose made document (an advance directive (living will) or power of attorney) contains requests or instructions to medical practitioners, staff or other persons as to which treatment the drafter consents to or which he or she refuses, such requests or refusals are just as legally valid as they would have been had the person given them orally, provided of course that the person was competent to make such requests or issue such instructions. Certain questions, however, may arise for the person who has to act on this request or instruction. Firstly, the validity of the document may be questioned. Furthermore, the possibility may always exist that the document may have been revoked. There may also be a dispute as to the interpretation of the

73 1992 4 SA 630 (D) 660.

74 Op cit 660 E - F.

contents of the document. Finally, medical staff could face difficult choices should the family of the patient issue different instructions to those contained in the document. It should also be remembered that an instruction given in a written document will not be legally valid if it would not have been legally valid had it been given orally. As the law stands at the moment, a deliberate act that causes the death of a patient would still be unlawful, except in exceptional circumstances, notwithstanding the authorisation contained in the document. Doctors are not jurists and they would therefore not always be able to judge out of hand whether requests and instructions contained in an advance directive (living will) are legally valid.

4.76 As can be seen from the comparative legal study above, some jurisdictions rely on enduring powers of attorney, sometimes combined with an advance directive (living will), whereby decisions as to the application, refusal or cessation of treatment are left to an agent who is usually a family member or confidant. Even if enduring powers of attorney were to acquire validity, there would still be other problems to consider. The central question is still whether the death of the patient can be brought about legally. By implementing the enduring power of attorney the decision-making is simply shifted from the doctor to the agent. The agent would still not be able to consent legally to action or treatment causing death if the patient would not have been legally able to do the same if he or she had been in a position to do so. The problem is aggravated where the death of the patient may be of pecuniary interest to the agent. Inevitably, a principal will not readily entrust decisions concerning his or her life or death to a total stranger.

4.77 It would appear that the ordinary case regarding consent to medical treatment, without the possibility of the termination of life, does not really cause problems. It is seldom, if ever, necessary to appoint a curator in order to get authorisation for an operation or other medical treatment. The usefulness of an advance directive (living will) is that the drafter's wishes in respect of the refusal of treatment can in certain circumstances be inferred from this document. **It seems desirable to gain statutory recognition for such a document, provided that compliance with the wishes set out in the document would not be unlawful. It is, however, questionable whether it is necessary to prescribe rigid requirements in this regard, such as the use of a**

specific form of document or a refusal of treatment certificate as is prescribed in other jurisdictions.

4.78 It would also be necessary to afford medical practitioners and persons acting under the direction of the medical practitioners legal protection against any civil or criminal liability if life-sustaining treatment is suspended. It is equally important to offer these medical practitioners and their assistants an escape mechanism to refuse to do anything in terms of this Act if this would be in conflict with their moral or ethical codes.

4.79 A legislative formulation of this principle might read as follows:

Directives as to the treatment of a terminally ill person

6. (1) *Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive declaring that if he or she should ever suffer from a terminal illness and would as a result be unable to make or communicate decisions concerning his or her medical treatment or its cessation, any medical treatment which he or she may receive should be discontinued and that only palliative care should be administered.*

(2) *A person as contemplated in subsection (1) shall be competent to entrust any decision-making regarding the treatment as contemplated in that subsection or the cessation of such treatment to a competent agent by way of a written power of attorney, and such power of attorney shall take effect and remain in force if the principal becomes terminally ill and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof.*

(3) *A directive contemplated in subsection (1) and a power of attorney contemplated in subsection (2) and any amendment thereof, shall be*

signed by the person giving the directive or power of attorney in the presence of two competent witnesses who shall sign the document in the presence of the said person and in each other's presence.

(4) When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) or (2) regarding his medical treatment or the cessation thereof have been issued, the decision-making regarding such treatment or the cessation thereof shall, barring any court order or the provisions of any other Act, vest in such guardian or curator.

Conduct in compliance with directives by or on behalf of terminally ill persons

7. *(1) No medical practitioner shall give effect to a directive regarding the refusal or cessation of medical treatment or the administering of palliative care which may contribute to the hastening of a patient's death, unless-*

(a) the medical practitioner is satisfied that the patient concerned is suffering from a terminal illness and is therefore unable to make or communicate rational decisions concerning his or her medical treatment or the cessation thereof; and

(b) the condition of the patient concerned, as contemplated in paragraph (a), has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition in view of his or her expertise with regard to the illness with which the patient is afflicted and his or her examination of the patient concerned.

(2) *Before a medical practitioner gives effect to a directive as contemplated in subsection (1) he shall satisfy himself, in so far as this is reasonably possible, of the authenticity of the directive and of the competency of the person issuing the directive.*

(3) *Before giving effect to a directive as contemplated in subsection (1), a medical practitioner shall inform the interested relatives and family members of the patient of his findings, that of the other medical practitioner contemplated in paragraph (b) of subsection 1, and of the existence and content of the directive of the patient concerned.*

(4) *If a medical practitioner is uncertain as to the authenticity of the directive or its legality, he shall treat the patient concerned in accordance with the provisions set out in section 8 below.*

(5) (a) *A medical practitioner who gives effect to a directive as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and his conduct in giving effect to the directive.*

(b) *A medical practitioner as contemplated in paragraph (c) of subsection (1) shall record in writing his findings regarding the condition of the patient concerned.*

(6) *A directive concerning the refusal or cessation of medical treatment as contemplated in subsection (1) and (2) shall not be invalid and the withholding or cessation of medical treatment in accordance with such a directive, shall, in so far as it is performed in accordance with this Act, not be unlawful even though performance of the directive might bring about the hastening of the moment of death of the patient concerned.*

B. There is no advance directive (living will) or power of attorney

4.80 In this case the question - whether the patient should be kept alive indefinitely by artificial means - has to be answered with reference to objective, legislative or judge-made rules.

4.81 The traditional view of our courts with regard to euthanasia in respect of an incompetent person is perhaps best reflected in the judgment of De Wet J P in **S v De Bellocq**.⁷⁵ In this case the mother, who had some medical knowledge, killed her child who had suffered brain damage at birth and who would have been an imbecile for the rest of his life. De Wet J P states as follows:⁷⁶

The law does not allow any person to be killed whether that person is an imbecile or very ill. The killing of such a person is an unlawful act and it amounts to murder in law.

The Court did however describe the case as very tragic and handed down a sentence which can effectively be regarded as a dismissal.

4.82 In the last few decades a turn-about has been observed in the traditional view of the law in these areas and in several countries judgments can now be found indicating that although euthanasia is not allowed, cessation of treatment may be permissible under specific circumstances and subject to certain conditions.

4.83 This means that the patient cannot be actively killed (as was the case in **S v De Bellocq**).⁷⁷ The life-sustaining mechanisms may however be withdrawn from the

75 1975 3 SA 538 (T). For a discussion of this case see Strauss, S A "Onvrywillige genadedood: 'n belangrike Transvaalse beslissing" 1969 **THRHR** 385.

76 Op cit 539 C - D.

77 Supra.

patient. The patient then dies from natural causes, for example cessation of one or other of his life-functions, infections that are not treated or, eventually, from thirst or hunger.

(a) Comparative law

4.84 We will now briefly discuss the main features of the development in comparable legal systems:

* **The United States of America**

4.85 The first and best-known judgment in this respect is the case of **Karen Quinlan**⁷⁸ that was decided in 1976 in the state of New Jersey. Karen Quinlan was in a persistent vegetative state and there was no hope of her recovering. Her father sought to be appointed as her guardian. He also applied for the power to authorise the cessation of all further extraordinary medical treatment that would prolong her life functions in an artificial manner. The Supreme Court of New Jersey granted the application and furthermore stated that should her father authorise the cessation of artificial preservation of life functions and Karen should die as a result, he would not be criminally liable for her death.

4.86 The judgment of the court was based on her constitutional rights to privacy and self-determination. The reasoning of the court appears from the judgment of Hughes C J:

Having concluded that there is a right of privacy that might permit termination of treatment in the circumstances of this case, we turn to consider the relationship of the exercise of that right to criminal law. We are aware that such termination of treatment would accelerate Karen's death. The County Prosecutor and the Attorney-General maintain there would be criminal liability for acceleration. Under the statutes of the State, the unlawful killing of another human being is criminal homicide. NJS 2A: 113 - 1, 2, 5. We conclude that there would be no criminal homicide in the circumstances of this case. We believe, firstly, that the ensuing death would not be homicide but rather expiration from existing natural

78 **In re Quinlan** 70/81 NJ 10; 355 A 2d 647 (NJ 1976).

causes. Secondly, even if it were to be regarded as homicide, it would not be unlawful.

These conclusions rest upon definitional and constitutional bases. The termination of treatment pursuant to the right of privacy is, within the limitations of this case **ipso facto** lawful. Thus, a death resulting from such an act would not come within the scope of the homicide statutes proscribing only the unlawful killing of another. There is a real and, in this case, determinative distinction between the unlawful taking of the life of another and the ending of artificial life-support systems as a matter of self-determination.

Furthermore, the exercise of a constitutional right such as we have here found is protected from criminal prosecution. See **Stanley v Georgia** (supra, 394 US at 559; 89 S Ct at 1245; 22 L Ed 2d at 546). We do not question the State's undoubted power to punish the taking of human life, but that power does not encompass individuals terminating medical treatment pursuant to their right of privacy. See **id** at 568; 89 S Ct at 1250; 22 L Ed 2d at 551. The constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime. **Eisenstadt v Baird** (supra, 405 US at 445-6; 92 S Ct at 1034-5; 31 L Ed 2d at 357-8). **Griswold v Connecticut** (supra, 381 US at 481; 85 S Ct at 1679-80; 14 L Ed 2d at 512-13). And, under the circumstances of this case, these same principles would apply to and negate a valid prosecution for attempted suicide were there still such a crime in this State.

4.87 This matter was taken further in three more decisions of the Supreme Court of New Jersey. In the case of **In re Claire Conroy**⁷⁹ the court furthermore explained why a person should be allowed to take a decision on behalf of an unconscious patient in the said circumstances:

.... on balance the right to self-determination ordinarily outweighs any countervailing State interests (in preservation of the individual's life) and competent persons generally are permitted to refuse medical treatment even at the risk of death. ... In view of the case law, we have no doubt that Ms Conroy, if competent to make the decision and if resolute in her determination, could have chosen to have her naso-gastric tube withdrawn. Her interest in freedom from non-consensual invasion of her bodily integrity would outweigh any State interest in preserving life or in safeguarding the integrity of the medical profession. In addition, rejecting her artificial means of feeding would not constitute attempted suicide, as the decision would probably be based on a wish to be free of medical

79 98 NJ 321; 486 A 2d 1209 (NJ 1985).

intervention rather than a specific intent to die, and her death would result, if at all, from her underlying medical condition, which included her inability to swallow.

4.88 In the case of **In re Nancy Ellen Jobes**⁸⁰ it is further explained why a person should be allowed to take the said decision on behalf of an unconscious patient:

We state again that the fateful decision to withdraw life-supporting treatment is extremely personal. Accordingly, a competent patient's right to make that decision generally will outweigh any countervailing State interests. See **Farrell** (supra, 108 NJ at 354; 529 A 2d at 414). An incompetent patient does not lose his or her right to refuse life-sustaining treatment. Where such a patient has clearly expressed her intentions about medical treatment, they will be respected. See **Peter** (supra, 108 NJ at 378; 529 A 2d at 425).

Where an irreversibly vegetative patient like Mrs Jobes has not clearly expressed her intentions with respect to medical treatment, the **Quinlan** 'substituted judgment' approach best accomplishes the goal of having the patient make her own decision. In most cases in which the 'substituted judgment' doctrine is applied, the surrogate decision-maker will be a family member or close friend of the patient. Generally it is the patient's family or other loved ones who support and care for the patient, and who best understand the patient's personal values and beliefs. Hence, they will be best able to make a substituted medical judgment for the patient.

This approach was confirmed in **In re Hilda M Peter**.⁸¹

4.89 In the **Jobes** case⁸² the court said that there was a pre-condition for the execution of the decision by the surrogate-guardian. The guardian had to obtain statements by at least two medical practitioners who were qualified neurologists, in which they declared that the patient was in a persistent vegetative state and that there was no possibility that the patient would ever recover to a state of intellectual consciousness.

80 108 NJ 394; 529 A 2d 434 (NJ 1987).

81 108 NJ 365; 529 A 2d 419 (NJ 1987).

82 Supra.

4.90 In 1990 the case of **Nancy Cruzan** was heard before the Supreme Court of America.⁸³ Nancy was involved in a car accident as a result of which she was in a persistent vegetative state for six years. Her parents sought a court order authorising the removal of her gastrostomy feeding tube, but this was refused. On appeal to the Supreme Court the decision was affirmed as it was found that the court **a quo** was constitutionally justified in requiring that a patient's wishes be proved by clear and convincing evidence. The reason for this is that the state has an unqualified interest in the preservation of human life and that it has a duty further to guard against potential abuse in such situations. An erroneous decision could furthermore not be rectified. The court **a quo** was therefore entitled to make a finding on the facts that clear and convincing evidence of the patient's wishes did not exist. (Nancy had before the accident merely indicated to friends in an informal manner that she would not wish to live in such a state.)

4.91 Although the US Supreme Court therefore acknowledged the patient's constitutional right to refuse treatment, it was not required to accept the substituted judgment of family members, in the absence of evidence that the wishes of the family and those of the patient corresponded. A court of lower jurisdiction did, however, subsequently consent to the removal of the gastrostomy feeding tube on the basis of new evidence.

* **The United Kingdom**

83 **Cruzan v Director Missouri Department of Health** 497 US 261 (1990); 111 L Ed 2d 224; 110 S Ct 2841. See also Dworkin, R **Life's dominion: an argument about abortion and euthanasia** London Harper Collins 1993 237.

4.92 The position concerning cessation of life-sustaining treatment (or selective non-treatment as it is known in England) was to a large extent resolved when this question was addressed by the House of Lords in February 1993 in the case of **Airedale NHS Trust v Bland**.⁸⁴ In this case the applicant health authority sought a declaratory order to the effect that, despite the inability of the patient to give consent, his life-sustaining treatment should be discontinued and that no further medical treatment should be furnished except for the purpose of enabling him to die peacefully with dignity and the minimum of pain, and that if death should occur then the cause of death should be attributed to the original cause of his condition and not to the cessation of medical treatment. The termination of medical treatment should therefore not give rise to any civil or criminal liability on the part of any person. The application was supported by the family of the patient.

4.93 The respondent, the 21-year-old Anthony Bland, had been in a persistent vegetative state for 3½ years after suffering a severe crushed chest injury which caused catastrophic and irreversible brain damage. Although not brain dead, he had to use a nasogastric tube, catheter and enemas for normal bodily functions and he had no cognitive function. The unanimous opinion of all the doctors who examined him was that there was no hope of recovery or improvement.

4.94 In these circumstances it was thought appropriate to cease further treatment (artificial feeding and furnishing of antibiotic treatment). It was conceded that this would probably result in the patient's death from starvation within one to two weeks. At no stage did Bland give his consent in this regard.

4.95 The application was opposed by the Official Solicitor (acting as guardian **ad litem**), who claimed that the proposed action would amount to murder.

84 [1993] 1 All ER 821 (CA). For a discussion of this case, see Finnis J M "**Bland**: Crossing the Rubicon?" 1993 **Law Quarterly Review** 329.

4.96 The judge granted the order as requested, whereupon the Official Solicitor appealed to the Court of Appeals and thereafter to the House of Lords. In both these instances the original order was affirmed.

4.97 The House of Lords held that a doctor, who has in his or her care a patient who is incapable of consenting to treatment, is under no absolute obligation to prolong the patient's life regardless of the quality thereof. The court referred with approval to the 'best interest' condition as set out in **F v West Berkshire Health Authority**⁸⁵ and held that medical treatment (which includes artificial feeding) may be withheld if it is in the patient's best interest not to be treated any further (since such treatment is futile and do not confer any benefit on the patient).⁸⁶

85 [1989] 2 All ER 545; [1990] 2 AC 1.

86 See also **Frenchay Healthcare NHS Trust v S** [1994] 2 All ER 403 (CA) and the discussion by Labuschagne, J M T "**Frenchay Healthcare NHS Trust v S** [1994] 2 All ER 403 (CA): Eutanatische beëindiging van mediese behandeling" 1996 **SACJ** 80.

4.98 To determine what course of action would further the best interests of the patient, the court used the test laid down in **Bolam v Friern Hospital Management Committee**,⁸⁷ namely whether the proposed conduct would be in accordance with the opinion of a large informed and responsible group of medical practitioners.

4.99 As the cessation of life-supporting treatment in this case was in accordance with the criteria set out in a discussion paper by the British Medical Association,⁸⁸ the court found that the **Bolam** requirement had been complied with.

4.100 The court stated, however, that similar cases should be referred to the court on an *ad hoc* basis and furthermore that the issue should be referred to Parliament for consideration of possible legislation in this regard.

4.101 It is generally accepted that a patient's stated will should be respected.⁸⁹ In **Airedale NHS Trust v Bland**⁹⁰ Lord Goff of Chieveley stated:

87 [1957] 2 All ER 118; [1957] 1 WLR 582.

88 British Medical Association **Treatment of patients in persistent vegetative state**, in which the following criteria were set out:

- (a) Rehabilitative efforts for at least 6 months after the injury;
- (b) the diagnosis of irreversible PVS should only be considered confirmed after 12 months;
- (c) the diagnosis should be confirmed by two other independent doctors;
- (d) the wishes of the family should be respected.

89 See **Re T (adult: refusal of medical treatment)** [1992] 4 All ER 649; [1992] 3 WLR 782; **Airedale NHS**

[I]t has been held that a patient of sound mind may, if properly informed, require that life support should be discontinued ... the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it.

4.102 The next question which was also argued in the British courts was whether cessation of treatment should also be allowed in cases where persons are not in a vegetative state, but have no normal brain function, and where this condition is irreversible. One thinks here of the child who is born as an imbecile as a result of a serious brain defect.

Trust v Bland [1993] 1 All ER 367.

90 [1993] 1 All ER 821 (CA) at 866 d - e.

4.103 In the case of **Re J (a minor)**.⁹¹ J, an infant, had suffered serious brain damage at birth. Large areas of his brain where there should have been brain tissue had become fluid-filled. He often suffered convulsions and there were episodes during which he stopped breathing. He was twice linked to a ventilator for fairly long periods. Chances were good that he would develop spastic quadriplegia. It was debatable whether he would ever be able to sit up or hold his head upright. He was unlikely ever to be able to speak. He would, however, be able to feel pain to the same extent as a normal baby and it was possible that he would achieve the ability to smile or to cry. His life-expectancy was limited. The question arose whether J should again be ventilated in the event of his again stopping to breathe. Two medical practitioners submitted a report which indicated that it would not be in J's interest to be ventilated again. The court issued an order in accordance with the experts' report. The argument raised against the issuing of the order was that the court was not in a position to evaluate the consequences of death and that respect for the sanctity of human life and the requirements of public policy precluded attempts by the court to evaluate the quality of life of a disabled person. This submission was rejected by the Court of Appeal.

4.104 The Court of Appeal based its decision on the best interests of the child. Balcombe L J stated:⁹²

I have already cited the passage from the speech of Lord Hailsham LC in **Re B (a minor) (wardship: sterilisation)** [1987] 2 All ER 206 at 212; [1988] AC 199 at 202 which established that issues of public policy, as such, cannot prevail over the interests of the ward. In my judgment there is no warrant, either on principle or authority, for the absolute submission. There is only the one test: that the interests of the ward are paramount. Of course the Court will approach those interests with a strong predilection in favour of the preservation of life, because of the sanctity of human life. But there neither is, nor should there be any absolute rule that, save where the ward is already terminally ill, i e dying, neither the Court nor any responsible parent can approve the withholding of life-saving treatment on the basis of the quality of the ward's life. (For my part I would not accept that the so-called "cabbage" cases could be treated as an exception to this suggested rule, since in deciding that a child whose faculties have been destroyed is a "cabbage" of itself involves making a judgment about the quality of that child's life.) I say that there is no such rule because there is no authority to that effect: indeed the judgments in **Re B (a minor) (wardship: medical treatment, 1981)** [1990] 3 All ER 927; [1981] 1 WLR 1421 are consistent only with there being no "absolute" rule. I say that there should be no such rule because it could in certain circumstances be inimical to the interests of the ward

91 [1990] 3 All ER 930.

92 Op cit 942.

that there should be such a requirement: to preserve life at all costs, whatever the quality of the life to be preserved, and however distressing to the ward may be the nature of the treatment necessary to preserve life, may not be in the interests of the ward.

4.105 It was also submitted that the court could not issue a life-ending order unless it was absolutely certain that the quality of the child's subsequent life would be intolerable to the child and demonstrably so awful that in effect the child must be condemned to die. Balcombe L J expressed his rejection of this argument as follows:⁹³

Here again I can not accept the submission in the terms in which it was framed, which treats the language used by Templeman and Dunn L J J in **Re B (a minor) (wardship: medical treatment)** [1990] 3 All ER 927 at 929 - 30; [1981] 1 WLR 1421 at 1424 as if they had intended to lay down a test applicable to all circumstances, which clearly they did not. Further, I would deprecate any attempt by this Court to lay down such an all-embracing test since the circumstances of these tragic cases are so infinitely various. I do not know of any demand by the Judges who have to deal with these cases at first instance for this Court to assist them by laying down any test beyond that which is already the law: that the interests of the ward are the first and paramount consideration, subject to the gloss on that test which I suggest, that in determining where those interests lie the Court adopts the standpoint of the reasonable and responsible parent who has his or her child's best interests at heart.

4.106 It was clear that the court was prepared to evaluate the quality of life of the patient and that considerations of public policy would not get in the way of such an evaluation.

93 Ibid.

4.107 In **Clarke v Hurst NO**⁹⁴ no criticism was raised against **Re J (a minor)**.⁹⁵ As a matter of fact the court based its decision on the principles stated. **But what is the view of our readers on this topic?**

(b) The position in South Africa

94 Supra.

95 Supra.

4.108 The question whether a court may order the cessation of life-sustaining mechanisms with regard to a patient in a permanent vegetative state on the application brought by an interested person was first discussed in **Clarke v Hurst NO**.⁹⁶

4.109 The patient had had a heart attack during 1988 as a result of which his heartbeat and breathing ceased. Resuscitative measures restored his heartbeat, but only after he had suffered serious brain damage. He became deeply comatose and never regained consciousness. His swallowing mechanism was not functioning and he had to be fed by means of a nasogastric tube. He was in what is commonly known as a persistent vegetative condition. He had been in this condition for about four years without any sign of improvement.

4.110 He was a member of SAVES The Living Will Society. He had signed a so-called "Living Will", the essential clause of which reads as follows:⁹⁷

If there is no reasonable expectation of my recovery from extreme physical or mental disability ... I direct that I be allowed to die and not be kept alive by artificial means and heroic measures. I ask that medication be mercifully administered to me for terminal suffering even though this may shorten my remaining life ...

The court's order was, however, not founded on Dr Clarke's directive as expressed in the Living Will.

4.111 As the Living Will did not have accepted legal status, his wife applied to the court for a declaratory order whereby she would be appointed **curatrix personae** to her

96 1992 4 SA 630 (D). For a discussion of this important case, see Lupton, M L "**Clarke v Hurst NO, Brain No & Attorney-General, Natal**" 1992 SACJ 342; Dörfling, D "Eutanasie: Die reg van die **curator personae** om verdere behandeling van 'n pasient te verbied - 'n nuwe regverdigingsgrond in die Suid-Afrikaanse reg" 1993 TSAR 345; Boister, N "Causation at the death?" 1993 THRHR 516.

97 **Clarke v Hurst NO** 1992 4 SA 630 (D) at 633 G-H.

husband's person with powers in that capacity to authorise the discontinuance of any further medical treatment or feeding to her husband. This in fact amounted to an application for a declaratory order to the effect that the discontinuance of her husband's artificial feeding regime, which would inevitably lead to his death, would not be unlawful - a case therefore of cessation of treatment. The Attorney-General of Natal, who was cited as respondent, opposed the application on the grounds that the proposed action would be **prima facie** unlawful and that the court did not have the authority to tie his (the Attorney-General's) hands with an order as proposed as to the question of whether prosecution should be instituted.

4.112 The court found that in determining legal liability for terminating a patient's life, there was no justification for drawing a distinction between the omission to institute life-sustaining treatment and the discontinuation thereof. Just as in the case of an omission to institute life-sustaining procedures, legal liability would depend on whether there was a duty to institute such procedures, so in the case of the discontinuance of such procedures liability depends on whether there is a duty to continue such procedures. A duty not to discontinue life-sustaining procedures could not arise if the procedures instituted have proved to be unsuccessful. The mere maintenance of certain biological functions such as heartbeat, respiration, digestion and blood circulation, without the functioning of the brain, cannot be equated with life. It would therefore not be unlawful to discontinue the artificial maintenance of that level of life.

4.113 The court further held that it would not be contrary to public policy if a court would in cases of this nature make an evaluation of the quality of life in order to determine whether life-sustaining measures should be discontinued.

4.114 The court held that the decision as to whether the discontinuance of artificial feeding of the patient and his resultant death would be wrongful depended on whether, judged according to the **boni mores** of the community, it would be reasonable to discontinue such feeding. The **boni mores** in turn depended on the quality of life that remained to the patient - in other words, the facts of the particular case.

4.115 In the present case, after extensive medical evidence was placed before the court, it was decided that the applicant would not act unlawfully by authorising the cessation of the artificial feeding of the patient, even though this would hasten the patient's death.

(c) Conclusion

4.116 In our opinion there is a clearly distinguishable trend in Western legal systems, as confirmed in the judgments of the courts, that in suitable cases and subject to suitable precautions, the life of a patient who is in an irreversible vegetative state, may be ended by cessation of life sustenance mechanisms and means.

4.117 In light of the judgment in **Clarke v Hurst NO**⁹⁸ the confirmation of the said principle in legislation will not be a revolutionary step. Legislation can, however, establish specific guidelines and set the conditions for such a step to be allowed. If legislation is deemed necessary or advisable to end the use of life sustaining mechanisms where a patient is kept alive by artificial means, should guidelines be laid down? Should the cessation of the use of life sustenance mechanisms and means be subject to medical approval only, or should a court order be necessary? **The guidance of our readers is sought on these questions.**

4.118 There are always cases in which the person concerned has neither drafted a document nor authorised any person to make decisions on his or her behalf and grant consent or refusal with regard to certain treatment. The same questions concerning the termination of life will however be raised in these cases. In these cases, and where the irreversible unconscious state of the patient is a fact, it would appear desirable to empower the chief medical officer of the hospital to authorise the cessation of treatment subject to the provision that the family and

98 Supra.

closest relatives agree with the decision. In such cases it would appear unnecessary to burden those involved with the costs that would be incurred in a court application. Any interested party is of course free to approach the court in this regard if this is deemed necessary. Comments in this regard will be welcomed.

4.119 In our opinion there is a need to ensure legal certainty as regards the problems now under discussion. Legislative confirmation and clarification of the position where there is no advance directive (living will) or power of attorney (i.e. to confirm and clarify **Clarke v Hurst NO**)⁹⁹ are necessary.

4.120 Should it be necessary to introduce legislation in this regard, we propose the following clause. (This clause should be read with the clauses below concerning the powers of the court):

Conduct of a medical practitioner in the absence of a directive

- 8.** (1) *If the chief medical practitioner of a hospital, clinic or similar institution where a patient is being cared for is of the opinion that the patient is in a state of terminal illness as contemplated in this Act and for this reason unable to make or communicate decisions concerning his or her medical treatment or its cessation, and his opinion is confirmed in writing by at least one other medical practitioner who has not treated the person concerned as a patient, but who has examined him and who is competent to submit a professional opinion regarding the patient's condition on account of his expertise regarding the illness of the patient concerned, the first-mentioned medical practitioner may, in the absence of any directive as contemplated in section 6(1) and (2) or a court order as contemplated in section 9, grant written authorisation for the cessation of all*

99 *Supra.*

further life-sustaining medical treatment and the administering of palliative care only.

(2) A medical practitioner as contemplated in section (1) shall not act as contemplated in subsection (1) if such conduct would be contrary to the wishes of the family members or close family of the patient, unless authorised thereto by a court order.

(3) A medical practitioner as contemplated in section (1) shall record in writing his findings regarding the patient's condition and any steps taken by him in respect thereof.

(4) The cessation of medical treatment as contemplated in subsection (1) shall not be unlawful merely because it contributes to causing the patient's death.

Powers of the court

Option 1:

9. *(1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may, if satisfied that a patient is in a state of terminal illness and for this reason unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, order the cessation of medical treatment.*

(2) A court shall not make an order as contemplated in subsection (1) without the close family having been given the opportunity to be heard by the court.

(3) *A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who are knowledgeable with regard to the patient's condition and who have treated the patient personally or have checked his or her medical history and have personally examined the patient.*

(4) *A medical practitioner who gives effect to an order of court as contemplated in this section shall not suffer any civil, criminal or disciplinary accountability with regard to such an act.*

(ii) Involuntary active euthanasia

4.121 In conclusion the question should also be discussed with regard to the nature of the life-ending behaviour. In all the decisions discussed above, it is the consent to cessation of life-sustaining mechanisms and measures that is at issue. In the end the patient dies a natural death, either from an illness like pneumonia left untreated, or as a result of hunger or thirst.

4.122 The following question is frequently posed in the euthanasia debate: why can't a person's life be ended actively in such circumstances by administering a lethal substance?. Why should the patient have to keep suffering until he or she eventually dies from hunger or thirst?

4.123 This question was also stated and discussed in **Clarke v Hurst NO.**¹⁰⁰ For the sake of completeness the question and answer suggested by Thirion J is quoted in full:¹⁰¹

But now, if it would be reasonable for the applicant in the present case to discontinue the artificial nutritioning of the patient knowing that such a step would

100 Supra.

101 Op cit 657 B-H.

result in the death of the patient, why would it not be reasonable for someone to simply suffocate the patient to death? The deprivation of food would as assuredly kill the patient as the deprivation of oxygen. I think the distinction is to be found in society's sense of propriety - its belief that things should happen according to their natural disposition or order. The person who pre-empts the function of the executioner and kills the condemned man while he is taking the last few steps to the gallows, acts wrongfully irrespective of his motive for killing the condemned man. He acts wrongfully because he has no right to meddle in the matter.

In my view the distinction between the act of the doctor who, while following the precepts and ethics of his profession, prescribes a drug in a quantity merely sufficient to relieve, and with the object of relieving, the pain of his patient, well knowing that it may also shorten the patient's life, and the act of the doctor who prescribes an overdose of the drug with the object of killing his patient, is that the former acts within the legitimate context and sphere of his professional relationship with his patient while the latter does not act in that context. Consequently, society adjudges the former's conduct justified in accordance with its criterion of reasonableness and therefore not wrongful, while it condemns the conduct of the latter as wrongful.

The distinction between what is wrong and what is right cannot always be drawn according to logic. Logic does not dictate the formation of society's legal or moral convictions.

The distinction can also be justified on rational grounds. The doctor who brings about the death of his patient by prescribing an overdose of the drug with the object of killing the patient, causes the death of the patient in a manner which is unrelated to his legitimate function as a doctor. He changes not only the course but also the cause of his patient's death. To allow conduct of this nature would open the door to abuse and subject people to the vagaries of unauthorised and autocratic decision-making.

4.124 For many there may be persuasive force in the arguments quoted above. But for others to allow the removal of the life-sustaining apparatus, but not to allow active euthanasia does not seem to be logical. The opinion as set out in **Clarke v Hurst NO**¹⁰² may, so it is argued, also result in serious suffering. One is inclined to take the patient in a persistent vegetative state, who cannot really express pain and suffering, as the point of reference and example. However, the argument is that one should take the example of a person bitten by a dog with rabies, who is in the final stages of an

102 Supra.

irreversible and unbearable state of pain and suffering. Such a patient is apparently legally and mentally totally incompetent; according to all medical knowledge it is an irreversible state; but what is more, the patient may be experiencing unbearable pain and suffering and if he could have talked, it would only have been to beg for the hastening of his death. Should the line be drawn right through? **We require the guidance of our readers on this topic as well.**

4.125 Legislative enactment of this viewpoint may read as follows:

Powers of the court

Option 2:

10. (1) *In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may, if satisfied that a patient is in a state of terminal illness and for this reason unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, issue an order for **the performance of any medical procedure** which would have the effect of terminating the patient's life.*
- (2) *A court shall not make an order as contemplated in subsection (1) without the close family of the patient having been given the opportunity to be heard by the court..*
- (3) *A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who are knowledgeable with regard to the patient's condition and who have treated the patient personally or have checked his or her medical history and have personally examined the patient.*

(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act.

CHAPTER 5

A DRAFT BILL ON THE RIGHTS OF THE TERMINALLY ILL

5.1 In the preceding chapters, we have endeavoured to set out the various distinguishable problem areas. Readers will have noticed that the Commission has not yet adopted a final stance, but is rather requesting guidance and encouraging discussion from the public at large.

5.2 Nevertheless, in order to focus the attention on the problem areas and to illustrate how the matter might be dealt with in legislation, we have deemed it advisable to include a draft bill in this working paper. The bill does not necessarily represent the views of the Commission and is published merely to elicit focussed response or, if the reader is in agreement with the principle under discussion in any clause, possible suggestions for better formulation. The draft is attached as Annexure A.

SUMMARY OF CLAUSES REFERRED TO IN THE TEXT, SOME OR ALL OF WHICH MAY FORM PART OF A DRAFT BILL ON THE RIGHTS OF THE TERMINALLY ILL (clauses have been numbered for purposes of reference only)

BILL

To regulate end of life decisions and to provide for matters incidental thereto.

To be introduced by the Minister of Justice

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:

Definitions

1. (1) In this Act, unless the context otherwise indicates-

- (i) 'competent witness' means a person of the age of 18 years or over who at the time he witnesses the directive or power of attorney is not

- incompetent to give evidence in a court of law and for whom the death of the maker of the directive or power of attorney holds no financial benefit;
- (ii) 'court' means a provincial or local division of the High Court of South Africa within whose jurisdiction the matter falls;
 - (iii) 'life-sustaining medical treatment' includes the maintenance of artificial feeding;
 - (iv) 'medical practitioner' means a medical practitioner registered as such in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);
 - (v) 'palliative care' means treatment and care of a terminally ill patient, not with a view to cure the patient, but rather to relieve suffering and maintain personal hygiene;
 - (vi) 'terminal illness' means an illness, injury or other physical or mental condition which-
 - (a) will inevitably result in the death of the patient concerned within a relatively short time and which is causing the patient extreme suffering; or
 - (b) is causing the patient to be in a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.

Conduct of a medical practitioner in the event of clinical death

[Chapter 2, page 4: Patient is clinically dead]

2. (1) For the purposes of this Act, a person is considered to be dead when two medical practitioners agree and confirm in writing that a person is clinically dead according to the following criteria for determining death, namely -

- (a) the irreversible absence of spontaneous respiratory and circulatory functions; or
- (b) the persistent clinical absence of brain-stem function.

(2) In the event of a person being considered to be dead according to the provisions of sub-section (1), the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of treatment.

Mentally competent person may refuse treatment

[Chapter 3, page 12: Competent person: Cessation of life-sustaining medical treatment]

3. (1) Every person above the age of 18 years and of sound mind is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.

(2) Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in subsection (1) is, that such a person's refusal is based on the free and carefully considered exercising of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.

Conduct of medical practitioner in relieving distress

[Chapter 3, page 16: palliative care and double effect]

4. (1) Should it be clear to a medical practitioner responsible for the treatment of a patient that the patient is suffering from a terminal illness and that such a patient's pain and distress cannot satisfactorily be alleviated by ordinary palliative treatment, he or she may, in accordance with responsible medical practice-

- (a) with the object to provide relief of severe pain and distress; and
- (b) with no intention to kill

increase the dosage of medication (whether analgesics or sedatives) to be given to the patient, even if the secondary effect of this action may be to shorten the life of the patient.

(2) No medical practitioner shall treat a patient as contemplated in subsection (1) unless the condition of the patient concerned has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition in view of his or her expertise with regard to the illness with which he or she is affected and on account of his examination of the patient concerned.

(3) (a) A medical practitioner who treats a patient as contemplated in subsection (1) shall record in writing his findings regarding the condition of the patient and his conduct in treating the patient.

(b) A medical practitioner as contemplated in subsection (2) shall record in writing his findings regarding the condition of the patient concerned.

Cessation of life

[Chapter 3, page 20: Competent person: Assisted suicide and voluntary active euthanasia]

5.(1) Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall not give effect to the request unless he or she is convinced that-

- (a) the patient is suffering from a terminal illness;
- (b) the patient is subject to extreme suffering;
- (c) the patient is over the age of 18 years and mentally competent;
- (d) the patient has been adequately informed as to the terminal illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;

(e) the request of the patient is based on an informed and well considered decision;

(f) the patient has had the opportunity to re-evaluate his or her request, but that he or she has persisted; and

(g) euthanasia is the only way for the patient to be released from his or her suffering.

(2) No medical practitioner to whom the request to make an end to a patient's suffering is addressed as contemplated in subsection (1), shall give effect to such a request, even though he or she may be convinced of the facts as stated in that subsection, unless he or she has conferred with an independent medical practitioner who is knowledgeable with regard to the terminal illness from which the patient is suffering and who has personally checked the patient's medical history and examined the patient and who has confirmed the facts as contemplated in subsection (1)(a), (b) and (g).

(3) A medical practitioner who gives effect to a request as contemplated in subsection (1), shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner with whom he or she has conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).

(4) The termination of a patient's life on his or her request in order to release him or her from suffering may not be effected by any person other than a medical practitioner.

(5) A medical practitioner who gives effect to a patient's request to be released from suffering as contemplated in this section shall not suffer any civil, criminal or disciplinary

accountability with regard to such an act provided that all due procedural measures have been complied with.

(6) No medical practitioner is obliged to give effect to a patient's request to assist with the termination of the patient's life.

Directives as to the treatment of a terminally ill person

[Chapter 4, page 50: Incompetent person: advance directive or power of attorney]

6. (1) Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive declaring that if he or she should ever suffer from a terminal illness and would as a result be unable to make or communicate decisions concerning his or her medical treatment or its cessation, any medical treatment which he or she may receive should be discontinued and that only palliative care should be administered.

(2) A person as contemplated in subsection (1) shall be competent to entrust any decision-making regarding the treatment as contemplated in that subsection or the cessation of such treatment to a competent agent by way of a written power of attorney, and such power of attorney shall take effect and remain in force if the principal becomes terminally ill and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof.

(3) A directive contemplated in subsection (1) and a power of attorney contemplated in subsection (2) and any amendment thereof, shall be signed by the person giving the directive or power of attorney in the presence of two competent witnesses who shall sign the document in the presence of the said person and in each other's presence.

(4) When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) or (2) regarding his medical treatment or the cessation thereof have

been issued, the decision-making regarding such treatment or the cessation thereof shall, barring any court order or the provisions of any other Act, vest in such guardian or curator.

Conduct in compliance with directives by or on behalf of terminally ill persons

[Chapter 4, page 50: Incompetent person, advance directive/power of attorney]

7. (1) No medical practitioner shall give effect to a directive regarding the refusal or cessation of medical treatment or the administering of palliative care which may contribute to the hastening of a patient's death, unless-

(a) the medical practitioner is satisfied that the patient concerned is suffering from a terminal illness and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof; and

(b) the condition of the patient concerned, as contemplated in paragraph (a), has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition in view of his or her expertise with regard to the illness with which the patient is afflicted and his or her examination of the patient concerned.

(2) Before a medical practitioner gives effect to a directive as contemplated in subsection (1) he shall satisfy himself, in so far as this is reasonably possible, of the authenticity of the directive and of the competency of the person issuing the directive.

(3) Before giving effect to a directive as contemplated in subsection (1), a medical practitioner shall inform the interested relatives and family members of the patient of his

findings, that of the other medical practitioner contemplated in paragraph (b) of subsection 1, and of the existence and content of the directive of the patient concerned.

(4) If a medical practitioner is uncertain as regard to the authenticity of the directive or its legality, he shall treat the patient concerned in accordance with the provisions set out in section 8 below.

(5) (a) A medical practitioner who gives effect to a directive as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and his conduct giving effect to the directive.

(b) A medical practitioner as contemplated in paragraph (c) of subsection (1) shall record in writing his findings regarding the condition of the patient concerned.

(6) A directive concerning the refusal or cessation of medical treatment as contemplated in subsection (1) and (2) shall not be invalid and the withholding or cessation of medical treatment in accordance with such a directive, shall, in so far as it is performed in accordance with this Act, not be unlawful even though performance of the directive might bring about the hastening of the moment of death of the patient concerned.

Conduct of a medical practitioner in the absence of a directive

[Chapter 4, page 78: Incompetent person: no advance directive or power of attorney, cessation of treatment]

8. (1) If the chief medical practitioner of a hospital, clinic or similar institution where a patient is being cared for is of the opinion that the patient is in a state of terminal illness as contemplated in this Act and for this reason unable to make or communicate decisions concerning his or her medical treatment or its cessation, and his opinion is confirmed in writing by at least one other medical practitioner who has not treated the

person concerned as a patient, but who has examined him and who is competent to submit a professional opinion regarding the patient's condition on account of his expertise regarding the illness of the patient concerned, the first-mentioned medical practitioner may, in the absence of any directive as contemplated in section 6(1) and (2) or a court order as contemplated in section 9, grant written authorisation for the cessation of all further life-sustaining medical treatment and the administering of palliative care only.

(2) A medical practitioner as contemplated in section (1) shall not act as contemplated in subsection (1) if such conduct would be contrary to the wishes of the family members or close family of the patient, unless authorised thereto by a court order.

(3) A medical practitioner as contemplated in section (1) shall record in writing his findings regarding the patient's condition and any steps taken by him in respect thereof.

(4) The cessation of medical treatment as contemplated in subsection (1) shall not be unlawful merely because it contributes to causing the patient's death.

Powers of the court

Option 1:

[Chapter 4, page 89: Incompetent person: no advance directive:cessation of treatment]

9. (1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may if satisfied that a patient is in a state of terminal illness and for this reason unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, order the cessation of medical treatment.

(2) A court shall not make an order as contemplated in subsection (1) without the close family having been given the opportunity to be heard by the court.

(3) A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who are knowledgeable with regard to the patient's condition and who has treated the patient personally or has checked his or her medical history and has personally examined the patient.

(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act.

Option 2:

[Chapter 4. Page 92: Incompetent person: involuntary active euthanasia]

10. (1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may if satisfied that a patient is in a state of terminal illness and for this reason unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, issue an order for the *performance of any medical procedure* which would have the effect of terminating the patient's life.

(2) A court shall not make an order as contemplated in subsection (1) without the close family of the patient having been given the opportunity to be heard by the court.

(3) A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who are knowledgeable with regard to the patient's condition and who have treated the patient personally or have checked his or her medical history and have personally examined the patient.

(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act.

Interpretation

11. The provisions of this Act shall not be interpreted as though a medical practitioner is obliged to do anything that would be in conflict with his conscience or any ethical code to which he feels himself bound.

Short title

Option 1:

12. This Act shall be called the Rights of the Terminally Ill Act 1997.

Option 2:

12. This Act shall be called the End of Life Decisions Act 1997.