BKM

ATTORNEYS

The Good Death

INTRODUCTION

One day you will die. That is a certainty. And so will I. And so will the 7.3 billion people currently living on planet Earth. The *only* certainty we have in life is that it will end. How it will end has been left to fate. You may choose how you will live, but society has decreed, until now, that you may not choose how you will die.

The debate around the right to die with dignity has been exhumed by a recent application in the Pretoria High Court. The Late Advocate Stransham-Ford wished to end his life with the assistance of a doctor. This was an unprecedented application dealing with active euthanasia, a seemingly controversial topic raising issues such as the sanctity of life, the uncertainty of death and the taboo of murder. As a lawyer and thus a contrarian by nature, I seek the counterargument: the difficult debate that sways you in both directions, leaving you dizzy. With issues of such emotional magnitude I have been on the edge of my seat waiting for the fierce debates to begin.

But too my surprise, the groundswell of popular opinion appears to be in favour of legalizing active euthanasia. I ask myself: where is the dumbfounding dilemma, the confounding conundrum, the perplexing paradox? Let us examine the concept of euthanasia and how it has been dealt with by the courts before coming to our own conclusions.

EUTHANASIA

Euthanasia literally means the *good death*. Practically, it involves the painless killing of a patient suffering from an incurable disease or in an irreversible coma. In the debate around the ending of life this term has been divided into:

i. ***Active euthanasia***: the killing of a person who is terminally ill, generally by the administration of a lethal agent; or

ii. ***Passive euthanasia***: the withholding or withdrawal of treatment of a terminally ill person resulting in death.

Some have argued that the distinction between active and passive is artificial. Both involve an act on the part of the medical professional which results in the death of the patient. However, the cause of death in each instance is different. In active euthanasia, the lethal agent is the cause of death whereas in passive euthanasia, the cause of death is the terminal condition of the patient. Nevertheless, this may be a descriptive statement devoid of normative force. However, if we descend down this rabbit hole we will be going far beyond the scope of this article. For a full examination of the morality of killing see *The Ethics of Killing – Problems at the Margin of Life* by Jeff McMahan. Mr McMahan makes an unnervingly cogent argument, not only for the *morally permissibility* of active euthanasia in certain circumstances, but for instances where such an act is a *moral imperative*.

Euthanasia can be further distinguished by the element of consent:

i. ***Voluntary****:* at the patient's request*;*

ii. ***Non-voluntary****:* unable to obtain the direct consent of the patient who is in a coma / permanent vegetative state*; and*

iii. ***Involuntary****:* against the patient's will*.*

On one end of the spectrum of moral impermissibility we have *involuntary active* euthanasia which should make us shudder. At the other permissible end we have *voluntary passive* euthanasia which is tantamount to allowing death to occur naturally.

PASSIVE EUTHANASIA – LEGALLY CONSIDERED

In 1992, the High Court had to determine whether passive euthanasia was legally permissible. Mr. Clark was admitted to hospital for surgery. During the operation he had a heart attack. Although, the doctors were able to get Mr. Clark's heart started again, his brain had been deprived of oxygen. He was left in a permanent vegetative state. Feeding tubes pumped nutrients into his stomach. His heart was beating and his lungs were filling with air, but no sparks of life were detected in his brain. For four years, he lay unmoving

in a hospital bed, being fed and cleaned. The Court held that the removal of the feeding tubes (passive euthanasia) in this situation would not be wrongful.

The law on passive euthanasia is relatively settled. A patient may refuse medical treatment and this decision must be respected by medical personnel. Also, a person may state in writing that they refuse medical treatment in certain situations. This document is known as a "*living will*" or "*advanced directive*" and must be respected as per the Health Professions Council of South Africa's Guidelines for the Withholding and Withdrawing of Treatment, 2008. Where a patient has not executed a valid living will but has nominated a proxy to make medical decisions on that patient's behalf, the decision of the proxy must be respected. In these instances, treatment will be *withheld*.

The situation is more complicated where treatment has begun before the wishes of the patient can be determined. If it is determined that the patient has a valid living will or proxy to state that she refuses such treatment can the doctor withdraw (e.g. remove the feeding tube) without first approaching the Courts? The law and the HSPCA Guidelines are unsettled on this point.

ACTIVE EUTHANASIA – LEGALLY CONSIDERED

The HSPCA Guidelines are explicit with regard to active euthanasia: any intervention with the intent of ending a person's life is both contrary to the ethics of health care and unlawful. However, these guidelines pre-date Mr. Stransham-Ford's case by 5 years. Based on the Stransham-Ford case, the legal convictions of the community as espoused by the Constitution no longer agree with the HPCSA's stance.

The Courts have grappled with assisted suicide in a handful of cases, the most famous of which is *S v Grotjohn* 1970 (2) SA 355 (A) where the assistance was found to be unlawful. However, this case left open the door for another court to find otherwise as it held that each case depends upon its own facts. In *Grotjohn,* a severely depressed but otherwise healthy woman told her husband that she wanted to die. He handed her a loaded gun. She pulled the trigger and he was convicted of murder.

Mr. Stransham-Ford's case could not be more distinguishable. He was an advocate of long-standing and high repute. He was mentally competent at the time he repeatedly, freely and voluntarily, requested the Court to authorize that he be assisted in an act of suicide. He was terminally-ill and suffering constantly.

The Court found that his right to dignity and freedom was being unjustifiably limited by the absolute prohibition on medically-assisted suicide. Accordingly, the Court found that the prohibition was unconstitutional and ordered that Mr. Stransham-Ford had the right to a medically-assisted suicide. The Court also held that any doctor who assisted Mr. Stransham-Ford would not be subject to prosecution. What this case does is resoundingly declare the rights of each and every person to die with dignity. Unfortunately, the Court order came too late for Mr. Stransham-Ford, who died before judgment was delivered.

CONCLUSION

It is important to note that this case did not generally legalize active euthanasia as the Judge explicitly stated that the order was limited the facts before it. Accordingly, each case will have to be determined on its own facts. This means that every person in a similar position to Mr. Stransham-Ford will have to approach a court for legal certainty around medically-assisted suicide. Such legal certainty comes at too great a price for the majority who will be denied such humane treatment until a law of general application (legislation) is put into place. The right has now been established. The mechanism of implementation must now be put into place to give effect to that right. The legislature must table the Bill on End of Life Decisions as presented 17 years ago by the South African Law Reform Commission and finally put into place a legally valid and generally enforceable mechanism to allow people to die with dignity.

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