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Rights and Access to Health Care: A Constitutional Perspective on the Ethics of Assisted Dying in South Africa.

Master of Arts, Applied Ethics for Professionals

Andrew Fourie – 542384

Supervisor: Dr Robert Kowalenko

A Research Report submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Arts, Applied Ethics for Professionals.

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Abstract

Assisted death is fast becoming a viable option for dying patients in many countries the world over where new legislation has made the practice legal and accessible. In South Africa, however, the practice remains a punishable offence by law. In this report I examine the current situation of death services in this country and put forward an argument that supports the conception of assisted death as a health care service. I argue that such a conclusion would necessitate the implementation of these services on the basis of section 27 of the Constitution of the Republic of South Africa which states that "everyone has the right to have access to health care services" (CRSA, 1996, p. 11). I show that, there is constitutional support to be found in other areas of the Constitution, for example the right to control over one's body in section 12. I argue that this would compel legislative provision for services of assistance in dying in South Africa.

Declaration of Authenticity

I declare that this research report is my own unaided work. It is submitted for the degree of Master of Arts, Applied Ethics for Professionals, in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

_____

Andrew David Fourie

Signed on the 13th day of September 2019 at the University of the Witwatersrand.

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Introduction

One fact that we can all be certain about in this life is that we are all going to die at some point. This is unavoidable. However, most of us live and think as though we live forever. We seem to see death as something far off in the future, way beyond the horizon. The truth is that in all honesty, we do not know for sure how long we have left; anyone of us could die at any point in the future. Furthermore, death is all around us – an ever-present reality of our lives – and something we seem acutely averse to. Perhaps we would all benefit from some *Brave-New-World* inspired death-conditioning (Huxley, 1932)? My aim here is not to depress with these sobering (perhaps macabre) thoughts, merely to remind us of a simple, all-to-often-forgotten reality about the nature of our world: death is the one universal certainty. It seems to go without saying that death and dying can be particularly difficult times for all parties involved, with untold pain, suffering and sorrow. I say, 'can be', because the opposite is also true; dying can also be a time of growth for the individual and solidarity for families. With these two facts in mind, the universality of death and the potential for improving the experience of death, the focus here will be on the ethical and legal aspects surrounding services of assisted death.

At the time of writing, 16[1] countries or US states have instituted legislation allowing access to services of assisted death, overcoming many ethical, political and legal hurdles in the process. Naturally, such a changing 'zeitgeist' does not happen overnight. The fact that so many others have been successfully able to institute services of assisted death should give us cause for hope: such a proliferation can lead us to conclude tentatively that necessary legislative change may occur in other regions. I believe that South Africa could be one such region and this report argues for this proposition.

[1] The following countries and US states have legislated some form of assisted death either in the form of voluntary euthanasia or physician assisted suicide. Voluntary euthanasia has been legalised in the Netherlands, Belgium, Luxembourg, Canada and Colombia; physician-assisted suicide has been legalised in Switzerland, Germany (Abrams, 2015), and the US states of Washington, Oregon, Colorado, Hawaii, Vermont, Montana, Washington DC, California and New Mexico (Dignitas, 2018). The Australian state of Victoria is expected to be legalising voluntary euthanasia in 2019 (Willingham & Edwards, 2017).

I have divided this report into five sections. In section one I define a few important concepts. In section two I present my research question and thesis. In section three I examine the inner workings of a general health care service; I argue for my own conception of health care and argue that services of assisted death are health care services. In section four I analyse the Constitution of the Republic of South Africa, with specific focus on section 27. I argue for the ethical permissibility of a service of assisted death and I argue that these services are constitutionally required. In section 5 I conclude with some final remarks.

Definitions

Let me begin by defining some concepts. It is worth taking some time to present these clearly, for two reasons. Firstly, there is no consensus on the precise boundary or scope of each of these terms, thus I will try and present the most widely accepted use of these terms. Secondly, there is nothing particularly inviolable about definitions in principle; one should be free to limit and extend the scope of definitions in such a way as to benefit an argument, so long as the definitions themselves are made clear beforehand, and they themselves may be criticised. Assisted death (AD) is the intervention in a human life such that the death of the person is aided or helped in some form or another by another group or individual in a legal and (arguably) morally sound way. Then, there are the actionable practices of euthanasia and physician-assisted suicide. Euthanasia, a Greek word directly translated as "good death", refers to the act of a medical professional to deliberately and painlessly bring about the end of life, usually by the administration of a lethal injection, which is a solution of a pharmaceutical substance which, when injected into the human body, brings about a physiological end to life. Generally, the practice of euthanasia should be carried out by a medical professional, although this is disputed by some.[2] A medical professional, is a trained, experienced and board-certified practitioner of the methods and practices involved in the maintenance, recovery and preservation of human health and well-being. Health care,[3] refers to the broad activities of medical professionals with the aim to improve, restore, and

[2] See Boudreau & Somerville (2013).
[3] Later, I introduce a slightly altered definition of health care which will be required for my argument.

prevent disease and disability as well as to maintain optimal human health or well-being. Health care services are those organised activities that can be physically implemented in order to bring about improved human health or well-being. These working definitions of health care and of health care services are circular, in the sense that both rely on the word 'health' on both sides of the definition. Health is a complex philosophical idea and the reliance on it in these definitions is less than ideal. For the moment, I leave them as stated and will return to this problem later in the report.

As I mentioned above, assisted death can be divided into the actionable practices of euthanasia and physician-assisted suicide, however euthanasia itself can be subdivided into two further forms – one of which adheres strictly to the definition of euthanasia as a practice, and the other is a more common use of the term. The first, active euthanasia (AE), is the intentional intervention in the life of a person in order to bring about the death of that person. Here, the medical practitioner's act is a commission with express voluntary consent[4] from the patient undergoing the dying process.

On the other hand, passive euthanasia (PE) can be defined as the intentional decision by a medical professional to *omit* potentially life-saving therapy, such that the usual course of illness or disease is left to run to its natural or biological end. In this case, rather than there being a commission – such as the case with AE – an omission of some kind occurs, whether it be the non-provision, non-escalation or even withdrawal of certain kinds of therapy. To include withdrawal here as an example of

[4] This type of active euthanasia is also known as voluntary euthanasia or active voluntary euthanasia (AVE) and will be the continued focus in this report. My argument will focus around the rights of individuals to *request* or to have *access to* services of assisted death, a focus which therefore puts voluntary euthanasia squarely in my cross hairs (along with physician-assisted suicide, to which I come shortly). For interest sake however, there are two further consent structures which fall under the category of AE. The first is non-voluntary euthanasia, in which the consent for AE is granted by a relevant and legally sound third party. There can be various reasons for such an occurrence – incompetence, mental retardation, immaturity etc. – but the basic principle is that the person to be killed is unable to make a *meaningful choice* with regards to their own life or death. The second is involuntary euthanasia, which occurs in the absence of consent for the procedure, either from the person who is to die, or from a legal third party. A perfect example of this form of euthanasia is practiced all over the world in countries in which the death penalty is legal. Note finally that wherever I refer to AE in this report I am strictly referring to voluntary euthanasia or AVE.

a PE strategy requires some further explanation. I grant that in general, the removal of an action (in this case therapy) can be argued a commission, because a positive action is required to bring about the end state of the *absence-of*. In order to withdraw from a running race, one needs first to make the decision, and second to go through the cancellation process, whatever that may be. In a similar way then, it seems obvious to see a withdrawal of, for example, an antibiotic treatment as a commission where there is an active decision by the medical professional to remove the treatment.

In order to see how this does not then fall under the definition of AE I need to first introduce and explain two further terms. These are the closely related concepts of ordinary and extra-ordinary care.[5] Shortly, ordinary means of care are those which are generally considered to be morally obligatory, such as food, water and air, whereas extra-ordinary means are those which are supererogatory, for example a complicated medical procedure with great risk, and considered to place an undue burden on the patient or society. While I do not wish to dwell any longer on this issue, nor draw any line about where ordinary care ends and extra-ordinary care begins, the two concepts are useful in understanding how withdrawal of care may fall under the definition of PE. For example, an elderly person who is suffering from intractable cardiac failure, the likes of which requires that they be supported by two or more cardiac inotropes,[6] may reach a stage in the disease process where a medical professional might consider the withdrawal of treatment. If we could all agree that this type of therapy constituted an extra-ordinary measure, then its withdrawal should be seen as a type of PE, as opposed to AE. I say this because one is still not actively involved in the dying process, only actively involved in the withdrawal process, although the consequence may indeed be death.[7] I admit that this is a

[5] Commonly associated with Roman Catholic Church doctrine, although a contentious, bioethical issue in its own right.

[6] Inotropes are pharmaceutical substances which have a direct impact on the contractility of the heart muscle to increase the amount of blood the heart can pump.

[7] Taking this line of argument to its logical conclusion, what if we were to withdraw *ordinary* means of care? In this case, it seems to me that our locus of action/commission has moved, and we find ourselves squarely involved in the dying process itself. The action of removing food, for example, from a patient's care is usually with the express intention of bringing about the death of the patient. This, it seems to me, should be thought of as a form of AE although with a significantly longer 'lag-time' than with 'standard methods'.

subtle distinction, but it is an important one for the simple reason that I will now be putting the practice of PE to one side.

Some authors, most notably James Rachels,[8] do not believe that a distinction can be drawn between commissions and omissions when it comes to active and passive euthanasia respectively. In his famous paper of 1975, titled *Active and Passive Euthanasia*, Rachels uses the example of a child drowning in the bath and claims that both the physical perpetrator of the drowning, as well as an inactive bystander (two separate cases), are both equally blameworthy. I think that Rachels makes a convincing and powerful case, about the potential moral equivalence between omissions and commissions, and our intuitions are aligned in the end – for the ethical permissibility of AE.

Physician-assisted suicide or PAS falls under the definition of assisted death and is the practice whereby a medical professional writes a prescription of medications in lethal doses which is then taken by the patient on a voluntary basis with the aim of ending their life. A prescription of medications in lethal doses refers to any one of many pharmacological substances (the details of which are not important), that are written in doses that are beyond therapeutic (causing beneficial change); rather in doses that are likely to cause death in that individual. Unlike in the case with AE described above where the medical professional's act is the proximate cause of death, with PAS, the proximity shifts to the patient, although the involvement and association between the medical professional and the patient cannot be understated. Many countries and states around the world allow this form of AD but prohibit AE. Indeed, some authors even argue that this may be the morally correct approach to have.[9] I do not find it necessary to present and criticise the various arguments for the moral distinguishability of AE and PAS. Suffice it to say that both fall under to umbrella term AD, and I will argue for both as a result.

Two last concepts need to be explained before moving on to the thesis of this report. The first, palliation, is defined by the South African Law Commission (SALC) in a

[8] See Rachels (1975).
[9] See Cohen-Almagor (2015).

report on end-of-life issues: "'Palliative care' means treatment and care of a terminally ill patient with the object of relieving physical, emotional and psycho-social suffering and of maintaining personal hygiene" (SALC, 1998, p. xiv). The field of palliative medicine is complex, involving a melting pot of many issues all culminating in the eventual demise of the patient.

> *In addition to symptom management, other objectives of comprehensive palliative support include establishing goals of care that are in keeping with the patient's values and preferences; consistent and sustained communication between the patient and all those involved in their care; psycho-social, spiritual and practical support both to patients and their family caregivers; and coordination across sites of care* (Okon, 2018).

Secondly, the doctrine of double effect is a technical term that relates to the use of pain or sedative medications during the palliative phase of an illness with the intended outcome of relieving pain or suffering even though this action may hasten the death of the patient. The overarching principle is that "an action with a bad effect (the patient's death) can be justified if that effect is not intended and is necessary to achieve a proportionately good effect (relief of the patient's suffering)" (Bole, 1991). With this, we are well prepared to move on. Next, I present my research question and thesis.

Question and Thesis

Question:

Given the South African constitutional provision for the right to access of health care services, does this right extend to provision for services of assisted death, if it can be shown that services of assisted death are health care services?

Thesis:

Individuals in our country have a constitutional right to services of assisted death and these services should be treated as 'health care services' which therefore fall under the constitutional provision for access to health care.

I believe that individuals in our country have a constitutional right to access services of assisted death, which would necessitate a legislative change and a shift in the functioning of our health care system. In order to argue for this position, I will be proposing that assisted death is an ethically permissible practice in principle. Furthermore, that this interim conclusion will necessitate implementation under the current writing of the Constitution. My argument will progress with the background knowledge of three pieces of legislation. First, the Constitution of the Republic of South Africa (CRSA) which is widely regarded as one of the most liberal and well-drawn-up constitutions of any nation. My focus will be section 2, known as the 'Bill of Rights', and more narrowly on section 27, entitled: "Health care, food, water and social security" (CRSA, 1996, p. 11). In this section, the Constitution makes provision for the access to health care, and a corresponding duty placed on the government to ensure reasonable progressive realisation of that right.

Second, the National Health Act (NHA)[10] is the legislation which "provide[s] a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services" (NHA, 2003, p. 2). The purpose of the NHA is to instruct clearly on the workings of the health care

[10] Act No. 61 of 2003 (NHA, 2003)

system at all levels – from municipal to national – including the rights and duties of users and health care personnel. Thirdly, the Health Professions Act[11] puts into law the functioning of the statutory body that oversees the training, registration, practice and discipline of all the health professionals that fall under its regulation. This, along with the regulations[12] that supplements the Act, is the legislation that defines the scope of practice for medical professionals. As I stated above, my goal here is to argue that we require a legislative change that would bring about a shift in the practice of medicine. This will take the form of a change in the scope of practice of doctors, with amendments needing to be made to the NHA but more importantly to the HPA and its regulations.

So, my argument will progress in the milieu of these pieces of legislation. I am concerned with the rightness or wrongness of the *legislative provision* of assisted death. In order to argue that AD legislation is ethically permissible, I will first need to argue that AD is *in and of itself* ethically permissible. A similar approach has been taken already in South Africa with regards to the abortion laws. The CRSA provides protection for the "right of persons to make decisions concerning reproduction and to security in and control over their bodies" (CTOP, 1996, p. 2). The Choice on Termination of Pregnancy Act was enacted as a result of the reading of section 12 (2) of the CRSA and puts into practice what *may* be considered an ethically permissible practice. In a similar way, I will argue that assisted death should receive a similar treatment in the eyes of the CRSA which would result in similar legislative change.

[11] Act No. 56 of 1974 (HPA, 1974)

[12] See Hogan (2009). Here I have only made reference to the regulation that defines the scope of practice for the profession of medicine, although rules and regulations can be found for each of the professional boards at https://www.hpcsa.co.za/Professionals/ProBoards, by clicking on the 'Rules & Regulations' tab.

Health Care and Services of Assisted Death

In this section I will argue that services of assisted death function as health care services. Firstly, I will discuss the current conception of health care and the precise functioning and structure of a health care service. Secondly, I will be presenting and arguing for my own conception of health care as a diverse practice that encompasses all human life from before conception until long after we die. Next, I turn to assess what exactly a service of AD entails, in principle, and how such a service might function within a health care system. I defend my position that AD is an ethically permissible practice and I argue that services of AD are in fact health care services.

What does it mean to be healthy? As defined by the World Health Organization (WHO), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946). This definition serves as a useful starting point for my discussion. It is not enough that people are merely free of disease, disability or suffering; health for humans is a complete state of well-being. How then does this translate into a system of health care? In short, the quality of a population's health is managed and improved by a variety of efforts; it is a team collaboration. This includes all the health care professionals[13] in their varying nature, all the physical buildings,[14] and the practices of health care services put in place. In South Africa, the National Health Act defines health services as follows:

a) *Health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution;*

b) *Basic nutrition and basic health care services contemplated in section 28(1)(c)15 of the Constitution;*

[13] "'Health Care Providers' means a person providing health services in terms of any law…" and then lists the various acts which they refer to (NHA, 2003, p. 10).
[14] "'health establishment' means the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services" (NHA, 2003, p. 12).
[15] Provision for the right of children "to basic nutrition, shelter, basic health care services and social services" (CRSA, 1996, p. 11).

c) *Medical treatment as contemplated in section 35(2)(e)*[16] *of the Constitution; and*

d) *Municipal health services* (NHA, 2003, p. 12).

Health Care Services

What is a health care service? A health care service consists of two distinct 'events'[17] which are at the heart of its functioning. The first 'event' that occurs is the discovery or realisation of an individual's own perceived health care need. Such a need is realised anytime someone becomes sick, injured, incapacitated, disabled, etc. and thereby requires a remedy in order to regain an appropriately normal mean of human health and well-being. This first event should not be a complicated one to grasp, it is right on the surface: think only of the most recent bout of influenza that you have experienced. Initially, you generally feel well enough to continue with your day; eventually however, you may realise that you need further assistance with your condition. Thus, there is a realisation of an existing health care need.

The second 'event' requires a little bit more explanation. Put simply, it is the physical act[18] that is performed with the goal of fulfilling or remedying the specific need. However, the nature of this physical act should be bound by the following four[19] constraints:

1) It is *medically indicated*: It is considered the best course of action to follow in the given situation. The term 'best practice' is used to mean that, among a group of reasonable health care providers, they will all generally conform to a limited range of equally beneficial, medically indicated remedies.

[16] Provision for the rights to medical treatment for arrested, detained and accused persons.
[17] I use the word 'event' here in the sense that it is something that is a 'happening' or an 'occurrence'.
[18] A physical act refers to any intervention in the life of the suffering person. This could naturally take various forms: surgical, chemical, radiological, emotional, social or even financial. The specific form is not important; what is important is that the act remedies the need that has been discovered.
[19] Although I never explicitly mention, or refer to it, my thinking here is strongly influenced by the principle-based ethics first expounded in 1979 by Tom Beauchamp and James Childress in their book *Principles of Biomedical Ethics*. These are: non-maleficence, beneficence, autonomy and justice.

2) It is in the patient's *best interests*: The best interest of the patient may indeed be the most complex prerequisite in this list and subject to the most fluctuation over time. In order to properly ascertain what the true best interests of the patient may be, a thorough understanding of the patient's situation may be required, including upbringing, socio-economic circumstances, personality traits, work, activities, family life, etc.

3) It falls in line with an expressed patient *preference*: The remedy for a specific health care need must be sufficiently explained to and understood by the patient, such that they can make a reasonable choice about which remedy, out of a potential number they wish to have.

4) It is *legal*: Any act that may be performed in order to remedy a need must conform to the current legislation present and to the 'scope of practice' of that specific profession. For example, the Health Professions Act sets out very strict boundaries on which 'remedies' may or may not be administered under which circumstances.

A practical example: A man is involved in a motor vehicle accident and breaks his leg and therefore realises that he has a health care need that requires remedying. The medical professionals attending to him must now ask themselves four questions: first, what is the medically indicated course of action in this case? Secondly, what is in his best interests? Thirdly, whether or not he has expressed a preference for one course of action over another? And lastly, is the act legal? Thus, the provider, in consultation with the patient, decides that an operation to place a pin in the bone is the best course of action because: it is medically indicated; it is in the patient's best interests; the patient has consented; and it is legal.[20] We thus see a closed loop – from realisation of a need to the remedy thereof – that forms the structure of every health care service.

[20] The opposite conclusion could have also been reached, namely that conservative, or non-operative management could be the correct course to follow because it too could potentially be indicated, in the patient's best interests, in line with patient preference and the law.

Astute readers of the above analysis may have generated a question in their minds: how is it that the two steps described above are brought together? This is done through the institution of a health care system. It is all very well that health care needs are created, and that medical professionals are standing by to remedy such needs; however, in almost all cases, these two activities do not occur in the same place. In order to bring the two together takes an impressive feat of logistics: specific health care needs require specific remedies. For instance, in the example I gave above, a broken leg that requires a pin would need to be treated by an orthopaedic surgeon. Such a patient would have been transported to a facility where just such an individual and the correct equipment was available. This is the basic structure of a health care system: a means of bridging the gap between the health care need, and the health care remedy through a complex web of auxiliary[21] services. What is important to note is that it does not really matter what, in practice, brings together the need and the remedy; this can be brought about in whatever way is feasible for that environment.

Health Care

So, we have a health care need that is discovered or realised, and we have a health care system that enables remedy of that need by a trained medical provider. Superficially then, one might assume that 'health care' is simply the combination of these two interrelated factors – the provision of health care services and their fulfilment – but I think it is more complicated than that. Can we understand health care in a way that does not depend on external factors? In order to highlight what I mean by this question, one need only realise that our current understanding of health care is by its very nature variable. It can include certain things, and it can exclude certain things. On this account, no specific time frame, illness, practice, person or anything for that matter is included by default. If we happened to only have knowledge about the science and practice of dentistry, and if it was the case that dental services were the only services that were provided, then we could assume that 'health care' was synonymous with dental care. Fortunately, this is not the case.

[21] Examples of these include (but are not limited to) ambulances and other patient transport and hospital buildings with their managerial personnel.

Despite the difficulty we may have in defining a concept such as 'health care', I think that something like the following may stand us in better stead:

> *Health care consists of a profusion of health care services, and relevant health care systems, that are controlled by a regulatory body for the general betterment of human health and well-being and cover a totality of human experience from before conception until after death.*

In a similar way to the WHO definition, I have introduced an unavoidable circularity into my definition of health. Human 'health' and human 'well-being' are similar terms and may even be used interchangeably. Both the WHO definition of health, as well as my own utilise the word 'health' on both sides of the definition. How then are we to resolve this concern? It seems that we may face more significant challenges in answering this question than might initially be assumed. What, for example, does it mean that well-being must be present in the dimensions of 'physical', 'mental' and 'social'? Physical well-being may take on a multitude of various forms and may fundamentally mean something completely different to different groups of people. Think of the vast difference between an ascetic's idea of physical well-being, as compared to an Inuit surviving on a diet of rich whale meat and blubber.

What is 'normal' regarding mental well-being? Does this entail that we always need to be happy or only sufficiently content with our lot in life? Furthermore, which dimension of the mind are we talking about when I ask if it is *well*? Are we referring to intelligence, to emotional maturity, to flexibility or to some other sense in which we can be said to have a mental state of consciousness? Or does it mean that one is free from psychosis and depression with a normal balance of neurochemical transmitters? Perhaps far more mystifying is what is meant by the concept of social well-being. Again, is this the social well-being of a monk in the Himalayas or of a celebrity in Hollywood? Certainly, they will have vastly dissimilar ideas about what constitutes a healthy social life. Is the political agenda of the left or of the right more socially 'healthy'? Is communism or capitalism more likely to produce greater levels of social well-being among the people?

Let me at the very least say this: I am aware of the significant challenges present in defining health and health care, and I am certainly not able to adequately explore this in more detail here. The rhetorical questions above highlight but a small fraction of the complexities. If the concept of human health is so broad and complex that it evades our adequate, concise definition, does this matter? Yes, and no. Yes, because it makes it significantly more difficult, nigh impossible, for me to argue that my own definition of health care is correct and infallible. No, because, even without a complete definition of health care, I can still make a case that *aspects* of health are important and morally required. In our hypothetical world where dental care was the only type of health care available for humans, I could still argue that dentures should be morally obligatory for people who have lost all their teeth, despite us not being able to fully define the concept of human dental health.

Why then do I think it necessary to propose my own definition at all? The reason is that I maintain that despite our difficulties in defining exactly what *it* may be, health care concerns a 'totality of human experience'. By this, I mean that health care is integrally involved in every aspect of a person's life. Health care does not occur in discrete time intervals; it is not 'punctuated' as most of us believe. Everything that we do and everything that we encounter, has the potential, in some form or another to impact on our health, for the better or worse. Environmental health care, for example, is a fundamental part of the work to keep the general population alive and healthy. This is an easy example, in that we all know that the quality of our environment affects our health on a continuous basis. People who live in a city like Beijing, which has some of the worst air pollution in the world, put their personal health in constant peril by doing so. Thus, there is always a need to manage the health of the environment. Yet, I maintain that such a conclusion can also be reached about all areas of medicine. Medicine, medical practice, human health and health care involve the totality of the human experience, which includes, I will contend, death and a service of assistance in dying.

Before conception, the health of the mother-to-be, her age, her socioeconomic circumstances, her general mood, all play a major role in the type of environment in which the new embryo will grow. During intra-uterine existence, the embryo is

totally dependent on the physiology of the mother, and small changes in her diet,[22] stress levels, emotional state and blood pressure, can have long-term health consequences for her child. Services aimed at this stage of health fall under the category of antenatal care. A young man who has been involved in a serious car accident and is left paraplegic will require rehabilitative health care services among others. A middle-aged diabetic woman who suffers a heart attack will need medical care as is appropriate. An elderly man who is suffering from terminal prostate cancer will require palliative health care services.[23] The family of a newly deceased woman may request for a post-mortem examination to be done in order to discover the possible cause of her death. They will require forensic medical services.

The definition of health care that I have described above is not *necessarily* or *inherently* linked to a specific or individual person. Health care needs do not, by definition, only apply to individuals. Groups of people, indeed whole populations can have very specific health care needs that they 'discover'. For example, the Human Immunodeficiency Virus (HIV) positive population, all have a very specific, serious health care need for which they require specialised remedies. Health care is not fundamentally a personal affair. It involves all persons, at all times and in all places. However, and importantly, the individual is a crucial *feature* of health care; without a multitude of individuals, there can be no population. Every HIV-positive person is their own individual case with their own requirements about what may be in their best interests and subject to their own personal preferences. In a similar way then, people who are dying have very specific health care needs, the remedies of which may vary depending on their own personal preferences, and certainly on how we, as a society view a service of assisted death.

This is not to say that health, health care and the health care service are not *usually* focused solely on the individual. All medical activities that take place in a hospital, for example, are related to individuals lying in the beds. They have all had their various health care needs identified and are receiving remedies appropriately. It

[22] Not to mention the more devastating effects of alcohol, smoking and other illicit substances for example.
[23] Or perhaps AD services, as I shall argue later.

does not follow from my statement that "health care is not linked to an individual person" that the priority of the group now takes precedence. Priority will vary depending on the nature of the health care needed. A paraplegic person who is undergoing rehabilitation in order to facilitate adequate mobility is an individual affair. The HIV-infected population have a unique feature that is (practically) identical between all of them and thus their health care needs can be treated as though for the entire group.

It may not be clear why I have detailed the individual vs group nature of health care. The simple answer is that it must be clear to the reader that my conception of health care is sufficiently *broad,* so as to apply to individuals, groups, and society. This is important because, while a service of assistance in dying may affect the individual, to leave out the concerns of, for example, the family, will be to gloss over a serious issue. The impact of AD is broad and far reaching, and as such, the way in which I have formulated my understanding of health care will need to be similarly flexible.

Assisted Death as a Health Care Service

Can one simply assume then that AD falls within the definition of a health care service as I have discussed above? In order to answer this question, I first wish to discuss the types of situations in which people may be considered 'peri-mortal', meaning an ill-defined period where the overlap between living and dying comes more starkly to the fore. People die for a myriad of reasons but the ones that I am particularly interested in are those in which it is known ahead of time that people have a fixed (or potentially fixed) date of death.[24] For our purposes it does not particularly matter what this length of time may be – six, nine, twelve months – nor how certain we can be of its accuracy; all that we must assume as a starting point is that there is a good statistical likelihood that the assessment by a qualified medical professional is accurate. Now, consider an individual who meets these prerequisites: we have here the *realisation* of a health care need, one that I contend is quite unlike

[24] In this way I am intentionally omitting from an already complex discussion those people that would potentially wish to utilise services of assisted death who do not have some fixed period left of their life. They raise further complications which I do not wish to pursue here.

many other health care needs of 'non-dying' people.[25] As I explained above, the discovery of a health care need is only the first step in the functioning of a health care service; a specific remedy should be *offered* to fulfil the need and complete the service loop.

I noted during the discussion on the workings of health care services that the provision of a remedy for a health care need must conform to four prerequisites for it to be considered permissible: namely that it is medically indicated; it is in the patient's bests interests; it is subject to patient preference; and it is legal. I further noted that determining what is in a patient's best interest is particularly challenging and may even go contrary to the medically indicated remedy for a given health care need; yet it may be the correct course of action to follow. In the case of a 'peri-mortal' individual, one choice that the patient may have is for palliative care. Even here they may have to express a variety of other choices relating to the specifics of their care. For example, does the patient wish to receive opiate pain medication even if these medications may shorten their life?[26]

A service of assisted death can, in principle, be medically indicated when the patient is in the terminal stage of a disease; it can in principle be offered to 'peri-mortal' patients as a choice among options – palliative care or AD. Patients are required to make difficult decisions about their health care daily, and the decision of the dying patient are no different. The practice of AD in South Africa currently remains illegal and punishable by law and as such, classifying AD as a health care service in a South African setting poses a significant challenge as it stands. However, and once again, I am not yet[27] concerned with a specific setting or location. In principle,[28] AD can function as a health care service if it were legal. Indeed, in many countries around

[25] I am aware of the tautological mess which one can get into when trying to discuss living and dying. Technically, we are dying from the very moment we are conceived, and, even in the best scenario, such a process may take up to 120 years. We are all then in a state of 'living death' in which any moment or day may be our last and we do not know for sure quite how long we have left. However, I wish to steer clear of this mess. 'Non-dying' here, is simply meant to refer to everybody else.
[26] The doctrine of double effect.
[27] I come to this in section 4.
[28] And in practice where AD is legal and legislated.

the world such a shift is occurring, and services of assisted death are now available to those meeting strict criteria.

I must stress the following point: the benefit of choosing AD does not accrue to the person who is dead. The decision to end one's own life only has the potential to alleviate the suffering of the person who is still alive. As I said, health care exists on a continuum which includes every moment right up to the physical death of the person (insofar as the interests of the dying person are concerned – naturally, health care, in the broader sense, does not stop with the death of an individual. It is both inter-generational as well as highly individual, existing simultaneously). So, services of assisted death can function as health care services because they adhere nicely to the inner structure that I have discussed above. This may seem contentious: that the ending of someone's life could be considered as a remedy for their health care need, and as such I will require a little more support than this.

Against the Right to Die

It is useful to consider what the role of the health care system is once people have died. There may or may not have been direct contact with the health care system; meaning that the person may have died under the care of medical professionals, or not. Regardless, it is the duty of the system to take over management of the case, whatever that may be, from determining the cause of death, to prevention of possible communicable diseases, to safe disposal of the dead. Note here that health care does not end when the person dies. Again, health care exists on a continuum that morph as an individual 'reaches' different stages of their life (or death).

This is not to say that people still retain an *interest* in what happens to their corpse after their death. The dying person retains interests of their own, right up to the very moment at which they take their last breath, or rather, up to the moment at which brain functioning ceases. Indeed, my thesis rests on the assertion that people still retain the right to self-determination even up to the last moment. I deal with this later under the heading 'Autonomy'. Society at large naturally retains some interest in the corpse after death, perhaps if it is infectious for example and poses a threat to others. I pose the question then: should we allow people who are dying

a preference that includes services of assisted death within that offering, if it can be shown that they accrue benefit right up to the very moment of their death?

In his 1992 paper titled *Against the Right to Die,* David Velleman argues that it may indeed be the case that doctors are entitled to perform services of assisted death, however patients may not have the right to receive these services. Velleman states:

> *I strongly believe that a person's life can sometimes be made worse by being prolonged and that a swift and painless death can then be a benefit … [and] that the benefit of death can sometimes be sufficiently important that providing it is morally obligatory … Furthermore, I believe that the proper goal of medical science is not to prolong life per se, but rather to make human life better* (Velleman, 1992, p. 667).

Velleman compares the process of facilitating at someone's death as similarly appropriate to the facilitation of the birth of a baby. He continues with a discussion about the possibility that more options may cause more harm than good, rather than having the desired outcome of being purely beneficial as one might initially assume.[29] A similar observation is made about euthanasia: "The problem is how to offer the option only to those patients who will have reason to welcome it" (Velleman, 1992, p. 673).

Velleman is concerned that if dying people were given options about their death then they may be forced to justify, with reasons, why they have chosen one choice over another, rather than not being given the option at all – in which case they would die a natural death by *default*. "Forcing a patient to take responsibility for this continued existence may therefore be tantamount to confronting [him] with the following prospect: unless he can explain, to the satisfaction of others, why he chooses to exist, his only remaining reasons for existence may vanish" (Velleman,

[29] He uses ethical frameworks developed by Thomas Shelling in his book *The Strategy of Conflict* (1960) and Gerald Dworkin's paper *Is more choice better that less?* (1982). He presents various examples, one of which will suffice for our understanding. An invitation to a dinner party leaves one with "the possibilities of choosing to come or choosing to stay away; but I deprive you of something that you otherwise would have had – namely, the possibility of being absent from my table by default, as you are on all other evenings. Surely, preferring to accept an invitation is consistent with wishing you had never received it" (Velleman, 1992, p. 672).

1992, pp. 674-675). Indeed, once he is offered euthanasia, he may believe that a refusal of the practice may have the potential to impact his standing as a rational person in the eyes of his family and friends, all of whom may secretly, or not, hope that he makes such a choice. Velleman believes that if such a practice were to be *institutionalised*, it would put too many people in the position of having to make a choice, that they should not have to otherwise make.

My own beliefs align with those of Velleman's, insofar as he is concerned about the potential to attract individuals who may not actually benefit from the service. This will be one of the most significant obstacles that will need to be overcome when deciding exactly how to institutionalise AD services into the current health care system. I do not believe that this is sufficient reason however, to restrict the right of those who genuinely require these services and I am not inclined to err on the side of caution, unlike Velleman. I think that medical professionals should be able to provide services of assisted death as part of their health care offering.

Velleman contends however, that we are morally obligated to withhold even presenting euthanasia as an option to patients. This, it should be noted, is not done for paternalistic reasons: "I am arguing that we must not harm others by giving them choices, not that we must withhold the choices from them lest they harm themselves" (Velleman, 1992, p. 676). Yet it seems to me that the potential benefit one may gain, by reaching those terminally ill patients, should not be underestimated. I concede that this may inadvertently attract patients who do not genuinely wish to die and end up requesting euthanasia for other reasons – guilt at the costs of health care, being a burden, causing suffering to family members and loved ones. How this is to be avoided will need to be spelled out meticulously in the legislation that governs this practice. Yet for those patients in whom a genuine preference is held and expressed, it should be morally permissible for doctors not only to inform their patients of all the options but to listen to and cede to the patient's preference.

In all other areas of medicine, we are very comfortable with offering patients all the available options and then coming to a decision together. On Velleman's logic

however, we should be refraining from informing patients of certain options for fear of harming them directly. Again, this is not to say that we are being paternalistic; I cannot raise that objection against Velleman. But it does seem to me that we would be missing something if we followed this logic to its end. A patient undergoing a bone marrow transplant for a blood cancer will need to be informed that the procedure is incredibly dangerous and not without significant risk. It would be considered questionable if the patient was told that there was no *choice* in the matter. It is of course within their rights to refuse medical intervention even if such a refusal may cause them to die very soon thereafter. I do not think that one can withhold the giving of choices even in matters of death.

That is not to say that these two cases are analogous. Most medical practice has the intended goal of continuing life for patients, with some dangerous procedures causing death in certain circumstances. Assisted death, however, has the intended goal of ending life. Thus, Velleman might point strongly to this distinction as an important reason for withholding the giving of choices in the second case. On what basis then can I support my assertion that there is still a place for the provision of AD as a health care service?

Autonomy

An argument posed in favour of the right to choose the timing of one's own death is that it will significantly improve the autonomy of the person involved.

> *Autonomy, or self-determination, means that individuals have the right to pursue their own personal views of what kind of life is best, including when and how to die. Thus, to respect autonomy requires permitting individuals to weigh their own values and decide when it is better to end their lives rather than continue living in the face of terminal illness* (Quill & Battin, 2018).

In the 2004 book edited by Timothy Quill and Margaret Battin, titled *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice,* one of the contributors (Lee) points out that "the secure knowledge that this option is available can enhance a person's sense of control over their condition, making suffering easier to bear because it is experienced 'voluntarily'" (Seale, 2006) reviewing (Quill &

Battin, 2004). The voluntariness of a negative state of being has a tremendous impact on the way in which it is experienced. For example, an athlete, training for the Olympics, may experience repeated episodes of excruciating muscle pain, the likes of which should be considered intolerable for a dying patient lying in a hospital bed.[30] The circumstances of the suffering matter, almost as much as the way in which they are perceived by the sufferer. As such, I agree that the giving of a choice to a dying person may empower them to experience their suffering voluntarily, the power of which should not be understated.

The objection against autonomy is nicely summarised, again, by Quill and Battin:

> *Opponents object that this construes autonomy too broadly and fails to take its limits into account, including challenges to the possibility of autonomy and limitation by the harm principle. The exercise of autonomy cannot include the ending of one's own life because that would mean ending the possibility of exercising autonomy and because ending one's own life would cause harm to others in multiple ways, including grief, loss of support, and setting dangerous precedents for others* (Quill & Battin, 2018).

There is some real concern in this objection: how is it morally permissible to exercise your autonomy, even if doing so would lead to circumstances in which it becomes impossible for further exercise of autonomy (i.e. death)? It seems to me that there is a flaw hiding in this line of argument. The reverse exposes this nicely: one would need to argue then, the reverse assertion that dying people are only permitted to exercise their autonomy if it can be shown that they will always retain the ability to be autonomous. Of course, no one could hold such a position. Indeed, the very notion of autonomy is predicated on the ability to exercise it at that moment, and not necessarily on the assumption that one will always have the ability to do so. An advance directive is based on this principle: one provides clear instructions that are created at a time when autonomy can be exercised, such that they can be followed at a time when there is no longer the ability to do so. Not having the ability to decide on the timing of one's own death, based on the concern that one will then

[30] See Sam Harris's *The Moral Landscape* (2010).

no longer be able to exercise autonomy, is not particularly dissimilar from not being able to make an advanced directive on a future management plan.

This conclusion is not affected by the fact that in one case we are *certain* that we will not be able to exercise our autonomy (in the case of AD), as opposed to merely *predicting* that it will occur in the future (the case of an advance directive). Neither the delay, or time period between the decision and the time when we no longer have the ability to make autonomous decisions, nor the statistical likelihood of the respective events, factors into the argument that I posed above.

Best Interests

The practice of assisted death may be in the patient's best interests because it has the potential to decrease their overall suffering. This is not to imply that the dead person still retains some benefit, because there can be no *further* benefit once dead. By way of illustration, let's assign the number zero to mean oblivion:[31] you did not exist before you were born (or were conceived) and in a similar way you will cease to exist when you die.[32] The scale runs in integrals, and as such the negative numbers denote suffering of various degrees, while positive numbers denote pleasure or happiness. For those who are 'peri-mortal', and suffering, one can generally assume that they fall on the negative side of the scale. Now, perhaps there was a level of suffering – a negative number – at which such a patient would do just about anything to increase their 'well-being' to zero. Perhaps the worst possible suffering imaginable?[33] Such a patient may *insist* that they would rather die than endure his current condition; it would be better off if they were dead, better off in oblivion. Not to offer such a patient a chance to decrease his suffering is in my view morally impermissible.

In each case of a health care service, there is a course of action to follow that is in the *best interests* of the patient. What does this mean? Put simply, it is the course of action that is most likely to bring about the greatest personal benefit or gain

[31] Substitute for nothingness, non-existence, void, nihility.
[32] See David Benatar's *Better Never to Have Been* (2006).
[33] See Sam Harris's *The Moral Landscape* (2010).

from a given action and is the most likely to mitigate suffering of some kind. This does not mean that there will be total removal of suffering or that the action will remove all hardship. In other words, there may never be a return to a positive number. In a range of possible choices, there is usually a limited number that may potentially be in the patient's 'positive' interest. The best interest is in principle opposed to a course of action that results in a net loss.

From a consequentialist perspective, the course of action that is in the best interests of the patient will be similar to what I have described above: what course of action is likely to produce the greatest net benefit, or the greatest total decrease in suffering (i.e. an increase in numerical value on the integer scale). In the case of a 'peri-mortal' individual then, the morally correct course of action would be to move closer to zero, and if possible, to attain a positive status. Now this is, in my view, possible right up to the moment of death. If a suffering, patient could be moved from a negative ten for example to a negative two for the remainder of their life – whatever that may be – then the consequences are better than the alternative of staying a negative ten for a longer period. The choice, merely available, may "provide 'psychological insurance' and be beneficial in the sense of relieving anxiety about the prospect of future pain and suffering" (Quill & Battin, 2018).

A service of assisted death does not sit well with some ethicists who feel that there is an intrinsic inviolability to the nature of human life. Authors such as "Aristotle, Thomas Aquinas, and Kant… argued that suicide is deeply morally wrong" (Quill & Battin, 2018). For these it may be significantly more challenging to allow that actionable killing is permissible for the special case of AD. Torbjörn Tännsjö argues that "deontology prohibits only active killing [and]… a system where, at the patient's request, a doctor actively and intentionally kills the patient" (Tännsjö, 2005, p. 689). Furthermore, Tännsjö agues that:

> *Deontology focuses exclusively on the moral agent, whereas… utilitarianism focus[es] on the patient as well. This counts against deontology, especially in the context of euthanasia… In addition, I believe the rigidity of the deontological view counts against its plausibility. The fact that it condemns in the same strict terms*

> *murder, euthanasia, suicide, and abortion, renders it implausible. It is as if it were blind to important moral distinctions* (Tännsjö, 2005, p. 690).

Unfortunately, I am limited in the extent to which I can expand upon and criticise the various positions that fall under the umbrella of deontology, as it relates to a service of AD. There are, of course, many nuances and ways in which the deontologist may hope to get around the issue of a strict rule against suicide,[34] however these seem to me strained and convoluted. The consequentialist framework moulds nicely to the complex problems of AD. Tännsjö agrees: "Utilitarianism is focused on the patient but not only on the patient; it is focused on everyone affected by the decision. This seems to me right." (Tännsjö, 2005, p. 690).

Professional Concern – The Slippery Slope

Some authors seem to think that the very idea of assisted death and health care services being discussed in the same breath is untenable. Donald Boudreau and Margaret Somerville in their 2013 paper make the claim that euthanasia should not be considered as medical treatment at all. They state:

> *The essential nature of physicianship has evolved over time in a direction that recognizes the extraordinary vulnerability of patients and guards ferociously against their exploitation. In part, this has been achieved by imposing inviolable limits on the physician's terrain of action. Moreover, we believe that, even if one accepted that euthanasia was ethically acceptable—which we do not—it opens up too many doors for abuse … healing and euthanizing are simply not miscible, and euthanasia can never be considered 'medical treatment'* (Boudreau & Somerville, 2013, p. 63).

Boudreau and Somerville claim that this new shift towards AD in society "has been abetted by those who espouse so-called 'progressive values'… seeing 'radical autonomy' as always being the overriding value" and is in no small part due to "the demotion of established religions as influential voices in the public square" (Boudreau & Somerville, 2013, p. 47). Furthermore, they claim that:

[34] See, for example, Iain Brassington (2006).

> *The profession must not disown its ethical tradition or abandon its basic precepts. The potential harm is not only to individuals, but also to the institutions of medicine and law and the roles they play in society, especially in secular societies, where they are the primary carriers of the value of respect for human life, at the level of both the individual person and society… Therefore, the degrees of freedom, in terms of legitimate actions and behaviours available to physicians confronted with a dying patient are, and must remain, clearly and strictly limited* (Boudreau & Somerville, 2013, p. 48).

Julian Prokopetz and Lisa Lehmann take a slightly different approach. They acknowledge, as I have argued above, that the physician should be involved in the patient right up to the point at which the assistance (in the form of prescription or injection) in the dying process may need to take place. Thus the medical professional would assess, prognosticate, treat and palliate as necessary and appropriate; yet as soon as it becomes clear that AD may be the only feasible way forward, then they must hand over to an "independent authority to obtain the prescription" (Prokopetz & Lehmann, 2012, p. 99). Regardless of whether the deed is to be performed by a medical professional or some other licensed individual, does not matter all that much. I do not agree with Prokopetz and Lehmann that a medical professional is the only person correctly placed to properly oversee the practice. Still, whether a service of assisted death is performed by a medical professional, or by some other health care practitioner, it remains a health care service, one that I think should be ethically permissible.

Boudreau, Somerville, Prokopetz and Lehmann espouse a conservative viewpoint. Why then, should one allow such a radical (at least as they may see it) change in society to occur? The answer to this question is that whether conservatives like it or not, they are forced to acknowledge that the world and society *has* changed and that humans now have the ability to manage our own welfare by making health care choices which can potentially extend and improve our mortal existence – something which was simply not possible a mere century ago. With this new-found power, the question of how far it may be extended, and where it is to be limited become critical. Naturally, the conservative and progressive viewpoint splits at this junction.

Boudreau and Somerville for example believe that the problem lies in the fact that religion is no longer an influential voice in the public domain. No doubt their world-view is religious, and it may be exceedingly tricky to utilise good reason and argument to extricate them from that position.

I believe that there are powerful reasons to be said for a more progressive stance on the issue of AD. For one, as I have said before, the unavoidable fact of technological progress has forced us to deal with many issues whether we like it or not. Secondly, the conservative standpoint fails to assign adequate weight to the consequences of the prevention of, even to a small number of people who suffer, the choice over when to die. Thirdly, contrary to Boudreau and Somerville's concern that euthanasia "opens up too many doors for abuse" it has been shown on multiple occasions that "there is no current evidence for [the slippery slope] argument [from] the jurisdictions where [AD] is already legal" (Quill & Battin, 2018).

That brings me to the end of this section which had two overarching goals: to argue for my position that services of assisted death are both ethically permissible and that they are health care services. In order to do this, I have examined the inner functioning of a health care service and argued for my own definition of health care as a broad practice that encompasses all human life from before conception until long after death. AD is founded in a real need that is experienced by real people who are suffering some intractable malady. I have argued that it is morally permissible in practice because it offers a level of autonomy to patients who wish to alleviate their suffering, and that it can be in their best interests to end their suffering. I now turn our attention to the South African Constitution and argue that services of assisted death are protected under the current writing of chapter 2, section 27.

Assisted Death and the Constitutional Provision

I will now propose an argument that specifically relates to the provision of a service of AD as a health care service. I shall argue that this service is required under the writing of the Constitution of the Republic of South Africa (CRSA).

In his 1994 book titled, *Life's Dominion,* the renowned American philosopher Ronald Dworkin argues that the writing and wording of the American Constitution supports the legal rights of woman to access abortion services and of competent adults to decide the timing of their own death (Dworkin, 1994). He does this through an extensive analysis of the American Constitution with an argument that makes a distinction between a literal reading of the text, and a reading that alludes to the intended *outcome* of the text. He argues that it remains more important that the constitution be used as a guide in our own times, rather than trying to impose the literal words of the founders in 1787.[35] Our own constitution, in its comparative infancy, can still have a similar analysis applied.

Broadly, we can classify any constitution into one of two kinds. Firstly, there is the document that is meant to be read literally, word for word, without much insinuation or guesswork required in the understanding of its provisions. Such a constitution is ironclad (or as much as is technically feasible) and no reading between the lines can take place. The second kind of document is one which is written in such a way as to convey a general idea of what it requires and leaves the provisions *open for interpretation*. It is fairly uncontroversial to say that the South African version, although far from being perfect, finds a workable middle ground. "The Constitution is not libertarian and is not socialist. It is a product of compromise, and should be understood as such" (Staden, 2018).

The Bill of Rights

Chapter 2, states that the "Bill of Rights is a cornerstone of democracy in South Africa … [which] enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom"; and further that "the

[35] The American Constitution was signed on 17 September 1787.

state must respect, protect, promote and fulfil the rights in the Bill of Rights" (CRSA, 1996, p. 5). For example, section 12 states that: "everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction; to security in and control over their body" (CRSA, 1996, p. 6). Naturally such a passage can be read in several ways, but I will argue that it is mainly related to the practice of freely exercised autonomy, of the physical and psychological body of the person. What does this mean? Simply put, the Constitution provides an unfettered right to personal control over one's own biological entity that we call a 'body', so long as such a right does not infringe upon the other rights contained within the Bill of Rights. Individuals are free to choose what to do with their own bodies and minds. They are in control.

What does it mean to say that "the state must respect, protect, promote and fulfil" this right? Section 12, which is primarily concerned with limiting the extent to which the state may interfere in the lives of its citizens – ensures sufficient *non-interference* by the state. Thus, the state must remain inactive and refrain from intervening even in cases where it thinks that it knows best. The right to control over one's body entails that the state should not prescribe or regulate the ways in which people use and change their bodies. If someone wanted to tattoo their skin, pierce their ears, undergo radical surgery, jump off a building with a parachute or to decide to be a Buddhist, then the state should remain indifferent. Furthermore, the state should take active positive steps to ensure that it remains indifferent – for example in the form of legislative provisions ensuring just such a stance.

Of course, such indifference can extend only so far. In his famous piece *On Liberty* (1859), John Stuart Mill argued that "the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others" (Mill, 1859). What constitutes harm to others is certainly an entire discussion on its own and I cannot do justice to it here. Clearly then, a person who wishes to exercise the right to control over their body by killing other people in cold blood should be prevented from doing so. Not only does they deprive those who are killed of their section 11 right (to life), but they also cause them grievous harm. Does the situation change when the person involved requests to be killed?

I am of course only concerned with those people who are 'peri-mortal', competent and request that their life be ended sooner than it would otherwise have been. I have two important questions that I need to answer. The first is whether such an act is constitutionally permitted; and the second is whether there is *harm* done. In the previous section I argued for the moral permissibility of AD based on two grounds: that it improves the autonomy of patients and that it may be in their best interests. How would intentional killing fare against sections 11 and 12. I think that section 12, which clearly allows for control over the body and the psyche, would allow that the person is able to choose to end their own life. It is after all, their body, and they are free to do with it as they please. Intentional killing however seems to stand in contradiction to the provision for the right to life in section 11. Is this so?

I will argue that this is not the case for two reasons which are quite dissimilar. The first is that section 11 does not make any specification as to the type of life that one is to live. The right to life is a very broad right indeed, and it certainly does not help us much in many of the complex medical cases that are becoming commonplace in our time of advanced medical technologies. Is the life that Nancy Cruzan[36] endured, the type of life that the writers of the CRSA envisaged? Is the life of a terminal cancer patient, who is incontinent and in a delirious state, the type of life that people have a right to? Now I am not trying to say that every type of life should have been made explicit in the writing of section 11. That would have been impractical. What I will argue is that the right to life is about what *type* of life the person is living rather than simply about them living *any* life. A life of suffering – perhaps a negative ten on the scale I described earlier, perhaps the life of Nancy Cruzan – is not the type of life that I think worthy of protecting. Thus, in these very specific, and highly unique cases, a right to life may not *necessarily* be a reason to deny its end.

The second reason is that although section 11 provides for the right to life for everyone, it does not say that this right is *non-revocable*, meaning that it can

[36] Nancy Cruzan, and American woman, was involved in a motor vehicle accident in 1983 that left her in a coma known as a 'persistent vegetative state', in which there is continued function of the lower brain functions but with the death of higher brain regions. See Doukas and Brody (1992) for one example of the case review and an assessment of the Supreme Court ruling in her case.

potentially be refused by the individual. The CRSA does make it clear that the right to life is *non-derogable*, meaning that the state can never *suspend* the right for any reason. However, the individual citizen is free to waive the right to their own life, as they are to any of the other rights provided for the in Bill of Rights. The opposing position, that individuals cannot waive their rights seems untenable in my opinion. It goes against the very fundamental nature of a right to insist that it can never be waived in principle.

Perhaps then the right to life should be argued for on the basis of the inviolability of human life. If life is sacred, it is argued, then we are forbidden to interfere in the natural order of things, but more specifically, to end it prematurely, in *any* case. There seems to be something special, unique and veritably ineffable in the human condition, so the argument goes. But is this in fact the case? I will make two points here. The first is that I remain truly agnostic as to the sacredness (or lack thereof) of the human condition. I do not think that we can argue with *good* reasons for one point of view over the other and I am sceptical of those who believe that we can; we usually simply present with reasons what we feel – or *hope* – to be the case. The second is that we need to find a workable, practical solution while we are having the debate. We cannot ask that women put on hold their unwanted pregnancies while we decide if the life of a foetus is inviolable; we cannot expect those in a persistent vegetative state to explain why their life is *not* sacred and thus why they wish to be left to die; we cannot expect dying people to all share the ineffable nature of the human condition or force them do so if they do not.

Does this mean that the CRSA supports suicide? No, I do not think that one can extrapolate that far, for many more powerful social reasons. It seems at least clear that, regardless of the Constitution's support or prohibition of the practice of suicide, it should never be legislated against or punishable in general. The reasons for this rest more on the biological nature of the problem and less with any ethical analysis that I may give. I will not go further into this here.

So then, the right to decide when to end one's own life is supported by section 12's provision for control over one's body, and section 11's provision for the right to life

and does not pose a problem. I will now argue that I find further constitutional support for the service of assisted death in section 27.

Constitutional Provision of Health Care Services

Section 27 states that "everyone has the right to have access to health care services" and that "the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of … [this] right" (CRSA, 1996, p. 6). The writers have intentionally left open the question of which health care services are required and which are not. In the landmark constitutional case of Soobramoney v the Minister of Health (KwaZulu-Natal) of 1997,[37] Thiagraj Soobramoney argued that he had a constitutional right to access a renal dialysis service because he was suffering from chronic kidney failure,[38] yet he was denied this treatment based on the lack of state resources for the provision of such an expensive treatment. The court, sympathising with Mr Soobramoney's predicament, did not compel the hospital or the local government to provide the service to him, essentially signing his death warrant.

The Constitution does not have a prescribed minimum core that relates to each of the socio-economic right provisions. If South Africa were a country where there was not a single renal dialysis machine available to a citizenship that was suffering from high levels of chronic renal failure, then a case could be made that the state should, potentially as a matter of urgency, make the necessary arrangements to implement such a service. Even one new machine bought per month, for example, could be used as *evidence* that the state was taking *reasonable steps* to achieve the progressive realisation of the right to this health care service. Note here that all that must be

[37] See Chaskalson (1997).

[38] Chronic kidney failure is an irreversible decline in the functioning of one's kidneys. In the short term, the problem can be mitigated by filtering out toxins from the blood in a process called dialysis. Dialysis machines are expensive to purchase, maintain and operate; quite apart from the technical skill and expertise required to safely connect, filter and disconnect a patient from such a machine. And a patient will need on average three sessions a week lasting roughly four hours. In the public health care system this makes dialysis a scarce resource; in the private health care system, it makes it an expensive luxury that only the rich can afford. Even more frustrating is that the only way a patient gets off the dialysis program (apart from dying) is if they receive a donor kidney for transplant. These, naturally, are even harder to come by, and patients may spend years receiving thousands of sessions of dialysis clogging up an already strained system.

shown is that the state is ensuring the progressive realisation of the specific right at hand.

In a similar way to section 11's provision for the right to life, section 27's provision for the right to access health care services suffers from a similar concern: notably that it does not make it explicitly clear which health care services are included and which are not. It simply makes provision for a health care service in general terms. What does this mean? It means, in essence, that the writers of the Constitution empowered the legislature to decide on exactly which services are classified as having to do with health and which do not. Such a position is highly future-focused because it allows for the inclusion of new services that may become or are specially developed to be health-care related.

In the previous section I argued that a service of assisted death can function in a health care system as a health care service. This is because it serves to remedy a need that dying people have – the need to decrease their cumulative suffering. As I have said, such an offering is never made in isolation, but always with the alternative of palliative care. I argued that the practice can be medically indicated, that it has the potential to be in the best interests of the patient, and that it can improve the autonomy of the patient. It is then, a health care service. It improves the lives of humans by giving them control over the timing of their death and has the potential to mitigate their suffering, in some small but beneficial way, while they are alive.

So, what are our options? Naturally there is the case to be made, à la Velleman, that we should not be giving dying people any options, not from the point of view of preventing them from harming themselves, but because by giving them choices we harm them directly. As I have argued above, I agree with Velleman to the extent that there is the *potential* to harm patients directly by giving them too many options and thereby forcing them to "justify [their] continued existence" (Velleman, 1992). However, I am not convinced that this is enough reason to cast aside the entire practice. For a 'peri-mortal' individual, the choice is usually one of three. Firstly, and rarely, a dying person can choose to receive no assistance from medical personnel whatsoever. In this case neither the dying process nor the symptomatic needs of the

patient are remedied in any significant way. Secondly, they can opt to have expert care and attention that meets their symptomatic needs and that seeks to improve their quality of life. In this case, the dying process is left largely unaltered, however all the concomitant concerns are managed appropriately. Pain usually features as the main concern in this regard and large doses of pain medication may be required. This, of course, has the potential to hasten death itself. The third option is to directly choose the timing of one's own death.

Each of these options comes with logistic and legislative requirements. Currently in this country, options one and two are legal. One can legally choose not to receive any medical care and one can legally choose to receive palliative end-of-life care. However, patients are unable to legally choose the timing of their deaths. I believe that such a position is unconstitutional. A service of assisted death functions as a health care service. More than this, it *is* a health care service. Afterall, what is the difference between something functioning *as* something and that something itself. The adage holds true: If it looks like a duck, swims like a duck and quacks like a duck, then it probably is a duck.

Surely if a service of assisted death is a health care service then it should be constitutionally required based on section 27's right to health care services? The objection might be raised at this point: we cannot simply allow all so-called 'health care services' simply because they appear to be concerned with an improvement in human health. I have deliberately phrased this question weakly in order to make an important point. In order to label a service as a health care service we need to be at least reasonably certain that the benefit to humans outweigh the risks in each case. I maintain that we *must* adopt a consequentialist attitude in deciding this. We cannot, in principle, go in having already decided which way the dice will fall.

So then, in order to call any service a health care service, it must produce some benefit to individuals, groups or society, that outweighs the harm. A patient who receives a bone marrow transplant, which as I have said before is enormously dangerous, does so at a tremendous personal risk to self. Even if they were to die in the process, it would have been *worth* the risk. It would have provided some hope

for a short period of time and may have empowered that person psychologically. If they live, all the better for it, yet, even so, it may only be for another five, ten or fifty years and then they will die anyway. We are happy to see this as a health care service because the *benefits* outweigh the potential *risks*, even if that risk is death.

As I have said, this case is not perfectly analogous to a service of assisted death, but it can help us get started. A service of assisted death is also enormously dangerous, in fact, it is more than likely to end in the death of the individual involved. Now even if they were to die in the process (which of course they are), then we would hope that there has been some gain from the decision and the action. On the one hand, a dying person has the choice made available to them and they decline the offer, wishing instead to undergo palliation. This person now *knows* that their suffering is endured voluntarily. This knowledge is powerful, in the sense that it may translate into real world metrics – the ability to endure higher levels of pain, an improved attitude to life, decreased depressive episodes etc. There is *benefit* even in the offering and the decline. And the person will of course die eventually anyway. On the other hand, a person decides to end their own life. For whatever reason the decision has been made, an overarching attitude may be *resolve*. Any firm decision once again has power to alter real world metrics. It may reduce stress or anxiety over future suffering, cause overwhelming relief at the thought of a near end, and may make the end time a certainty and even more precious. Once again, there is benefit to be found. And then the person will die at a date and time that they have *decided*.

What are the potential risks for harm? I have dealt with several of these throughout this report – from the concern over the slippery slope, to the problem of harming patients by giving them choices – but the one big harm that concerns me is of catching in our nets those who do not genuinely wish to die but find themselves in the situation. The potential for such a harm seems to me very great indeed. How are we to mitigate this risk? The South African constitutional law scholar Pierre de Vos has one suggestion, that of strict legislation.

> *Personally, I believe Parliament should pass comprehensive legislation in this (euthanasia) regard. Such legislation should allow for strictly regulated ways in which doctors could assist patients to end their lives if the patients so request. Such legislation should also allow doctors to actively end the life of a patient in cases where family members wish to end the life of a loved one who is in a vegetative state. What is the difference, after all, between starving a person to death and giving that same person a high dose of morphine? Is the second case not more humane than the first? Why would the first then be legal and the second not?* (Vos, 2010).

So, the way in which the potential harm to patients would need to be mitigated would be through 'comprehensive legislation' and 'strictly regulated' practices. In order to pass legislation of this kind, it would first have to be agreed upon that a service of assisted death is constitutionally required, and that the current paucity of its offering is unconstitutional.

I have neglected to say much in this report about the potential suffering that may be endured by the family and friends of the dying person. As I said in the beginning, death and dying have the potential to be extremely difficult times for *all* parties involved. Spouses or partners who are closest to the dying individual may suffer greatly through their grief and rumination. Friends may not know how to help, or what to say and may feel powerless. Different worldviews, religions, life philosophies all make for a stormy sea that becomes increasingly difficult to navigate. Children may be losing a parent, and perhaps, parents face losing a child. There is, of course, the potential that dying may be easier on families and loved ones, but I am inclined to think that, no matter how 'well' the process goes, it is a difficult time. In fact, my argument throughout has never hinged solely on the assertion that we will make dying an *easy* process in any sense of the word. I only believe that having a service of assisted death available to people, will make dying a *better* way of dealing with the process.

Death is the one universal certainty. Perhaps then it should also be seen as the one universal difficulty? It is a given that we are going to die, and it is a given that it will

be challenging in some ways, and less in others. This difficulty, that dying people, their friends and family endure, is a form of harm. Furthermore, it is a 'harm to others', the likes of which Mill would have permitted us to intervene in. However, the cause of the harm (death) is as unavoidable as our need to eat food if we wish to endure. This is the great conundrum we face.

There is a misconceived notion that a service of assisted death may cause the individuals surrounding the person who has chosen to die, to suffer as a result *of the decision itself*. Perhaps it is the *interventional nature* of AD that is seen as the problem, in that, the active step towards death may cause anger among family members who either do not share the same opinion or hold a worldview in which life is sacred. Perhaps the *certainty* about it may frighten some people and cause them undue and excessive anxiety at the thought of that approaching day. Perhaps it is a combination of factors. Now, I am not going to try to argue here that these people are wrong to feel the way that they do. The person is dying, and so loved ones will have to face their grief at some point – whether it is a conscious decision to terminate the life or whether nature is allowed to take its course. Through proper counselling, preparation and explanation, the *perceived* harm that deciding on a service of AD may cause, can, in my opinion, be mitigated.

Conclusion

Justice Brenan, in his dissenting opinion of Cruzan v Director, Missouri Department of Health states that

> *Nearly every death involves a decision whether to undertake some medical procedure that could prolong the process of dying. Such decisions are difficult and personal. They must be made on the basis of individual values, informed by medical realities, yet within a framework governed by law. The role of the courts is confined to defining that framework, delineating the ways in which government may and may not participate in such decisions* (Brennan, 1990) quoted in (Sachs, 1997).

Certainly, the words of Justice Brenan hold true in a time such as this. The nature of the medical profession has allowed for phenomenal feats of improvement in human health at the cost of complicating the way in which these matters need to be thought about. Surely, this is a small price to pay. Every day, millions of people around the world, suffering from illness and disease, find that they are at the very edge, peering over into an abyss from which there is no return. It is a one-way ticket. Every day, a large percentage of these people have their tickets revoked and are wrenched – often with tremendous effort – back from the brink. Many however, are not so fortunate and find themselves drawing their last breath among the living.

The issues surrounding this precipice are numerous and complex in nature. In this report I have touched on but a small percentage of them, yet I have tried to be as comprehensive as is necessary for my argument. I have argued that a service of assisted death functions as a health care service because it can improve the lives of the people who would qualify to access it – notably, 'peri-mortal' individuals. I have argued that assisted death is in principle a morally permissible practice. I have argued that a service of assisted death does not stand in contradiction to section 11's right to life and have argued that not to provide for a service of assisted death in our country is unconstitutional based on section 27's right to access health care services.

I have said very little about the type of legislative changes that would be required by my conclusion, and it should certainly stay that way. That is up to the legislature. What I do hope to see is the ability for patients in our country to have access to a service of assisted death in an integrated way as part of the offering of existing health care services. For example, a terminally ill patient with prostate cancer would be referred to a centre where a comprehensive assessment could take place. Thorough medical evaluation, psychiatric and psychologic assessment, social and rehabilitative evaluations could be performed, following which a decision could be made. What I am arguing for would not make it legal for medical practitioners in the country to simply start killing off their patients. Not everyone is simply allowed to access a service of abortion. In a similar way then, this service will be allocated and given to *those who need it most*.

I end off with this quote from Velleman, because I could not say it better myself:

> *I believe that the proper goal of medical science is, not to prolong life per se, but rather to make human life better – often by prolonging it, of course, but also by relieving pain, restoring function, or facilitating natural processes. And I know of no cogent reason why facilitating the process of death, when death would be a benefit, is a less appropriate activity for medical practitioners than that of facilitating the process of birth. I therefore believe, not only that a patient can have a moral right to passive or even active euthanasia, but also that his physician may be the appropriate person to provide it.* (Velleman, 1992, pp. 667-8)

References

Abrams, A., (2015). *Assisted Suicide Law In Germany Passes Despite Concerns Over Nazi Association.* [Online]
Available at: https://www.ibtimes.com/assisted-suicide-law-germany-passes-despite-concerns-over-nazi-association-2172889
[Accessed November 2018].

Benatar, D., (2006). *Better Never to Have Been: The Harm of Coming into Existence.* Oxford: Clarendon Press.

Bole, T., (1991). Double Effect: theoretical and bioethical implications.. *Journal of Medicine and Philosophy,* 16(Special Issue), pp. 467-585.

Boudreau, D. & Somerville, M., (2013). Euthanasia is not medical treatment. *British Medical Bulletin,* Volume 106, pp. 45-66.

Brassington, I., (2006). Killing people: what Kant could have said about suicide and euthanasia but did not. *Journal of Medical Ethics,* Volume 32, pp. 571-4.

Brennan, J., (1990). *Cruzan v Director, Missouri Department of Health, et al 97 US 261,* s.l.: s.n.

Chaskalson, P., (1997). *Soobramoney v the Minister of Health (KwaZulu-Natal) 1998 (1) SA 765 (CC), 1997 (12) BCLR 1696.* s.l.:Constitutional Court of South Africa.

Cohen-Almagor, R., (2015). An argument for physician-assisted suicide and against euthanasia. *Ethics, Medicine and Public Health,* Volume 1, pp. 431-441.

CRSA, (1996). *The Constitution of the Republic of South Africa, Act No. 108.* [Online]
Available at: http://www.justice.gov.za/legislation/constitution/SAConstitution-web-eng.pdf

CTOP, (1996). *Choice on Termination of Pregnancy Act, No. 92.* [Online]
Available at:

https://www.parliament.gov.za/storage/app/media/ProjectsAndEvents/womens_month_2015/docs/Act92of1996.pdf

Dignitas, (2018). *Countries with End-of-Life help laws and/or regulations.* [Online]
Available at:
http://www.dignitas.ch/index.php?option=com_content&view=article&id=54&lang=en
[Accessed November 2018].

Doukas, D. & Brody, H., (1992). After The Cruzan Case: The Primary Care Physician And The Use Of Advanced Directives. *Journal of the American Board of Family Practice,* Volume 5, pp. 201-6.

Dworkin, R., (1994). *Life's Dominion.* New York : Vintage Books.

Harris, S., (2010). *The Moral Landscape: How Science Can Determine Human Values.* London: Bantam.

Hogan, B., (2009). *Regulations Defining the Scope of the Profession of Medicine.* [Online]
Available at:
http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/legislations/regulations/mdb/regulations/regulations_gnr_237_2009.pdf

HPA, (1974). *Health Professions Act No. 56.* [Online]
Available at:
http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/legislations/acts/health_professions_ct_56_1974.pdf

Huxley, A., (1932). *Brave New World.* New York: Harper Brothers.

Mill, J. S., (1859). *On Liberty.* London: Longman, Roberts & Green.

NHA, 2003. *National Health Act, No. 61.* [Online]
Available at: https://www.gov.za/sites/default/files/a61-03.pdf

Okon, T., (2018). *Overview of comprehensive patient assessment in palliative care.* [Online]
Available at: https://www.uptodate.com/contents/overview-of-comprehensive-patient-assessment-in-palliative-care?search=palliative%20care&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1
[Accessed 13 February 2019].

Prokopetz, J. & Lehmann, L., (2012). Redefining Physicians' Role in Assisted Dying. *The New England Journal of Medicine,* 367(2), pp. 97-9.

Quill, T. & Battin, M., (2004). *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice.* Maryland: Johns Hopkins University Press.

Quill, T. & Battin, M., (2018). *Physician-assisted dying: Understanding, evaluating, and responding to requests for medical aid in dying.* [Online]
Available at: https://www.uptodate.com/contents/physician-assisted-dying-understanding-evaluating-and-responding-to-requests-for-medical-aid-in-dying?search=euthanasia%20and%20physician%20assisted%20death&source=search_result&selectedTitle=1~22&usage_type=default&displ
[Accessed 4 March 2019].

Rachels, J., (1975). Active and Passive Euthanasia. *The New England Journal of Medicine ,* 292(2), pp. 78-80.

Sachs, J., (1997). *Thiagraj Soobramoney versus Minister of Health (KwaZuluNatal); Case CCT32/97,* s.l.: Constitutional Court of South Africa.

SALC, (1997). *Euthanasia and the Artificial Preservation of Life - Discussion Paper 71,* s.l.: South African Law Commission.

SALC, (1998). *Euthanasia and the Artifical Preservation of Life - Project 86,* s.l.: South African Law Commission.

Seale, C., (2006). Physician Assisted Dying: the Case for Palliative Care and Patient Choice - edited by Quill, T.E. and Battin, M.P.. *Sociology of Health & Illness,* Volume 28, pp. 661-2.

Staden, M. v., (2018). *Is the South African Constitution the 'Best in the World'?.* [Online]
Available at: https://rationalstandard.com/is-the-south-african-constitution-the-best-in-the-world/
[Accessed 5 March 2019].

Tännsjö, T., (2005). Taking the Final Step: Changing the Law on Euthanasia and Physician Assisted Suicide. *The British Medical Journal,* 331(758), pp. 689-691.

Velleman, D., (1992). Against the Right to Die. *The Journal of Medicine and Philosophy ,* Volume 17, pp. 665-681.

Vos, P. D., (2010). *Constitutionally Speaking.* [Online]
Available at: https://constitutionallyspeaking.co.za/on-euthanasia/
[Accessed 10 February 2019].

WHO, (1946). *Preamble to the Consitution of the WHO,* New York: International Health Conference .

Willingham, R. & Edwards, J., (2017). *Voluntary assisted dying bill passes Victoria's Upper House, state set to make history.* [Online]
Available at: https://www.abc.net.au/news/2017-11-22/euthanasia-victorian-parliament-passes-assisted-dying-laws/9156016
[Accessed November 2018].