

Stransham-Ford v. Minister of Justice and Correctional Services and Others: Can active voluntary euthanasia and doctor-assisted suicide be legally justified and are they consistent with the biomedical ethical principles? Some suggested guidelines for doctors to consider

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The recent case of *Stransham-Ford v. Minister of Justice and Correctional Services and Others* held that voluntary active euthanasia and doctor-assisted suicide may be legally justified in certain circumstances. The court observed that the distinction between 'active' and 'passive' voluntary euthanasia is not legally tenable as, in both instances, the doctors concerned have the 'actual' or 'eventual' intention to terminate the patient's life and have caused or hastened the patient's death. It is argued that as the South African Constitution is the supreme law of the country, the fundamental rights of patients guaranteed in the Constitution cannot be undermined by ethical duties imposed on healthcare practitioners by international and national professional bodies. The court in the *Stransham-Ford* case did not use ethical theories and principles to decide the matter. It simply applied the values in the Constitution and the provisions of the Bill of Rights. However, in order to assist medical practitioners with practical guidelines with which many of them are familiar – rather than complicated unfamiliar philosophical arguments – the biomedical ethical principles of patient autonomy, beneficence, non-maleficence and justice or fairness are applied to active voluntary euthanasia and doctor-assisted suicide in the context of the *Stransham-Ford* case. Although the case has not set a precedent or opened the floodgates to doctor-assisted voluntary active euthanasia and it is open to Parliament, the Constitutional Court or other courts to develop the concept or outlaw it, some guidelines are offered for doctors to consider should they be authorised by a court to assist with voluntary active euthanasia.

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This article is intended to enable medical practitioners to understand the reasons for the judgement in the recent *Stransham-Ford v. the Minister of Justice and Correctional Services and Others*^[1] case in which the North Gauteng High Court granted an order stating that a terminally ill patient who was 'suffering intractably' was entitled to commit suicide with the assistance of his doctor and that the doctor's conduct would not be unlawful or subject to disciplinary action by the Health Professions Council of South Africa (HPCSA). The court avoided discussing ethical issues and based its decision solely on the values and the bill of rights in the Constitution. However, the biomedical ethical principles^[2] are a useful tool to assist doctors in deciding whether or not they will be acting ethically if they assist patients in their end-of-life decisions where such patients have obtained a court order authorising such conduct.

The biomedical ethical principles of patient autonomy, beneficence, non-maleficence and justice or fairness^[2] have been used – because in the writer's experience of conducting numerous medical law and ethics continuing professional development workshops – they are the ethical principles with which most doctors are familiar. For the purposes of this paper the biomedical principles themselves have not been interrogated. They are presented in an easily digestible form to provide doctors with clear and concise ethical guidelines. This paper is not aimed at legal

philosophers and ethicists, and it is not intended to overwhelm medical practitioners by exposing them to the debates on euthanasia of legal philosophers and ethicists, such as Hart,^[3] Dworkin,^[4] Singer^[5] and others.

The court in the *Stransham-Ford* case stated that its decision was limited to the circumstances before it and was not a general rule. Parliament, the Constitutional Court or 'future courts' would have to decide whether to provide guidance in a general rule or to outlaw the practice altogether. The court made it clear that its decision was not a precedent for opening the floodgates to active voluntary euthanasia because each case would have to be considered on its merits by the relevant court.^[1] As it was a judgment by a single high court judge the decision is not binding on any courts in the country, although it may be of persuasive value.^[6] However, at the end of this paper some practical and ethical guidelines are offered for consideration by doctors that have been authorised by a court to assist a patient with voluntary active euthanasia.

In order to decide whether doctor-assisted suicide and voluntary doctor-assisted death can be legally justified in terms of the Constitution,^[7] and in terms of the biomedical ethical principles^[2] in the context of the *Stransham-Ford* case, it is necessary to consider:

- The facts of the *Stransham-Ford* case
- The relevant constitutional provisions and their relationship to the biomedical ethical principles

- The meaning of 'euthanasia'
- The meaning of 'intention' and 'motive' in euthanasia cases
- The meaning of 'causation' in euthanasia cases
- The test for 'unlawfulness' in euthanasia cases
- The false distinction between 'passive' and 'active' euthanasia
- 'Doctor-assisted suicide' v. 'doctor-assisted death'
- The application of the biomedical ethical principles to the case
- Suggested guidelines for doctors contemplating assisting patients with voluntary active euthanasia when authorised by a court order.

The facts of the Stransham-Ford case

In *Stransham-Ford v. Minister of Justice and Correctional Services*^[1] the applicant was a highly qualified lawyer who had contracted terminal stage 4 cancer which had spread to his lower spine, kidneys and lymph nodes. He suffered from severe pain, nausea, vomiting, stomach cramps, constipation, disorientation, weight loss, loss of appetite, high blood pressure, increased weakness and frailty related to the kidney metastasis. He was unable to get out of bed and had injections and drips, endured anxiety, could not sleep without morphine or other painkillers, and when he used pain medication it made him somnolent. He had tried a number of traditional and other forms of medication as well as palliative care but none of these alleviated his suffering. He had only a few weeks left to live and died of natural causes just before the judge made his order.^[1]

The court was satisfied that the applicant was 'mentally competent' and had 'freely and voluntarily and without undue influence, requested [it] to authorise that he be assisted in an act of suicide.'^[1] In addition he was 'terminally ill and suffering intractably and had a severely curtailed life expectancy of some weeks only.'^[1] The court issued an order stating that if Mr Stransham-Ford was assisted to die by a doctor who provided or administered a lethal drug to him the doctor would not be acting unlawfully, and not be subject to prosecution or subject to disciplinary proceedings by the HPCSA.^[1] The court order stated that the applicant could be assisted by a qualified doctor, but no doctor was obliged to assist him to commit suicide.^[1]

The court did not find it necessary to use the proposals in the Draft Bill on End of Life in the 1998 Law Commission Report^[8] 'as the necessary or only conditions for the lawful assistance of a qualified medical doctor to commit suicide.'^[1] The court reiterated that where the South African common law is in conflict with the Constitution^[7] the common law must be developed by the courts to bring it into line with the Constitution. The court concluded that the common law crimes of murder or culpable homicide in the context of assisted suicide by medical practitioners unjustifiably limited the patient's constitutional rights to human dignity (section 10) and freedom and security of the person (section 12), and were 'overbroad' and unconstitutional.^[1] However, apart from the recognition of voluntary active euthanasia in the context of the Stransham-Ford case, the common law crimes of murder and culpable homicide were not affected by the judgment.^[1]

The relevant constitutional provisions

The Constitution^[7] is the supreme law of South Africa (SA) (section 2) and any laws or conduct in the country must conform to the Constitution. It is submitted that this means that although patients in SA can be granted rights in excess of those in the Constitution by professional

ethical rules, they may not have their constitutional rights reduced unless it is reasonable and justifiable (section 36(1)).

A court 'must declare any law or conduct that is inconsistent with the Constitution ... invalid to the extent of its inconsistency' (section 172(1)(a)). It is self-evident that the words 'laws or conduct' will include the ethical rules of the different professions, including those of the medical profession. For instance, the HPCSA's rules are referred to as 'ethical rules of conduct for practitioners registered under the Health Professions Act'.^[9]

The HPCSA may impose a duty on doctors to provide greater protection for patients than the Constitution, for instance, as it does in the duty to respect the confidentiality of patients after death.^[10] The HPCSA may not, however, impose a duty on doctors that limits the constitutional rights of patients, such as the rights to dignity (section 10) and freedom and security of the person (section 12); unless the HPCSA can show that the limitation is reasonable and justifiable (section 36(1)).

The Constitutional Court, the Supreme Court of Appeal and the High Courts have the 'inherent power' to 'develop the [South African] common law in line with the Constitution,^[7] taking into account the interests of justice' (section 173), and 'may consider foreign law' in this respect (section 30(1)(c)). It is in this context that the judge in the Stransham-Ford case interpreted the Constitution, and referred to a recent similar Canadian Supreme Court case^[11] that had authorised doctor assisted suicide. Accordingly, the court in the Stransham-Ford case ordered that the applicant could be actively assisted to die by a doctor without the latter being subjected to prosecution or professional disciplinary proceedings.^[1]

Constitutional values and the biomedical ethical principles

The South African Constitution^[7] includes a bill of rights which sets out the fundamental rights and freedoms to which everyone in SA is entitled. The Constitution is founded on the values of 'human dignity, the achievement of equality and the advancement of human rights and freedoms' (section 1(a)). The bill of rights in the Constitution provides that everyone has the right to:

- 'Inherent dignity' and 'to have their dignity respected and protected' (section 10)
- The right to life (section 11)
- Freedom and security of the person, which includes 'the right not to be treated or punished in a cruel, inhuman or degrading way' (section 12(1)(e))
- Bodily and psychological integrity, which includes the right 'to security and control over their body' (section 12(2)(b))
- The right to privacy (section 14).

All of these rights, including the right to life – which refers to a right to life and not a right to mere 'existence'^[12] – are linked to dignity.^[6] The Constitution protects the right to life, but not the right to an 'existence' that undermines a person's right to dignity.^[1,12] These provisions are consistent with the biomedical ethical principles of patient autonomy, beneficence, non-maleficence and justice or fairness.^[2]

As previously mentioned, the court in the Stransham-Ford case did not base its judgment on ethical principles. However, aspects of the biomedical ethical principles^[2] are consistent with the Constitution,^[7] and may be of practical value to medical practitioners faced with

situations similar to that in the Stransham-Ford case. For instance, the right to autonomy^[12] can be found in the sections in the Constitution dealing with the right to freedom and security of the person (section 12) which – except in very limited situations – requires doctors to obtain an informed consent before treating patients. The requirement of an informed consent is also to be found in the National Health Act^[13] (section 7(1)) and the South African common law.^[14] Likewise, except in very restricted cases, the right to privacy (section 14) requires doctors to preserve the confidences of their patients. This requirement is also found in the National Health Act (section 14(1)) and the common law.^[15]

The ethical principle of beneficence or the obligation on doctors and healthcare practitioners to contribute to the welfare of their patients^[2] is found in the sections dealing with the right to basic healthcare services for children (section 28(1)(c)) and the right of access to healthcare services for adults (section 27(1)). These provisions are also to be found in the objects of the National Health Act^[13] (section 2 (c)) which is designed to take into account the obligations imposed by the Constitution (Preamble). Conversely, the ethical principle of non-maleficence or obligation not to harm patients^[2] is to be found in the sections providing that nobody may be refused emergency medical treatment (section 27(3)), and the right to an environment that is not harmful to their health or well-being (section 24(1)). The National Health Act^[13] also provides that nobody may be refused emergency medical treatment (section 5) and acknowledges that the people of SA are entitled to an environment that is not harmful to their health or wellbeing (section 2(c)(ii)). The ethical principle of justice or fairness^[2] is to be found in the sections of the Constitution that provide everyone with the right to ‘full and equal enjoyment of all the rights and freedoms’ (section 9(2)) and the right not to be unfairly discriminated against (sections 9(3) and (4)). The objectives of the National Health Act^[13] are to protect, respect, promote and fulfil the constitutional health rights of the people of SA (section 2(c)), and to ensure the equitable provision of healthcare services in the country within available resources (section 2(b)(ii)).

In short, medical practitioners who use the biomedical ethical principles in their decision-making and treatment of patients will be generally acting in conformity with the Constitution, the National Health Act and the SA common law.

Application of the Constitution to the Stransham-Ford case

As previously mentioned, the court in the Stransham-Ford case decided the case without recourse to any ethical principles and solely on its interpretation of the values in the Constitution and the provisions of the Bill of Rights. The court considered the constitutional rights to dignity (section 10) and freedom and security of the person (section 12) in particular detail, and observed that the right to dignity and life (section 11) were ‘intertwined’.^[11] The court also mentioned that the Constitutional Court had observed that the ‘right to life is more than existence’^[12] and the right to dignity ‘informs the interpretation of possibly all other fundamental rights’.^[16] The court agreed with Mr Stransham-Ford that ‘there is no dignity’ in ‘having severe pain all over one’s body; being dulled with opioid medication; being unaware of your surroundings and loved ones; being confused and dissociative; being unable to care for one’s own hygiene; dying in a hospital or hospice away from the familiarity of one’s own home; and dying at

any moment, in a dissociative state unaware of one’s loved ones being there to say goodbye’.^[11] The court stated that in deciding such cases the test for whether a person’s dignity is being violated is subjective – not objective.^[11]

In the end the court said that it ‘must give effect to where [South African] common law does not provide for the given situation [that of Mr Stransham-Ford], and in effect, totally negates the rights that every human being is entitled to’.^[11] The court was satisfied that a sufficient case had been made by Mr Stransham-Ford to prove that ‘assisted dying was the only way that he would be released from his eventual unbearable suffering and for him to prevent the imminent intolerable and undignified suffering that was to occur in the future’.^[11]

The court was careful to respect the constitutional right of doctors to freedom of conscience, religion, belief, thought and opinion (section 15(1)) and stated that no doctor was obliged to assist Mr Stransham-Ford to commit suicide.^[11]

The meaning of ‘euthanasia’

The dictionary definitions of ‘euthanasia’ have remained reasonably constant over the years. The Oxford English Dictionary defines ‘euthanasia’ as ‘a gentle and easy death’ or ‘the means of bringing about a gentle and easy death’ or ‘the action of inducing a gentle and easy death’.^[17] Another non-medical dictionary meaning of ‘euthanasia’ is the ‘bringing about a mercifully easy and painless death for persons suffering from an incurable and painful disease’.^[18] No distinction is made between so-called ‘passive’ or ‘active’ euthanasia in English language dictionaries, and medical dictionaries indicate that euthanasia might be either. Therefore ‘euthanasia’ has been defined as ‘deliberately taking of somebody’s life when continued existence would mean only further suffering’.^[19] However, ‘[ethical] and legal questions arise when a patient is allowed to die through the withholding of treatment, or when there is a question over the definition of “life” in relation to the person’.^[19] Euthanasia has also been defined as: ‘The act or practice of ending the life of an individual suffering from a terminal illness or an incurable condition, as by lethal injection or the suspension of extraordinary medical treatment’.^[20] In the medical sense ‘euthanasia’ refers to situations where doctors hasten the death of a patient by prescribing or administering a particular medicine or agent or by withholding or withdrawing treatment. As this article is concerned with voluntary active euthanasia and doctor-assisted suicide, it is not necessary to consider the other categories of euthanasia.^[21] As mentioned, the court in the Stransham-Ford case did not dwell on the philosophical distinctions between ‘passive’ and ‘active’ euthanasia, and based its judgment solely on the common law and the values and provisions in the Constitution.^[11] The concepts of ‘passive’ and ‘active’ euthanasia were, however, discussed in passing by the court and will be considered later. Beforehand, however, it is necessary to consider the legal meanings of ‘intention’ and ‘motive’, ‘causation’ and ‘lawfulness’ in the context of euthanasia.

The meanings of ‘intention’ and ‘motive’

In law intention may be ‘actual’ or ‘eventual’. ‘Actual intention’ occurs where perpetrators direct their will to kill a particular person knowing that their act is unlawful. In the past such conduct has been held to be unlawful.^[22] ‘Eventual intention’ occurs where perpetrators subjectively foresee that their conduct or omission may cause the death or injury of another person and reconcile themselves with this

possibility (*dolus eventualis*).^[11] The latter occurs, for instance, where doctors withhold or withdraw treatment or prescribe or administer palliative drugs and subjectively foresee that their conduct will hasten the patient's death, and reconcile themselves with this possibility. The doctors have the 'eventual intention' to hasten the patient's death,^[11] but such conduct is lawful and does not require a court order unless it is opposed by somebody on behalf of the patient.^[12]

According to the law 'motive' must be distinguished from 'intention'. 'Motive' is the reason behind the intention – and a 'good motive' will not cure an unlawful act or omission,^[23] but may reduce a sentence in a criminal case^[2] (for instance in cases of voluntary active euthanasia).^[22]

Therefore, under the SA common law, in 'active' euthanasia cases where the accused had a good motive, the courts tended to impose much lighter sentences than usual, although the professional consequences may still be severe.^[22] Conversely, a bad motive may make an otherwise lawful act or omission unlawful, e.g. where a person is arrested by the police out of spite or malice.^[24] This may occur, for instance, if in a 'passive' euthanasia case the sole motive for withdrawing treatment is to allow the person ordering such withdrawal to inherit from the patient's deceased estate, rather than to alleviate the patient's pain and suffering. Such conduct may be unlawful, although it will depend on the particular circumstances.

The meaning of 'causation'

Causation is an essential element in crimes or civil wrongs. In the case of murder or culpable homicide 'causation' refers to an act or omission that causes or accelerates the death of another person.^[25] Any person who contributes to the death of another person will be regarded as having caused the death of the person.^[26] Where a doctor's act is the sole cause of a patient's death by administering a fatal dose of medication which pre-empts the underlying illness or injury killing the patient, 'causation' is clear.^[26] Where more than one event contributes to the death of a person, the event that finally hastens the death is regarded as its cause.^[26]

A good example of how causation is present in 'passive' euthanasia cases is to consider the situation of a person who is bleeding to death. If treatment to prevent the bleeding is withheld and the patient dies, it cannot be argued that the bleeding caused the death of the patient and not the withholding of the treatment, which hastened the death. Likewise, if treatment to prevent the bleeding is withdrawn and the patient dies – it cannot be argued that the bleeding caused the death of the patient and not the withdrawal of treatment. In both instances, the failure to prevent the bleeding caused the death of the person. Whether or not the withholding or withdrawal of treatment to prevent the bleeding was legally justified will depend upon whether or not it was lawful.

The principle of 'double effect' involves providing a patient with palliative care which simultaneously hastens the death of the patient.^[27] The hastening of death in these situations is relevant to the question of causation. Where increasing doses of medication are administered with the motive of lessening pain and suffering with the result that they hasten the patient's death, the increased dosages will be regarded as having 'caused' the death of the patient – even though the conduct of the person administering the dosages may not be considered unlawful. The reason is that the increased dosage has caused the patient to die sooner rather than later from the underlying illness or condition.^[28]

The meaning of 'unlawfulness'

The question of unlawfulness is often the litmus test of whether a doctor will be found guilty of murder or culpable homicide in situations where the deaths of patients have been caused by 'passive' or 'active' conduct on their part.^[6] At common law, before the Constitution was enacted, the test for unlawfulness applied by the court in the Clarke case was based on the 'legal convictions of the community'.^[29] In Clarke's case Dr Clarke had been in a persistent vegetative state for a period of four years from which there was no prospect of recovery. His wife applied for a court order enabling her to become her husband's curatrix in order to authorise the withdrawal of treatment and nasogastric feeding. The court granted her application and stated that if she did authorise the withdrawal of treatment and feeding she would not be acting unlawfully. The court used the 'legal convictions of the community' in order to determine whether Mrs Clarke's actions would be lawful or unlawful.^[29]

Since the advent of the Constitution, however, the courts have made it clear that the values of the Constitution – and not public opinion – should influence a court's decision when dealing with the question of unlawfulness.^[12] The court in the Stransham-Ford case approached human dignity as 'a value and a right [and] ... a categorical imperative'.^[11] As previously stated, dignity is closely linked to the right to life to which it is 'inextricably linked'.^[11] The Constitutional Court has said that the right to life is not simply 'the right to exist'^[12] and must be 'a life worth living'.^[12] The right to life is 'not life as mere organic matter' but rather 'the right to share in the experience of humanity'.^[12] In the words of the Constitutional Court: 'The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished'.^[12]

In Clarke's case,^[29] the court said that doctors should not seek to preserve life at any cost irrespective of quality, and authorised the withdrawal of treatment and artificial feeding from Dr Clarke because it would 'not serve the purpose of supporting human life as it is commonly known'. Similarly, in the Stransham-Ford case the court stated that the right to life 'cannot mean that an individual is obliged to live, no matter what the quality of his life is'.^[11] This approach has also been adopted by the English courts,^[30] and was applied in a situation where a 'do not resuscitate' order was granted after the court was satisfied that the patient's life would be 'so afflicted as to be intolerable'.^[31]

The false distinction between 'passive' and 'active' euthanasia

In the Stransham-Ford case the court indicated that there was 'no logical or justifiable distinction between the withdrawal of life-sustaining or prolonging medical treatment and active voluntary euthanasia or assisted suicide'.^[11] In both instances the objective was 'to ensure the patient's quality of life and dignity', and the result in both was 'death or the hastening of death'.^[11] The withdrawal of treatment is a positive act – 'it remains an active and positive step taken by medical staff directly causing the death of the patient (on a factual basis)'.^[11] In cases of withholding of treatment it would 'constitute an omission only'.^[11] Once it is conceded that 'a medical practitioner has a duty to recognise and ensure that a terminally ill patient's dignity is protected by an omission or passive euthanasia, then, the same duty remains on a medical practitioner through a commission or active euthanasia'.^[11]

As previously mentioned, in 'passive' euthanasia cases doctors subjectively foresee and reconcile themselves to the fact that their withholding or withdrawal of treatment or increased use of certain medication will hasten the patient's death, and therefore have the 'eventual' intention to hasten the death of the patient (*dolus eventualis*).^[6] In 'active' euthanasia cases doctors who administer or prescribe lethal medication to patients direct their minds to hasten the death of the patient and have the 'actual' intention to hasten the death of the patients.^[6] In both instances, the doctors have the intention to cause or hasten the death of their patients and have in fact caused or hastened their deaths.

'Doctor-assisted suicide' v. 'doctor-assisted death'

Although the terms 'doctor-assisted suicide' and 'doctor-assisted death' seem to be used interchangeably, for instance the Netherlands Termination of Life on Request and Assisted Suicide Act Termination of Life on Request and Assisted Suicide Act^[32] does not distinguish between voluntary active euthanasia and assisted suicide. The dictionary meaning of 'suicide' is 'taking one's own life'.^[19] Therefore the term 'doctor-assisted suicide' technically means that doctors provide patients with the means to take their lives and patients use such means to end their lives. The doctors merely provide patients with the means, which is different from doctors actually using the means to end the lives of their patients. For instance, 'physician-assisted suicide' has been medically defined as 'suicide by a patient facilitated by means or information (as a drug prescription or indication of the lethal dosage) provided by a physician who is aware of how the patient intends to use such means or information'.^[37] However, legally, even though the doctor has merely prescribed and not administered the fatal agent, and the patient has taken his own life, the doctor is still regarded as having acted with 'eventual' intention and contributed to the patient's death.^[34]

Where doctors have assisted patients to die by administering a fatal agent after a request by their patients, semantically such deaths may be better described as 'doctor-assisted death', and not 'doctor-assisted suicide'. This is because such patients have not taken their own lives, the doctors have. The same applies where doctors withhold or withdraw treatment at the request of their patients, or administer increasing doses of a palliative drug to patients and the doctors and patients know that the drug will shorten the lives of the patients. According to the law, however, there is no difference between 'doctor-assisted suicide' and 'doctor-assisted death'.^[6] In both instances, the doctor has either the 'actual' intention (where a fatal agent is administered) or 'eventual' intention (where treatment is withheld or withdrawn, or shortens the patient's life), and has contributed to the early death of the patient.^[6] However, whether or not a doctor is guilty of murder or culpable homicide will depend on whether the courts regard such conduct as lawful in terms of the values in the Constitution.^[11]

Ethical aspects of 'active' voluntary euthanasia

The HPCSA has provided Guidelines for the Withholding and Withdrawing of Treatment^[35] in line with the World Medical Association (WMA) Declaration of Venice on Terminal Illness.^[36] The Guidelines prohibit 'active' euthanasia by stating that they are 'based

on the premise that any medical intervention where the health care professional's primary intention is to end the patient's life is both contrary to the ethics of health care and unlawful'.^[35] They go on to state that 'active euthanasia, or the wilful act by a health care professional to cause the death of a patient is unacceptable, notwithstanding whether or not such an act is performed at the request of the patient or his or her close relatives or of any person'.^[35] This is qualified by stating that the 'health care professional may alleviate the suffering of a terminally ill patient by withholding treatment, i.e. allowing the natural process of death to follow its course',^[35] which implies that a doctor may engage in 'passive' euthanasia if he or she has a good motive.

The WMA Resolution on Euthanasia^[37] repeats much of what is in the Declaration on Terminal Illness^[36] regarding active euthanasia and doctor-assisted suicide, and 'reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice', although it does not mention whether it is referring to 'active' or 'passive' euthanasia. The distinction between 'active' and 'passive' euthanasia is, however, made in the WMA Declaration on Euthanasia^[37] which states that euthanasia is 'the act of deliberately ending the life of a patient, even at the patient's request'. However, this 'does not prevent the physician respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness'.^[37]

Presumably, the 'basic ethical principles' referred to in the WMA Resolution are those relating to patient autonomy, beneficence, non-maleficence and justice or fairness.^[2] It is therefore useful to consider whether these bioethical principles support the WMA's assertion that active euthanasia is against medical ethics, in the light of the facts and decision in the Stransham-Ford case.

Patient autonomy

Patient autonomy means the health practitioners recognise and respect the rights of mentally competent patients to make decisions for themselves after being given the available options.^[2] The law has always recognised the right of mentally competent patients or their legal proxies to refuse treatment, even if such refusal may result in their death. As previously mentioned, the right to autonomy is recognised in the Constitution,^[7] the National Health Act^[13] and the South African common law. Patient autonomy is also recognised in the WMA Declaration on Terminal Illness^[36] which states: 'The patient's right to autonomy in decision-making must be respected with regard to decisions in the terminal phase of life' – although 'actively assisting patients in suicide' is ethically prohibited.^[36]

The court's decision in the Stransham-Ford case was squarely based on the right of patients to autonomy as it is reflected in the Constitution^[7] by the rights to respect for dignity (section 10), freedom and security of the person (section 12) and the right to privacy (section 14). The court referred to the Canadian case of *Carter v. Canada (Attorney General)*,^[11] which dealt with the provisions in the Canadian Charter of Rights that are very similar to those in the South African bill of rights^[11] and in which the Canadian court stated that 'an individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy'.^[11] Much earlier, the South African Law Commission had concluded in its report on End-of-Life Decisions^[8] that 'euthanasia is a matter of personal autonomy and individual choice'.

There are, however, limits to the personal autonomy of patients for instance, where a patient requests a doctor to engage conduct that is unlawful or unethical – as occurred in the Michael Jackson case.^[38] In such situations doctors should apply the other biomedical ethical principles to determine whether or not their conduct is ethical.^[38]

Beneficence

Beneficence means that healthcare professionals should contribute to the welfare of their patients.^[2] This means that generally they should act in favour of preserving the lives of their patients, which is in accordance with the right to life in the Constitution^[7] (section 11). Terminally ill patients, with hopeless prognoses, should be encouraged to undergo palliative care before seeking to end their lives. As previously mentioned, however, the Constitutional Court has acknowledged that ‘life’ in this context is not synonymous with mere ‘existence’. For this reason, although the court in the Stransham-Ford case agreed that ‘the right to life was paramount and was sacrosanct’^[1] it acknowledged that the rights to life and dignity are ‘intertwined’, and that the ‘sacredness of the quality of life should be accentuated rather than the sacredness of life per se’.^[1] Clarke’s case^[29] and the English courts^[30] have held that the duty to preserve life does not mean preserving it at all costs, irrespective of quality. Therefore, where a terminally ill patient with a hopeless prognosis is merely in a state of ‘existence’ it can be argued that the principle of beneficence may well justify ending such patient’s ‘existence’ at their request, irrespective of whether it is done as an act of voluntary passive or active euthanasia. Although the court did not rely on the biomedical principles, on the facts in the Stransham-Ford case it could be further argued that it would be an act of benevolence to actively release the patient from ‘eventual unbearable suffering’ and to prevent future ‘imminent intolerable and undignified suffering’.^[1]

Non-maleficence

Non-maleficence is linked to beneficence and means that doctors should not unnecessarily harm their patients.^[2] In the context of end-of-life decisions it could be used to justify outlawing ‘active’ euthanasia because it would expose weak and vulnerable patients to abuse.^[1] This is a valid concern, but as the Stransham-Ford case pointed out it can be safeguarded against by providing ‘minimum safeguards’.^[1] Such standards were suggested by the SA Law Commission^[8] but never implemented by the State. The court did not adopt the Law Commission standards but left it open for Parliament or the Constitutional Court to decide what to do.^[1]

Until then the court suggested that in each case any court would ‘scrupulously scrutinise the facts before it’ and would deal with the case ‘on its own merits’.^[1] The approach by the Stransham-Ford court requiring a court order for cases involving voluntary active euthanasia is in line with the criticisms of the United Nations Human Rights Committee of the Dutch^[39] and Swiss laws.^[40,41] In respect of the Dutch law the committee criticised it because it lacked provision for ‘independent review by a judge or magistrate to guarantee that [the] decision was not the subject of undue influence or misapprehension’.^[41] The same criticism was levelled at the Swiss law which the committee stated lacked a provision for ‘independent or judicial oversight to determine that a person seeking assistance to commit suicide is operating with full, free and informed consent’.^[41] The court in the Stransham-Ford case concluded by stating that the ‘relief was case dependent and certainly not a precedent for a general

uncontrolled “free for all” as was suggested’.^[1] This appears to have been overlooked by some commentators on the case.^[42]

As was mentioned in respect of the patient autonomy principle, in the Stransham-Ford case the court agreed with the Constitutional Court’s observation that the right to life does not refer to ‘mere organic matter’ and is ‘more than existence’.^[1,2] Therefore, it could be argued that condemning a terminally ill person with a hopeless prognosis to an undignified situation where he or she is existing as ‘mere organic matter’ is clearly a violation of the non-maleficence principle. Ironically, such a violation seems inherent in the WMA Declaration on End-of-Life Medical Care,^[43] where it states that in certain cases ‘palliative sedation to unconsciousness may be offered when life expectancy is a few days’^[43] even though the WMA Declaration on Terminal Illness^[43] states: ‘The physician must not employ any means that would provide no benefit for the patient’.^[40]

Justice or fairness

The principle of justice or fairness^[2] requires doctors to treat their patients fairly and equally without discrimination. The Constitution outlaws unfair discrimination (section 9(3) and (4)) where persons in similar situations are discriminated against for reasons that are not reasonable and justifiable (section 36(1)). An example would be where two patients are in the same condition of ‘mere existence’, both terminally ill and suffering intractably. Patient A is kept alive with a ventilator, while Patient B is able to breathe by himself. Patient A is legally able to request that ventilator support is withdrawn without the doctors having to obtain a court order.^[29] Prior to the Stransham-Ford decision, Patient B would not legally be able to request doctor-assisted suicide because such assistance would be illegal. It seems unreasonable and unjustified for Patient B to be denied the right to have a doctor assist him to die by providing or administering a lethal agent, while Patient A who is experiencing similar and suffering is kept alive by a life-support system may legally request the removal of such support to enable him to die with dignity and in peace.^[1] The legal requirements regarding intention and causation in both instances are the same^[6] and there is no logical reason for distinguishing them when considering the question of unlawfulness or indeed the ethical principle of justice or fairness. This is in essence what the court in the Stransham-Ford case found and remains the position unless it is overruled on appeal or Parliament introduces legislation setting out guidelines that are in line with the Constitution.^[6]

WMA Resolution on Euthanasia

The WMA Resolution on Euthanasia^[37] has noted that ‘the practice of active euthanasia with physician assistance has been adopted into law in some countries’, but ‘reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice’^[37] without specifying to which principles it is referring. The WMA then ‘strongly encourages all national medical associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalises it under certain conditions’.^[37] The WMA resolution merely ‘encourages’ physicians to refrain from participating in euthanasia, which is consistent with the ‘conscience’ clause (section 15) in the SA Constitution,^[7] and enables doctors to decide for themselves whether they wish to be involved in voluntary active euthanasia where this is legally sanctioned. However, as mentioned in the Stransham-Ford case,^[1] the Constitution^[7] puts a premium on human dignity (section 10) and freedom and security of

the person (section 12). This allows doctors to respect their patients' right to autonomy and to honour a legal request for voluntary active euthanasia, despite the encouragement to desist offered by the WMA.

It is submitted that in SA the admonitions by the WMA must yield to the precepts of the Constitution if their effect is to reduce the constitutional rights of patients in the country. The same applies to the WMA Council Resolution on the Relation of Law and Ethics,^[44] which asserts that 'ethical responsibilities supersede legal obligations'. Such an approach cannot hold water in constitutional democracies if such professional 'ethical responsibilities' undermine the fundamental human rights of patients that are enshrined in the Constitution and laws of SA.

Some suggested guidelines to be considered by doctors contemplating assisting patients with legally authorised voluntary active euthanasia

Until such time as the Constitutional Court or Parliament overrules the decision in the Stransham-Ford case, it is submitted that doctors requested to assist a terminally ill patient with voluntary active euthanasia, before engaging in such assistance, should consider whether:

- Legally, there is a court order stating that a doctor may assist the patient to commit suicide through voluntary active euthanasia, and that such a doctor may not be subject to criminal prosecution, a civil action or disciplinary proceedings by the HPCSA.
- Ethically, the biomedical ethical principles indicate that it is justified to assist the patient to commit suicide.^[2]
- The patient's autonomy can be respected because the patient is mentally competent, has not been unduly influenced, has made the decision freely and voluntarily, and has not requested the doctor to do something illegal or unethical – in which case the doctor should decline and use the other biomedical ethical principles to come to a decision.
- The terminally ill patient with a hopeless prognosis has been encouraged to undergo palliative care before seeking assistance to commit suicide.
- Further treatment of the patient is futile.
- The mentally competent patient has indicated that he or she still wishes to be subjected to voluntary active euthanasia.
- The patient's next-of-kin have been consulted.
- The doctors have preserved careful records of all the steps taken by them before and while assisting the patient to end his or her life.

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