

THE RIGHT TO DIE: DOES THE CONSTITUTION PROTECT THIS RIGHT?

by

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## 1. INTRODUCTION

There are several reasons why a brief investigation into the question whether or not the Constitution allows us the right to die is so important. The South African Law Commission has issued a Discussion Paper on Euthanasia and the Artificial Preservation of Life.<sup>1</sup> This paper might bring long awaited law reform and certainty.

Advances in medicine and technology have reached such a stage that death can become a long process. Sometimes a patient can be kept artificially alive for years in a hospital at a very high cost which may not be justifiable where such a patient has no hope of either improving or recovering. Palliative care measures have also improved and are constantly being viewed as options to allowing a person the right to die.

In South Africa the introduction of a paramount constitution with an entrenched Bill of Rights<sup>2</sup> has also brought about a shift in philosophy. We now put more emphasis on a person's right to self-determination, autonomy privacy etc. where decisions have to be made about the individual's life, health and welfare.

There has also been an increased concern for the rights of the dying. People are now dying mostly from chronic degenerative diseases which occur later in life. This means that more old people are dying in nursing

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<sup>1</sup> Discussion Paper 71, Project 86.

<sup>2</sup> The Constitution of the Republic of South Africa Act 108 of 1996.

homes and hospitals which trend has increased the loneliness of patients and their estrangement from familiar surroundings.<sup>3</sup>

This study aims to show that terminally ill patients who are in unbearable pain should be allowed to end their life in a peaceful, painless and dignified manner where there are no prospects of improvement and/or recovery. The study also aims to show that the practice of active, voluntary euthanasia should be allowed for these patients. Once this right is acknowledged, ways of realising it must also be determined.

Therefore this study will be confined to :

- **Terminally ill competent patients who are in pain. These patients do not want to linger on in pain, but want to die. In fact the patients will be asking for death because they know that the end of their life is near and certain, all that they want is to end their life on their own terms.**
- **Mentally incompetent patients for whom there is no prognosis of improvement or recovery whatsoever. These patients might have expressed a wish either in writing or orally that should they be in this condition, they would like to end their life.**

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<sup>3</sup> **B G Ranchod "Another Legal View of Euthanasia" in Euthanasia ed Oosthuizen et al, 133.**

## 2. EXPLANATION OF TERMS

A definition of some of the terms that will be frequently referred to is necessary and as follows:-

### **Euthanasia**

The act of killing someone painlessly, with a view to relieve suffering from an incurable illness<sup>4</sup>. Euthanasia is synonymous with mercy killing, the latter phrase being the one commonly used. Here we are dealing with intense physical pain and not emotional distress.

### **Voluntary Active euthanasia<sup>5</sup>**

A positive act whereby someone's life is ended with the aim of sparing them pain or to end a meaningless existence. Usually a terminally ill patient will request the termination of his or her life because of being in her extreme pain and someone else will administer a lethal procedure.

### **Voluntary Passive euthanasia**

The removal of life sustaining apparatus at the patient's request. With passive euthanasia we are dealing with the discontinuation of treatment or the cessation of life-prolonging treatment.

### **Non-Voluntary Passive euthanasia**

The removal of life sustaining apparatus without the patient requesting this. This is where the patient's doctor (usually after consulting some colleagues) or family members decide that embarking on treatment or

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<sup>4</sup> Labuschagne JMT, "Dekriminalisasie van Eutanasië" 1988 (51) THRHR 178,. My translation : Vir doeleindes van die verdere bespreking kan eutanasië omskryf word as die opsetlike dood van 'n medemens met die doel om lyding of 'n sinlose lewe te beëindig.

<sup>5</sup> Ibid, my own translation.

continuing with some form of treatment will be fruitless. Usually palliative care is administered until the patient dies.

### **Non-Voluntary Active euthanasia**

The termination of a terminally ill patient's life, without the latter requesting such termination, by another. Usually this is done by a person close to the patient out of compassion.

## **3. IS THERE A RIGHT TO DIE?**

### **3.1. South African Law Before the 1996 Constitution**

Nowhere in the common law is there toleration for ending the life of another human being with the aim of alleviating their pain and suffering. The state of South African law regarding euthanasia before 1996 can be summarised as follows<sup>6</sup>:-

- (a) Mercy killing by means of an act of commission constitutes the crime of murder, and acts of commission would include the withdrawal of medical aid by means of a positive action, such as disconnecting a machine.
- (b) Where mercy-killing is administered passively, that is, by simply withholding treatment that could prolong the patient's life, criminal responsibility can, in the appropriate circumstances be founded upon either the protective relationship assumed by a

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<sup>6</sup> Oosthuizen et al, Euthanasia, 119.

doctor towards his patient, or the prior conduct of the doctor evidenced by initial medical treatment that would increase the likelihood of death, that the particular treatment were to be discontinued.

- (c) In all instances, consent on the part of the deceased is no excuse, though it may, as an extenuating circumstance, have a bearing on the sentence imposed by the court.

Although suicide and attempted suicide are no longer crimes, assisting someone to commit suicide remains a punishable offence. In general the situation in South African law is not at all clear. Persons concerned with euthanasia in all its forms, viz doctors, remain in the dark about what is legally permissible.

### **3.2. The Right to Die and the Constitution**

In a recent decision<sup>7</sup>, a living will was accepted by the court. The court continued to grant authorization to the wife of a patient in a vegetative state to cease artificial feeding, which was keeping the patient alive. This instance is an example of the already acceptable passive euthanasia. It is nevertheless important in that it accepted the notion of quality of life, rather than mere existence. More importantly it recognised that the prior expressed consent of the patient must be respected.

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<sup>7</sup> **Clarke v Hurst NO 1992 (2) SA 630 (D)**



In most instances regarding active euthanasia<sup>8</sup>, although the acts were found to be unlawful, the sentences were lenient.

It has to a large extent been accepted by the legal, medical and moral communities that life-prolonging treatment may be discontinued if it becomes apparent that there is no hope for the recovery and/or improvement of the patient. Recovery should not be defined simply as the ability to remain 'alive', it should also mean life without intolerable suffering.

Continuation of life by artificial means in instances where the patient is terminally ill or dying is not only traumatic to the patients but to their next of kin. In instances such as these, the patient and/or his next of kin will not only be faced with emotional distress but also with financial difficulties. Modern medicine is equipped with all sorts of gadgets that could keep a dying person alive for ages. It is a reality that most families will be faced with enormous medical bills for sustaining a life whose quality is non-existent. It may seem heartless to be thinking about finances when the care of a loved one is at stake but most of these life prolonging treatments are too expensive and may spell financial disaster for the average family.<sup>9</sup>

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<sup>8</sup> S v De Bellocq 1975 (3) SA 538 (T), S v Hartmann 1975 (3) SA 533 (T).

<sup>9</sup> "A right to die?", Bhagaloo K, WUSLR 83-84.

It may be true that in the past people were opposed to euthanasia, either active or passive, but now dying patients are becoming slaves of the medical profession. In the interests of science they seek to see how long they can keep a body alive. In the past even though euthanasia was opposed the period that medicine could prolong the life of such a patient was also limited.

**Christiaan Barnard**, the famous heart surgeon contends that life should be allowed to continue only when it is enjoyable:<sup>10</sup>

'Why should modern medicine try to prolong the process of life when it can no longer be enjoyed? In fact we are no longer prolonging the process of life, in this way we are actually prolonging death.'

**Van der Vyver** believes that every man has what he terms a 'sacred right' to die peacefully and with dignity and that a person who is ready to do so, should be allowed to meet his God.<sup>11</sup>

The South African Constitution<sup>12</sup> with its entrenched bill of rights lends a number of rights and freedoms to the individual.

### ***Life***

S11 provides that

'Everyone has the right to life'

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<sup>10</sup> **Strauss, Doctor, patient and the law, 337.**

<sup>11</sup> **Ibid.**

<sup>12</sup> **Act 108 of 1996.**

It is true that everyone has a right to life, but this almost begs the question: "What is life?". Of course this is a philosophical question but it does depend on a few practical issues. The presence of a heart beat is no longer a sufficient criterion to evaluate life. For terminally ill patients in pain and those in a persistent vegetative state, the quality of life that they have or might have in future should be a consideration.

Death is, for each of us, among the most significant events of life. As the Chief Justice of the USA said in Cruzan v Missouri<sup>13</sup> "the choice between life and death is a deeply personal decision of obvious and overwhelming finality". Most of us see death - whatever we think will follow it - as the final act of life's drama, and we want that last act to reflect our convictions, those we have tried to live by not the convictions of others forced on us in our most vulnerable moment.

"Different people, of different religious and ethical beliefs, embrace very different convictions about which way of dying confirms and which contradicts the value of their lives. Some fight against death with every weapon their doctors can devise. Others will do nothing to hasten death even if they pray it will come soon. Still others, want to end their lives when they think that living on, in the only way they can, would disfigure rather than enhance the lives they had created. Even if it were possible to eliminate all pain for a dying patient - and frequently that is not possible - that would not end or even much alleviate the anguish some would feel at remaining alive, but intubated, helpless, and often sedated near oblivion."<sup>14</sup>

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<sup>13</sup> 497 U S 261, 281 (1990).

<sup>14</sup> Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon and Judith Sarvis Thomson. assisted Suicide: The Philosopher's Brief, The New

Man must be entitled to demand the release of death from hopeless and helpless pain, and a physician who gives this release is entitled to moral and legal absolution for his act.<sup>15</sup>

We must start recognising that the quality of life matters because absolute interdiction of euthanasia involves the impossible assertion that every life, no matter what its quality or circumstances, is worth living and obligatory to be lived. On any rationally acceptable philosophy there is no ethical value in living any sort of life : the only life that is worth living is the good life. Sidney Hook, after quoting Aristotle to this effect, continued:

"We may define the good life differently, but no matter what our conception of the good life is, it presupposes a physical basis - a certain indispensable minimum of physical and social well-being - necessary for even a limited realization of that good life. Where that minimum is failing together with all rational probability of attaining it, to avoid a life that at its best can be only vegetative and at its worst run the entire gamut of degradation and obloquy, what high-minded person would refuse the call of the '*moet mourir entre les bras du sommeil*'? We must recognise no categorical imperative 'to live', but 'to live well.'"<sup>16</sup>

In **S v Makwanyane & Another**<sup>17</sup> it was decided that the core of 'the

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**York Review March 27, 1997.**

<sup>15</sup> **Glanville Williams, The Sanctity of Life and the Criminal Law, 277.**

<sup>16</sup> **Chapter 2, The Republic of South Africa Constitution Act of 1996.**

<sup>17</sup> **1995 (3) SA 391 (CC), 1995 (6) BCLR 665 (CC).**

right to life' is the right not to be put to death by the state. Should the quality of life be read into the ambit of section 9 it will broaden it. This is possible as in **Clarke v Hurst NO**,<sup>18</sup> Judge Thirion did refer to the quality of life although he was concerned with the artificial maintenance of life. The court found that:

" The maintenance of life in the form of certain biological functions such as the heartbeat, respiration, digestion and blood circulation but unaccompanied by any cortical and cerebral functioning of the brain, cannot be equated with living in the human context. If then the resuscitative measures were successful in restoring only these biological functions then they were in reality unsuccessful and consequently artificial measures of maintaining that level of life, such as naso-gastric feeding, could also be discontinued."

This is an instance where the court was willing to consider the quality of life.

This section has to be read in conjunction with the right to human dignity and privacy.

### ***Human Dignity***

S10 provides that

'Everyone has inherent dignity and the right to have their dignity respected and protected'

The right to human dignity has been described as the most important of all human rights alongside the right to life.<sup>19</sup> This right also forms the foundation of many other rights. In fact human dignity is the founding

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<sup>18</sup> 658 B-E.

<sup>19</sup> S v Makwanyane supra, 144.

value of the 1996 Constitution.

There are certain illnesses e.g. failure to control one's bowels that not only keep a patient in constant pain but also erode their dignity. Terminally ill patients who are certain that death is near and are in pain are often given quantities of pain-killers or sedatives that make the pain bearable. The effect of this practice is that the patients will often be kept in a semi-conscious state because if they are fully aware they will not be able to stand the pain. So they start to slip into an area of dying slowly.

This is where medical technology effectively creates the so-called 'twilight zone' of suspended animation where death commences while life in some form, continues.

Medical professionals in this instance know that should they give the patient the correct dose to alleviate the pain altogether it will most certainly end up killing the patient which could be regarded as a form of euthanasia. It is however a moral duty that we, as humans have to relieve pain.

The above scenario is known as the 'double effect' principle where it all depends on the intention of the medical practitioner. As **H JJ Leenen** had observed<sup>20</sup>, the doctor's aim in this situation is not to terminate life, but to alleviate the patient's suffering:

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<sup>20</sup> **Strauss, op cit 346.**

"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."

Therefore if the doctor's intention was to relieve pain and not to cause death, but death did occur as a secondary effect, there will be no question of criminal or civil liability on his part.

Judging by the instances that have come before our courts on this issue, a great deal of compassion was elicited for the accused. Although they were all found guilty, the sentences that were meted out show the understanding that our courts have of what terminally ill patients in pain and their families go through, even where the accused's primary intention was to cause death. As Strauss puts it, we have a criminal "non law" which no one wants to enforce.<sup>21</sup>

We all want to live as long as we can, but pain and suffering can diminish our dignity to such an extent that the desire to live diminishes altogether. What this patient will be asking for is to die in a manner that keeps their dignity intact. People worry about their dignity when they are defamed or insulted and yet that has nothing to do with their physical being and yet we are willing to deny a dying person, his last wish to die in dignity and are almost driving him to commit suicide.

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<sup>21</sup> Op cit 342.

Why do we deny him the relief of a humane exit? Because we value the quantity of life more than the quality of life to such an extent that we are willing to force a person to live in pain because we could not live with ourselves if we allowed them to die? That does not sound humane at all. We put down animals in pain or those without anyone to look after them, yet we do not show the same consideration and compassion for people.

The constitutional birth and survival of this proposed right to die will depend on whether the legislation proposed by amongst others the South African Law Commission<sup>22</sup> is given favourable interpretation by the constitutional court.

"The Constitutional Court has to give 'life' a content value so that some form of quality of life beyond mechanical existence is read into the right to life, so that where quality is not in existence, a limitation to the right to life guarantee will be acceptable. The continuation of a life whose quality has degenerated to such a degree that to prolong the dying process runs counter to the right to life guarantee.

The right of a terminally ill patient to dignity, self determination and privacy embodies the values of an open and democratic society which would justify limitation of the right to life in circumstances where a person is little more than alive."<sup>23</sup>

The right to privacy at its minimum, ensures that certain aspects of an individual's life remain free from interference by the state. Since the

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<sup>22</sup> SALC Project 86, Euthanasia and the Artificial Preservation of Life.

<sup>23</sup> Chaskalson et al, Constitutional Law of South Africa 15 - 8.



Second World War and the atrocities committed by the Nazis, there has been more emphasis on human autonomy,<sup>24</sup> and the right to privacy ensures that important decisions about one's life are free from state interference.

#### **4. POSSIBLE SUBJECT OF THE RIGHT TO DIE**

Like any other right, the right to demand assistance to end one's life is not absolute. This right will be limited to the terminally ill patients : both competent and incompetent. These are persons who cannot do anything to alter their circumstances, for them the next certain event in their life is death. It is true that every competent person can decide whether or not to continue living but not all these people can claim to be assisted with their death.

This study therefore excludes the so-called ordinary suicides<sup>25</sup> . For these persons granting them death will be denying them a chance to go through all the aspects of life, because emotional distress and pain that can ultimately be overcome are part of life. These persons will still continue to take their lives. However they cannot be legally assisted to do so.

Therefore the possible subjects of the right to die will be :

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<sup>24</sup> **General Assembly Resolution 3103 (XXVII), 1973.**

<sup>25</sup> **Eg emotionally troubled people.**

#### 4.1. The Terminally Ill and Competent Patient

Ellen Bartlett relates how her mother, Martha who had suffered two massive cerebral haemorrhages in January and February 1984 finally died in 1987<sup>26</sup>. Since 1984 she had been in constant pain. She was diagnosed with thalamic pain syndrome. This syndrome is rare in stroke survivors because it results from the kind of brain injury that few survive. Physicians know little about it. It is unpredictable, indescribable, incurable and likely to worsen over time. An array of pain killers and anti-depressants taken in ever-increasing doses could take the pain to a more indistinct level, but never take it away.

She had tried to kill herself in several ways, throwing herself down a flight of stairs, wearing a plastic bag over her head and taking an overdose of pills several times. The family had also discussed administering cyanide to her at one stage. She finally did manage to kill herself and of that death Ellen writes :

"I do not regret her death. My regret is that I was not there for it, to tell her I loved her, to kiss her goodbye, to be with her when she died. Had there been less stigma attached to the unnatural means of dying, perhaps she would have invited us to be with her. But she chose to go alone, in her time, when she was ready. She had lost so much of herself in the past three years that only by doing what she had done, she had got some of herself back. By ending her life, she had taken control of it, had made herself whole again."

What forced Ellen's mother to resort to the kind of measures that she did is the prevailing laws against active euthanasia in South Africa. In our

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<sup>26</sup>The day my mother took her own life,' Mail & Guardian April to May 1 1997, 12.

law a terminally ill person who requests the termination of his/her life due to experiencing unbearable pain cannot be assisted. Should you assist, then you will be charged and convicted with murder.

Consent on the part of the deceased is no excuse, though it may, as an extenuating circumstance, have a bearing on the sentence imposed by the court. As Van Winsen J so concisely stated in the case of *S v Hartmann*<sup>27</sup>:

"... the fact that the deceased wished to be killed does not exclude the criminal responsibility of him who gratifies the deceased's wish".

It is accordingly beyond the power of an individual to consent , for whatever reason, to be killed.<sup>28</sup>

#### **4.1.1 Comparative Survey**

In most countries aiding, abetting and assisting suicide is punishable by law.

Section 241 of the **Canadian Penal Code** states that:

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 14 years.

In the **United States**, the constant prosecution of Dr Kervokian shows

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<sup>27</sup>1975 3 SA 532 C at 534.

<sup>28</sup>R v Peverett 1940 AD 213, S v Robinson & Others 1968 (1) SA 666 (A) at 678.

that voluntary active euthanasia is not allowed and that the person assisting will be punished by law. On 26 June 1997 the American Supreme Court handed down its long-awaited judgement on the legality of physician assisted suicide in the USA, in the case of **Washington et al v Glucksberg et al.** In its judgement the court unanimously declared that a 1994 Washington State law, which declared assistance to a person who attempts suicide a criminal offence, is not unconstitutional. The court regarded assisting suicide as inconsistent with American philosophical, legal and cultural values.<sup>29</sup>

The attempt by the legislature of the **Northern Territory of Australia** to legalise voluntary active euthanasia in terms of the **Rights of the Terminally Ill Act in 1996**<sup>30</sup> drew world-wide attention. This Act provided for both active voluntary euthanasia and assisted suicide in that it provided that a patient who, in the course of terminal illness, is experiencing pain, suffering or distress to an unacceptable extent may request his or her medical practitioner to assist in terminating his or her life. The Australian Medical Association welcomed this new development but the federal government overturned it because they do have the powers to veto the laws in the state and territories.

The **Netherlands**<sup>31</sup> so far seems to be the one country where physician

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<sup>29</sup> **Straus SA, "US Supreme Court rules prohibition of assisted suicide to be constitutionally valid."** Article distributed to Medical Jurisprudence students at UNISA.

<sup>30</sup> **Pretoria News, 7 January 1997, at 7.**

<sup>31</sup> **Holland's use and abuse of death, Mail & Guardian, Feb 21 to 27 1997, at 8.**

assisted suicide is for all practical purposes legal. Section 293 of the **Dutch Criminal Code** read with section 294 states that:

S293

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

S294

Hij 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.

Although these sections exist a physician who assists a mentally competent adult to commit suicide can escape criminal liability if he pleads *overmacht* in the form of necessity. Since then, the Netherlands have refined their voluntary active euthanasia laws to such an extent that the practice can be monitored objectively.

#### **4.2 The Terminally Ill and Incompetent Patient**

Mentally incompetent patients usually find themselves in a persistent vegetative state which is a condition most often caused by brain injury or asphyxiation where the oxygen supply to the brain is shut off for an extensive period of time thereby resulting in irreversible brain damage. These patients will never be conscious, they are being kept alive by

artificial means. One or more of their basic bodily function(s)<sup>32</sup> is being performed by someone or something else.

For this patient we are concerned with life-sustaining medical treatment. Sometimes the patient might have left an advance directive, either written or oral, that should he be in this condition, they would prefer that his family ask/request that the life-sustaining treatment be stopped. At other times this directive might be absent.

#### **4.2.1. Where There is An Advance Directive - Current SA Law**

It is an acceptable principle in our law that a mentally competent person is entitled to refuse medical treatment, even where such treatment is life-sustaining.<sup>33</sup> With an advance directive (living will) the competent person tries to issue advance directives to people who will be in charge of his medical treatment when he is no longer in a position to make such decisions.

Professor Strauss defines a 'Living Will' as follows<sup>34</sup>:

"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."

There is no judgment in our case law where the issue of advance

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<sup>32</sup>**Breathing, feeding, etc.**

<sup>33</sup>**Phillips v De Klerk March 1983 TPD (unreported).**

<sup>34</sup>**Strauss, Doctor, Patient and the Law 3rd Edition, 344.**

directives has been discussed thoroughly. However in **Clarke v Hurst** **NO**<sup>35</sup> it was stated that effect should be given to a patient's wishes as expressed when he was in good health. Although the court's decision was guided by the convictions of the community as interpreted by the court, the patient's wishes as provided in the 'Living Will' were referred to<sup>36</sup> :

"It is indeed difficult to appreciate a situation, save where a patient is suffering unbearable pain or is in a vegetative state, where it would be in the 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."

#### **4.2.1.A. Comparative Survey**

In the **United Kingdom**, a patient of sound mind can also refuse any medical treatment. The validity of advance directives has not been expressly tested by the courts and there is no legislation in this area. The usefulness of such a document is acknowledged by writers but the courts will still have to determine to what an extent they would recognise such a document.

In **Airedale NHS Trust v Bland**<sup>37</sup> the court did on several occasions refer positively to the usefulness of such a document. Lord Goff expressed

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<sup>35</sup>1992 4 SA 630 (D).

<sup>36</sup> **Strauss, Doctor, Patient and the Law 3ed, 344.**

<sup>37</sup> [1993] 1 ALL ER 821.

that a patient's right to refuse treatment can be extended to an incompetent patient, who expressed his wishes to refuse treatment at an earlier stage.

At this stage there is no legal certainty on the issue. Legislation is necessary.

In the **USA** since **1976**, most states have accepted legislation governing advance directives, where refusal of medical treatment is concerned. Although in all states the document must be written, there are variation as to further validity requirements in different states. Some states have also made provision for enduring powers of attorney, in terms of which decisions can be made on behalf of incompetent patients in respect of their medical treatment.<sup>38</sup>

In **Australia** the question regarding the refusal of consent to medical treatment and the artificial support of life is dealt with differently in 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.<sup>39</sup> 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.<sup>40</sup>

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<sup>38</sup> SALC, Discussion Paper 71.

<sup>39</sup> SALC, Discussion Paper 71.

<sup>40</sup> Ibid.



#### 4.2.2. Where There is no Advance Directive - Current SA Law

The legal position in our law is best reflected by the courts in S v De Bellocq<sup>41</sup> where the accused, a young married woman had given birth to a premature baby who was suffering from a mental illness which would have prevented him from ever leading a normal life. The accused had drowned the baby. In finding her guilty the court per De Wet J P stated:

"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<sup>42</sup>."

##### 4.2.2.A. Comparative Survey

The United States' first instance was that of Karen Quinlan in 1976<sup>43</sup>. In 1975 after Karen had been in a vegetative state for seven months, her father applied to court to have her respirator disconnected. In granting the order, the New Jersey Supreme Court relied on her constitutional rights to privacy and self-determination.

Then in 1990 the Supreme Court of the United States was approached

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<sup>41</sup> **Supra.**

<sup>42</sup> **Supra.**

<sup>43</sup> **In re Quinlan** 70/81 NJ 10, 355 A 2d 647 (NJ 1976).

by Joyce and Joe Cruzan,<sup>44</sup> the parents of Nancy Cruzan aged 32, for an order granting them permission to end their daughter's life. Nancy had for the past seven years lain awake but unaware after a car crash. Unlike Karen Quinlan, Nancy was not on a life-support system, she was in a persistent vegetative state. Her parents were asking the court to remove a feeding tube so that she could starve to death.

The Supreme Court did acknowledge Nancy's right to refuse treatment, but would not affirm substituted refusal by family members without clear and convincing evidence that what the family was asking for was in line with what the patient had wanted.

In the **United Kingdom** cessation of life-prolonging treatment was dealt with in **Airedale NHS Trust v Bland**<sup>45</sup>. Anthony Bland, 21 had been in a persistent vegetative state for over three years when the health authority applied for a declaratory order to the effect that his treatment should be discontinued and that the only medical treatment that should be furnished should be aimed at enabling him to die peacefully with dignity and no pain and that no criminal liability would arise on the part of the applicant. He had a feeding tube and was being assisted in other bodily functions but his brain had no cognitive functions.

The judge granted the order and it was affirmed on appeal. The House

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<sup>44</sup> **Cruzan v Director Missouri Department of Health** 497 US 261 (1990), 111 L Ed 2d 224, 110 S Ct 2841.

<sup>45</sup> **Supra.**

of Lords decided this instance with reference to the best interest condition as set out in **F v West Berkshire Health Authority**<sup>46</sup> and held that medical treatment including 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 does not confer any benefit on the patient.

## **5. EUTHANASIA AS A FACTOR IN THE RIGHT TO DIE**

Now that the right to die has been established and a criterion for identifying the cases has been set, a humane method for the actual implementation of this right and a panel of competent persons who could make final decisions in this regard should be established. Euthanasia, which is described above as 'the act of killing someone painlessly, with a view to relieve suffering from an incurable illness' will be the proper route to take to realise the right to die.

Whether it is supposed to be active or passive euthanasia will depend on the patients' circumstances.

### **5.1 Passive Euthanasia**

It has to a large extent been accepted by the legal, medical and moral communities that life-prolonging treatment may be discontinued if it becomes apparent that there is no hope for the recovery and/or improvement of the patient. Passive euthanasia therefore, involves the

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<sup>46</sup> [1989] 2 ALL ER 545, [1990] 2 AC 1.

cessation of life-prolonging treatment.

Passive euthanasia might be voluntary in that the competent patient might decide to refuse any life-prolonging treatment and the incompetent patient might have stated prior to becoming incompetent that in circumstances like these they would like to be allowed to die, or involuntary in that an incompetent patient's doctor or duly appointed representative might decide that the life-prolonging treatment be ceased.

### **5.1.1 Arguments for passive euthanasia**

#### ***(a) Allowing a patient to die***

This is really the only argument for passive euthanasia and the situation is well summed up by Mason and McCall Smith<sup>47</sup>:

"We, by contrast believe that a morally significant difference between inactivity and action exists and that this rests on a firmer base than a mere intuition. The essence of discrimination lies in the means to obtain the same end, in that the taking of active steps implies an autocratic control over the way in which the event occurs. The doctor who administers a drug intended to end the life of a suffering patient determines the moment and the manner of the patient's death. The action of the drug changes the physical cause of death and this must be a matter of importance. The process is quite different from allowing another agency - e.g. illness - to cause death."

We feel differently when we allow a patient to die than when we

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<sup>47</sup>Mason and McCall-Smith, Euthanasia in Law and Medical Ethics 1987, 233.

actively participate in bringing about the patient's death. While only a minuscule number of physicians would work actively to end the life of a patient, passive euthanasia is practised fairly widely. It is also accepted that there is a difference in intent between acts of commission and those of omission. This difference in intent becomes important in distinguishing between the rightness of an act and the worthiness of an act.<sup>48</sup> For example, if a doctor administers what is intended to be a life-saving drug but the recipient has an unusual reaction to it, the doctor will be said to have done the wrong thing but would not be blameworthy. This is because the doctor's intentions were good. Intention might be morally relevant in deciding whether the act was wrong as well as blameworthy.

### **5.1.2 Arguments against passive euthanasia**

While passive euthanasia has gained general acceptance as part of good medical practice, it is clear that it will not gain moral acceptance in all its forms.

#### ***(a) Failure to provide treatment***

"A failure on the part of a medical doctor to provide his patient with treatment thought to be appropriate in the circumstances might well be considered to be a morally culpable omission."<sup>49</sup>

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<sup>48</sup>Veatch, Death, Dying and the Biological Revolution 83-85.

<sup>49</sup> Mason and McCall-Smith, *supra*.

Therefore non-treatment of those with deteriorating health might be considered inappropriate.

***b) Who decides?***

Most instances concerning passive euthanasia deal with incompetent patients. Therefore it inevitably involves someone else taking the decision on behalf of the patient. This is almost always a family member or a person closest to the patient. It is they who are likely to know the patient's personal history, beliefs and wishes. The doctor may also know this if he/she has communicated with the patient previously on the issue. It is submitted that rarely, if ever, is a judge capable of making the decision. Despite his judicial wisdom he can never really know what the patient would have wanted.<sup>50</sup>

Sometimes it is the medical practitioner who makes an informed decision not to commence with medical treatment or to cease any medical treatment.<sup>51</sup> **The concern here is: who supervises these medical practitioners.**

It is submitted that simple legislation that sets up a tribunal within the confines of the hospital and subject to review by a court of law will be

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<sup>50</sup> Bhagaloo, A Right to Die, WUSLR 84.

<sup>51</sup> Those who favour passive euthanasia are, however, quick to point out that this situation can be remedied by accepting a statement made by the patient whilst still competent. In South Africa and in the United States the courts do put considerable value on the prior statements made by a patient but the degree of proof required is very high. A living will statute would certainly go a long way towards rectifying this concern.

the most efficient way of reaching a decision. In the implementation of euthanasia final decisions in this regard will have to be taken rapidly, responsibly, reliably and with the prospect of review.<sup>52</sup>

## **5.2 Active Euthanasia**

The scope of this dissertation will be limited to voluntary active euthanasia, i.e. where the patient requests that somebody else perform a positive act that will bring about his death. This will include an incompetent patient who makes this decision prior to becoming incompetent. Involuntary active euthanasia raises too many legal and ethical issues to be dealt with in a dissertation of this scope.

### **5.2.1. Arguments for Active, Voluntary Euthanasia**

#### ***(a) The Self-Determination of Patients***

It is already an established principle in our law, as in many other jurisdictions, that competent patients must consent to any medical treatment. They also have the right to refuse any medical treatment even if such a refusal will shorten their lives.<sup>53</sup>

Where a competent person concludes a Living Will, stating that should he/she contract an incurable disease accompanied by unbearable pain and it is certain that he/she will die from that disease, then he/she will

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<sup>52</sup> Oosthuizen et al, 121.

<sup>53</sup> Jehovah's Witnesses refusing blood transfusions, which treatment is regarded as essential whenever considered.

like the physician to hasten their death. When this patient becomes sick, if he/she continuously restates his/her position, such a patient must be allowed to die in peace and dignity. Although in South Africa we do not have a Living Will statute yet, thousands of people, mostly members of the South African Living Will Society, have signed such a will.<sup>54</sup> The Living Will may serve as a persuasive expression of the patient's wishes where he/she is incompetent.

More people could indeed benefit from relief that is already available to the middle and upper classes of society - illegally. A good doctor knows ways of hastening death that cannot be detected in most circumstances. The more fortunate people, who have established close and intimate relationships with their doctors have a sense that if necessary their own doctors 'will know what to do.' This helps to explain why the "political pressure is not stronger for a fairer and more open system in which the law acknowledges for everyone what influential people now expect for themselves."<sup>55</sup>

For the incompetent patient, other jurisdictions recognise the durable power of attorney which enables persons to appoint an attorney to make health care decisions for the principal, should the latter become unable to give an informed consent.<sup>56</sup>

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<sup>54</sup> **Strauss, The Right to Die and the Cruzan Judgement in the USA, 1992 SA Practice Management, 12.**

<sup>55</sup> **New York Review, March 27 1997, 41.**

<sup>56</sup> **In the United States all 50 states and the District of Columbia have general durable power of attorney statutes.**



Usually with incompetent patients we are dealing with a decision to discontinue treatment or not to commence medical treatment at all. This phenomenon is widely supported today because somehow it is seen as allowing death to take place. This is what Veatch<sup>57</sup> refers to as the ethics of killing and letting die. Joseph Fletcher, an ethicist at the University of Virginia School of Medicine, recognises that some moralists have "put great store by the distinction between 'direct' and 'indirect' actions" and states what is apparently his own position :

"To others this seems a cloudy and tenuous distinction. Either way the intention is the same, the same end is willed and sought. And the means used do not justify the end in one case if not the other, not are the means used anything that can be justified or 'made sense of' except in relation to the gracious purpose in view."

The pragmatist may indeed ask what difference it makes whether positive action is taken to cause death or a treatment is simply withheld so that death takes place. In either case the patient dies. Is it not philosophical obscurantism to dwell on the differences?<sup>58</sup>

In both active and passive euthanasia the result is the death of the patient whether was the intention of the doctor or not.

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<sup>57</sup> Veatch, *supra*.

<sup>58</sup> *Ibid*.

***(b) The Role of Medical Practitioners Faced with Dying Patients has Changed***

In an attempt to keep terminally ill patients alive, doctors prescribe dosages of painkillers that end up turning the patient into a morphine addict. These patients are often terminally sedated through intravenous drugs which induce a pharmacological coma during which the patient is given neither water nor nutrition and dies sooner than he otherwise would, but these patients actually do die in pain.<sup>59</sup>

Studies tend to show that most medical practitioners would honour a request for death initiated by patients. Forty per cent of Michigan oncologists surveyed reported that patients had initiated requests for death, eighteen per cent said they had participated in assisting their patients and four per cent had injected the drugs themselves.<sup>60</sup> These numbers would probably be higher if doctors did not fear prosecution. These statistics are said to approach the rates at which doctors help patients die in Holland, where active euthanasia by physicians is indeed legal.

If the Hippocratic oath is progressively interpreted - after all it is over 2000 years old<sup>61</sup> - as society and the medical profession that serves it changes it will be realised that nowadays the doctor's duty is not only

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<sup>59</sup> **Supra.**

<sup>60</sup> **The New York Review, March 27, 1997, 42.**

<sup>61</sup> **Strauss, 1988 (51) THRHR, 188.**

to keep the patient alive at all costs, but to relieve pain and suffering, hence the use of anaesthetic in childbirth and operations.<sup>62</sup> However some medical practitioners argue that active euthanasia, if commonly practised will undermine the whole ethos of healing and the doctor's role as care giver.

***(c) Palliative Care Measures will be Improved***

Terminal sedation is widely accepted and is not subject to stringent regulations. Should active euthanasia be legalised, it will be subject to stringent regulations. Before a request is considered, it must be demonstrated that effective medical care including state-of-the-art pain management has been offered, but has failed. Doctors and patients eager to avoid expense have no incentive to begin a process that would focus attention on their palliative care practices. Medical ignorance and fear of liability inadequate hospital funding and the failure of insurers and health care programme to cover the cost of palliative care will then be addressed. Legislation requiring coverage will improve the situation.

It is indeed the view of the Coalition of Hospice Professionals that 'removing legal bars on active euthanasia will enhance the opportunity for advanced hospice care for all patients because regulation of active euthanasia would mandate that all palliative measures be exhausted as

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<sup>62</sup>Anaesthetics are also used in minor things, e g pulling out a tooth.

a condition precedent to active euthanasia.<sup>63</sup>

***(d) Certainty in Diagnosis of Terminal Illness***

There is more certainty in medicine today than there was a decade ago. Nowadays the profession recognises its limitations and challenges.

Where active euthanasia is concerned, at least two specialist doctors will have to agree on the diagnosis and prognosis. This will help minimise the degree of error. Besides, "to try to ignore our fallibility is unrealistic, while to insist on remembering it only in the context of the question of voluntary euthanasia is arbitrary."<sup>64</sup>

***(e) Morality***

"Whatever opinion may be taken on the general subject of suicide, it has long seem so some people that euthanasia, the merciful extinction of life, is morally permissible and indeed mandatory where it is performed upon a dying patient with his consent and is the only way of relieving his suffering.... a man is entitled to demand the release of death from hopeless and helpless pain and a physician who give this relief is entitle to moral and legal absolution for his acts.

One of the earliest expressions of the opinion in England came from no less a Catholic than Sir Thomas More, who, in the second book of his *Utopia*, wrote that in his imaginary community 'when any is taken with a torturing and lingering pain, so that there is no hope either of cure or ease, the priests and magistrates come and

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<sup>63</sup> Amicus brief by the Coalition of Hospice Professionals filed with the United States Supreme Court.

<sup>64</sup> Ibid, 187.

exhort them, that, since they are now unable to go on with the business of life, are become a burden to themselves and all about them, and they have really out lived themselves, they should no longer nourish such a written distemper, but choose rather to die since they can not live but in such misery.'

Perhaps an opinion to the same effect, though not couched in the same forthright terms, can be seen in Francis Bacon's *New Atlantis*. 'I esteem it', he wrote, ' the office of a physician not only to restore the health but to mitigate pain and dolours; and not only when such mitigation may conduce a recovery, but when it may serve to make a fair and easy passage.'

A hundred years later, the Reverend Charles Moore, in his monumental treatise designed to condemn suicide, conceded that 'the most excusable cause seems to be an emaciated body; when a man labours under the tortures of an incurable disorder, and seem to live only to be a burden to himself and his friends. This was thought to be a sufficient apology for the action in ancient days and can only be combated in modern ones by the force and energy of that true religion, which both points out the duty and reward of implicity resignation'.

This writer's opinion that euthanasia as a form of suicide can be condemned only according to a religious hope of immortality was supported by Hastings Rashdall, who approached the subject, like Charles Moore, as a Christian moralist. Rashdall wrote:

'It does not seem possible to decide whether the continuance of moral discipline is worth the prolongation of an existence from which all else that gives value of life has departed without asking what are to be the fruits of this moral discipline, whether it is rational to hope for another state in which the character thus formed may have further opportunities of expressing itself in moral activity.... I may add that this is almost the only case (unless we include also the somewhat parallel question of infanticide) in which the answer to any detailed question of ethics can rationally be affected by the answer that is given to a purely theological problem.'

If it is true that euthanasia can be condemned only according to a religious opinion, this should be sufficient at the present day to remove the prohibition from the criminal law. The prohibition imposed by a religious belief should not be applied by law to those who do not share the belief, where this is not required for the worldly welfare of society generally. But, further, the ancient opinion that religion requires resignation, that the more unpleasant of two alternatives has some intrinsic moral superiority, has lost nearly all its support. At the present day it seems self-evident to most of us that laughter is better than sorrow, oblivion better than the endurance of purposeless pain."<sup>65</sup>

It is a matter that gives food for thought when one comes to consider that, had we been talking about animals instead of human beings, so far from there being anything blameworthy in a man's action in putting an end to its suffering, he would actually have been liable to punishment if he had not done so.

If wholesale killing in war and the punitive killing of criminals are not 'murder' surely a killing done with the patient's consent and for his benefit as an act of mercy can claim to be excluded from murder. Moreover medicine is continuously influencing nature. Sterilization, artificial insemination and birth control are everyday occurrences. Labuschagne quotes Fletcher, who states that :

"are all medically discovered ways of fulfilling and protecting human values and hopes in spite of nature's failures and foolishness. Death control, like birth control, is a matter of human dignity"<sup>66</sup>

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<sup>65</sup>Williams G, The sanctity of life and the criminal law, 277 - 278.

<sup>66</sup> Labuschagne supra.

## 5.2.2 Arguments Against Active, Voluntary Euthanasia

### *(a) Patient is Incapable of making the Decision*

A patient in immense pain although fully conscious is not 'competent' to consent to an act aimed at hastening their death because he/she is in a vulnerable position where third parties - like doctors and nursing homes that need a free bed for the next patient and beneficiaries who stand to gain from the patient's death - might influence his decision.

Who is going to watch over all these people and make sure that the ultimate decision made is that of the patient alone? It will not only be costly but impossible to watch over the medical profession and an issue of this importance cannot be left to the profession itself to regulate.

### *(b) Active Euthanasia is Against the Role of the Physician*

It is often argued that the role of the physician is to preserve life. In the Hippocratic Oath, physicians pledge that they "will neither give a deadly drug to anybody if asked for it, nor ... make a suggestion to this effect."

A physician-patient relationship is one based on trust, and a move to introduce active euthanasia would undermine this relationship. This is expressed by Capron<sup>67</sup> :

"I never want to have to wonder whether the physician coming into my hospital room is wearing the white coat (or the green

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<sup>67</sup> A M Capron, "Legal and Ethical Problems in Decisions for Death", Medical Health Care, (1986), 14.

scrubs) of a healer, concerned only to relieve my pain and restore me to health, or the black hood of the executioner. Trust between patient and physician is simply too important and too fragile to be subjected to this unnecessary strain."

**(c) *Palliative Care is the Best Option***

As early as 1973, Cecily Saunders, the medical director of St. Christopher's Hospice in England, claimed that 'pain and suffering can virtually always be controlled by the proper use of painkilling drugs and sleep-inducing medication.<sup>68</sup> Pain can be made tolerable through advanced and expensive palliative techniques.

**(d) *The Slippery Slope Argument***

If we accept the killing of the terminally ill for human reasons, may that not lead to the killing of the severely retarded child, the antisocial personality, or the ethically unattractive?

"... Once a society agrees that at some stage life is no longer worth sustaining, patients could become suddenly vulnerable. While we would begin with competent patients making their own decisions, we would be led too easily, into the realm of involuntary euthanasia - either manipulating people into asking for suicide or actually doing it to them without their permission because they have become too burdensome and costly."<sup>69</sup>

Once this right is acknowledged for the terminally ill, how can it be limited? Why should it be denied to dying patients who are so feeble or

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<sup>68</sup> Veatch, 94.

<sup>69</sup> Bhagaloo, 84.



paralysed that they cannot give consent for themselves? Or to patients who are not dying but face years of intolerable physical or emotional pain, or crippling paralysis and dependence? Even if it were extended this far, on what grounds would it be denied to anyone who had formed a desire to die or to a sixteen year old suffering from a severe case of unrequited love, for example?<sup>70</sup>

**(c) *The Religious and Moral Arguments***

Euthanasia entails one person murdering another and that is against the sixth commandment, "Thou shalt not kill". Besides, pain and suffering of the human body should be endured as this has a purpose prescribed by God.

By allowing active euthanasia, man is entering God's domain. God has a specified time and manner for each and everyone's' death and man should not interfere with this.

**6. CONCLUSION**

The law already accords all competent persons the constitutional right to make momentous personal decisions which involve fundamental religious or philosophical convictions about life's value for themselves. The Constitution recognises that individuals have a protected interest in making those grave judgements for themselves, free from the

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<sup>70</sup> New York Review, March 27, 1997, at 41.

flows from the right of people to make their own decisions about matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy."<sup>71</sup>

Decisions about religious faith, political and moral allegiance, marriage, death and procreation pose controversial questions about how and why human life has value. In a free society, like ours, individuals must be allowed the freedom to make these decisions out of their own faith, conscience and convictions.<sup>72</sup>

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<sup>71</sup> **Planned Parenthood v Casey** 505 U S 833, 851 1992

<sup>72</sup> **Planned Parenthood v Casey**, *supra* and **West Virginia State Board of Education v Barnette**, 319 U S, 624, 542(1943) : "If there is any fixed star in our constitutional constellation it is that no official ... can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein."

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