The South African Law Commission's proposed euthanasia Act makes provision for a medical practitioner who is requested by a patient to put an end to the patient's suffering to do so under certain conditions.
'A competent person may refuse any life-sustaining medical 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.' – SA Law Commission recommendation (Project 86)

The debate about whether a terminally ill patient can be assisted to die continues. In the state of Michigan in the United States of America, assisted-suicide crusader Dr Jack Kevorkian, a 70-year-old retired pathologist, was sentenced for ten to fifteen years in prison on 13 April 1999 for second-degree murder for the killing of a terminally ill Michigan man, Thomas Youk.

Oakland Country Circuit Judge Jessica Cooper rejected emotional pleas for leniency from the widow of Thomas Youk who received a lethal injection from Dr Kevorkian in September 1998.

The CBS television news programme 60 Minutes broadcast portions of Dr Kevorkian’s home-made videotape of Mr Youk’s death to an estimated 15.6 million American homes in November 1998.

In the segment, Dr Kevorkian, who campaigned for the legalisation of assisted suicide, dared prosecutors to charge him and settle the issue once and for all.

At his trial Justice Cooper told Dr Kevorkian that a courtroom was the wrong forum for challenging laws. Justice Cooper said:

‘This trial is not about the political and moral correctness of euthanasia. It was all about you, sir. It was about lawlessness. It was about disrespect for a society that exists and flourishes because of the strength of its legal system. No one, sir, is above the law.’

Dr Kevorkian who earned the nickname ‘Dr Death’ for helping at least 130 people end their lives, said he acted to relieve the suffering of Youk (52) who suffered from a fatal illness.

The ‘living will’

Modern medical technology has produced sophisticated equipment for maintaining the circulation, respiration and other bodily functions of patients who can no longer perform these functions spontaneously and would otherwise die. Whether and to what extent the right to refuse medical treatment includes the right to refuse such self-sustaining treatment has also been the subject of extensive litigation.

This factor and the increasing importance attached to patient autonomy have resulted in large-scale use by many individuals of the document known as the living will. A ‘living will’ is an advance directive by a person to the effect that if at any time he should suffer from an incurable disease or injury which cannot be successfully treated, life-sustaining treatment should be withheld and the patient left to die naturally. Living wills are not wills in the sense that they are governed by the South African Wills Act 7 of 1953, which applies to testamentary dispositions. They are essentially advance directives or declarations refusing treatment, in which patients state that under certain conditions they do not want to be kept alive by artificial means. A living will is not like a power of attorney which loses its authority when the principal becomes mentally incompetent.

In the United States of America many states have statutes which can broadly be described as ‘living will laws’.

Although we do not have a living will statute in South Africa as yet, the South African Living Will Society has a membership of more than 20 000.

The South African Living Will Society suggests that the declarant should have three copies of the living will made at the time of execution: one kept at home in a safe place; one lodged with the family doctor; and one in the patient’s in-patient file.

All members of the SA Living Will Society are also provided with a living will wallet which can be carried on their persons.

It is generally accepted that a patient has the right to refuse treatment even if such refusal may cause injury or death. A doctor may not treat a patient without his consent except in the case of an emergency or if there is a statutory duty to do so. For the consent requirement to be satisfied the patient must have had the legal capacity to consent to treatment and such consent must be based upon essential knowledge regarding the nature and effect of the proposed treatment.

In the United States of America living will legislation has been criticised. George B Pozgar in his book Legal Aspects of Health Care Administration holds the following opinion:

‘Although many interest groups hailed the enactment 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 helpless he will feel at the time of 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 the 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.

The case of Clarke v Hurst & Others 1992 (4) SA 630 (D) is one of a number of recent cases decided in various legal systems in which judicial approval was sought to end the life of a terminally ill patient.

In an article in 1999 (10) SALJ 440 Jérôme Leonard Taizt concludes as follows:

‘It is interesting to note that evidence was led in Clarke to the effect that the patient (a qualified medical practitioner) was a life member of SAVES (the South African Voluntary Euthanasia Society). He had signed a “living will”: a document directing that should he in the future contract a terminal illness with no hope of recovery and become permanently unconscious, he must not be kept alive by artificial means but be allowed to die. Further, the patient even delivered a public speech in favour of the right to die in certain circumstances (Clarke at 633H–J). In regard to this evidence, Thorton J stated that’

“these statements undoubtedly stemmed from a settled, informed and firmly held conviction on the patient’s part that should he ever be in the condition in which he has been since the cardiac arrest, no effort should be made to sustain his life by artificial means but that he should be allowed to die” (Clarke at 633I–634B).

‘None the less, in his judgment his lordship placed no emphasis on these directions, nor did he rule on the validity of the “living will”. The reason for this probably lies in the fact that, as yet, the “living will” has not been recognized in South African law. An examination of the document shows that it is not a will, nor can it be described as a power of at-
torney. ... Perhaps at best it may be regarded as a written directive having no force of law.

It appears that the South African Law Commission which is currently considering legislation (to regulate end-of-life decisions and to provide for matters incidental thereto) has proposed that legislation be enacted as follows:

'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.' (South African Law Commission, Discussion Paper 71, Project 85: Euthanasia and the artificial preservation of life).

Euthanasia

Euthanasia is defined in the dictionary as 'gentle and easy death; bringing about of this, or its equivalent, the ending as painlessly as possible of the life of the person who is fatally ill and suffering pain'.

The word 'euthanasia' comes from the Greek ' euthanatos' derived from the words 'eu' meaning good and 'thanatos', meaning death. It has also been defined as 'mercy killing of the hopelessly ill, injured or incapacitated', and 'the ending as painlessly as possible of the life of the person who is fatally ill and suffering pain'.

Euthanasia includes:
• death by administering drugs without the patient's explicit request;
• a decision to withhold or withdraw potentially life-prolonging treatment or hasten a patient's death;
• alleviating pain with large doses of opioids, allowing for a probability of causing death, but not explicitly intending to cause death; and
• alleviating pain with large doses of opioids, partly intended to hasten the patient's death.

Euthanasia is sometimes divided into voluntary and involuntary euthanasia and active and passive euthanasia.

Most attempts to legalise the termination of life on medical grounds have concentrated on what is generally known as voluntary euthanasia. This expression implies that a patient specifically requests that his life be ended. It is generally agreed that to attain any semblance of validity, this request must come from one who is either in intolerable pain or is suffering from an illness which is agreed to be terminal.

An act of involuntary euthanasia involves ending the patient's life in the absence of an indication of such a desire on his part. The motive - the relief of suffering - may be the same as that involved in voluntary euthanasia but its only justification lies in a paternalistic decision as to what is best for the victim of disease.

Active euthanasia takes place where a person commits a positive act to cause the

dearth of another, while passive euthanasia is an omission to do something which results in the death of the patient. In South African law active euthanasia which involves the intentional killing of another, whatever the motive, is unlawful. The law does not leave the issue in the hands of doctors; it treats euthanasia as murder.

Death

When the moment of death occurs remains an open question in South African law. In the case of S v Williams 1986 (4) SA 1188 (A) the trial court found that, according to traditional medical standards, the moment of death occurs when brain-stem death sets in. Thus, according to the Williams case, a doctor who disconnects a life-supporting system cannot be said to have caused the death of the patient as the patient was already medically dead.

The unconscious patient

Respirators, artificial kidneys, intravenous feeding, new drugs - all have made it possible to sustain an individual's life artificially and long after the individual has lost the capacity to sustain life independently. The dramatic advances in medical technology have enabled doctors to ventilate patients and keep them alive. These are patients who are in a persistent vegetative state (PVS).

Most of the euthanasia cases where the courts have allowed the withdrawal of life-sustaining treatment have involved PVS patients. Such patients' prospects of recovery were extremely remote.

The Clarke case is the first reported South African case to deal with the ques-

pacity to maintain the vegetative part of neurological function but has no cognitive function. In such a state the body is functioning entirely in terms of its internal controls. It maintains digestive activity, the reflex activity of muscles and nerves for low level and primitive conditioned responses to stimuli, blood circulation, respiration and other biological functions but there is no behavioural evidence of either self-awareness or awareness of the surroundings in a learned manner.

Thirion J held that, according to the 'legal convictions of society' in South Africa, it would not be wrongful or unlawful to discontinue any medical treatment or artificial feeding regime previously administered to the patient that had merely kept his body alive.

Power of attorney

As stated above, there is no living will statute in South Africa such as exists in the USA.

Furthermore, the living will is not like a power of attorney which loses its authority when the principal becomes mentally incompetent. In the light of the Clarke case, it can be argued that the existence of a power of attorney, in which a person is authorised to apply the cessation of life-sustaining procedures on behalf of another person, will be acceptable as sufficient authority to end the life of a patient who is in an irreversible vegetative state.

Should doctor-assisted suicide be allowed?

In South African law the position is that the person who knowingly supplies a drug to a patient for use in a suicide is guilty of aid-

'The arguments in favour of legalising euthanasia are not sufficient reason to weaken society's prohibition of intentional killing'

- SA Law Commission Report (Project 86)
ing and abetting suicide and can accordingly be found guilty of murder. In the case of *R v Peverell* 1940 AD 213 the accused 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.

In *R v Nbakwa* 1956 (2) SA 557 (SR), the facts were that Nbakwa, a man who lived according to the traditions of his tribe, suspected and accused his mother of causing the death of his child. The mother then requested him to kill her. Nbakwa went to the hut where his mother was lying ill, tied a rope to the rafter in the hut and tied a noose at 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 court found that his mother had caused her own death.

The *Nbakwa* case was followed in *State v Gordon* 1962 (4) SA 727 (N).

In South African law a doctor’s conduct will not be unlawful if the doctor’s assistance to the patient’s suicide took the form of passive euthanasia. If, however, the assistance took the form of active euthanasia, the doctor would be found guilty of murder.

In the Netherlands, although euthanasia is technically illegal, doctors will not be prosecuted for performing euthanasia if they follow the procedural guidelines issued by a state commission.

The South African Law Commission’s proposed euthanasia Act makes provision for a medical practitioner who is requested by a patient to put an end to the patient’s suffering or to enable the patient personally to put an end to his suffering by way of administering or providing some or other lethal agent, to do so on condition that the medical practitioner is convinced that

- the patient is terminally ill;
- the patient is subject to unbearable suffering; and
- the patient is over the age of eighteen years and mentally competent.

According to Amanda Louw, a researcher for the South African Law Commission, in a survey on euthanasia sent to some 14 000 members of Medical Association of South Africa

“more than 12% of the 450 doctors who responded said that they had practised active euthanasia. Passive euthanasia had been practised by 58%, while 9% said that they had participated in physician-assisted euthanasia and 64% had practised palliative care.”

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