

# Last Rights

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**I**s an advance directive to refuse medical treatment recognised in our legal system? An advance directive is a document prepared by a person while competent in anticipation of a situation when he no longer has the legal capacity to make legal decisions.

This examination places us directly in the realm of euthanasia. This emotive topic is not just restricted to the esoteric realm of philosophy but impacts on daily social interaction and the law that governs conduct.

The debate was reactivated by the current media attention around Professor Sean Davison who, on his release from a five-month house detention in Christchurch, joined forces with the group Death with Dignity, which is currently gathering signatures for a petition to legalise euthanasia.

### Euthanasia

Euthanasia has also become relevant in response to the dramatic advances in medical technology leading to longevity and the prolongation of the lives of those terminally ill. The general secularisation of society and the emphasis placed on human rights have fuelled the debate.

The debate in South Africa arose when the current organisation SAVES – the Living Will Society requested research by the South African Law Commission (viz South African Law Commission, Discussion Paper 71/Project 86) culminating in a draft bill titled The

Rights of the Terminally Ill Act alternatively End of Life Decisions Act. The bill must still be debated in parliament.

Advance directives relate to a specific form of euthanasia, necessitating an introduction of the forms recognised.

### Voluntary Passive Euthanasia

Voluntary passive euthanasia refers to a situation where a patient, who is legally competent, refuses the commencement or requests the withdrawal of medical intervention on the basis that it will merely prolong his suffering in the absence of an imminent cure. Compliance with this instruction will usually hasten the death of the person. The right to refuse medical treatment by a patient who has the necessary mental capacity is recognised in our common law. This stems from the fundamental right to self-determination (viz *Castell v De Greeff* 1994 4 SA 408(C)).

In situations like this a patient will often request relief in the form of medical drugs to alleviate suffering. The administration of palliative intervention may have a secondary effect of hastening the patient's death, which is referred to as a double effect. Strauss maintains that if the medical practitioner, in administering palliative medication, acted in good



Jacobs

## Humanrights law

faith and used the normal drugs in reasonable quantities with the object of relieving pain and without the direct intention of causing the death of the patient, the actions will be lawful (*viz* S A Strauss, *Doctor, Patient and the Law*, 3rd edition, Pretoria, J L van Schaik Publishers, 1991, page 345).

### Assisted Suicide

Leading on from this, is a further variation of euthanasia called assisted suicide. This occurs when the means are supplied by a third person to facilitate the act that ultimately causes the patient's death. The patient may, for instance, request a hypodermic needle containing lethal drugs in order to self-administer a fatal injection. The latter form is referred to as physician assisted suicide.

In our law, to aid and abet a suicide is unlawful and the person can be found guilty of murder (*viz* Ex Parte Die Minister van Justisie: In re S v Grotjohn 1970 2 (SA) 355 (A)).

### Voluntary Active Euthanasia

In this situation, a person intervenes to terminate the life of a person experiencing unbearable pain and suffering by, for instance, administering a lethal injection. In South Africa, such an act would be criminally unlawful.

Interestingly, an analysis of case law illustrates that our courts tend to accept a legal justification for this act or, where the person has been found guilty, to apply lenient punishment. In *S v Hartmann* 1975 (3) SA 353(C), a matter whose facts were similar to those of the *Davison* case, a medical practitioner was found guilty of murdering his father by administering a lethal dose of medication. The sentence was that he be detained until the rising of the court, and the remaining one-year sentence was suspended. He was, however, removed from the roll as a medical practitioner, illustrating the dire civil consequences.

### Involuntary Euthanasia

Common to all these is the patient's competence to make a decision and make his request known – the variable being his capability to execute the plan or not.

What, however, of the situation of the patient who is incompetent – such as a person who is unconscious or comatose or in a vegetative state – but who is patently suffering and has no prospect of recovering. In such a situation, another person may be moved by sympathy and compassion to terminate the patient's life, either by an omission or by a positive act. In these circumstances, there is no request or act by the patient himself to terminate his life. This form of euthanasia is unequivocally unlawful and unlikely to be tolerated, no matter how noble the motives.

However, it is lawful for a medical practitioner to discontinue medical support on his own volition if clinical death has set in. For legal purposes, the definition of death in section 1 of the National Health Act (61 of 2003) has settled the question of whether death is evident by referring to irreversible loss of spontaneous circulatory and respiratory functions or lack of brain stem activity, that is, so-called brain death.

### Prospective Voluntary Passive Euthanasia

But what of the situation where the person wishes to plan and make known his intentions, in anticipation of a situation when he may wish to

end his life, or express a wish to do so, at a time when he is not competent or able. This advance directive could take two forms: he could prepare a document requesting this or, alternatively, he could appoint an agent who would make these decisions for him and communicate them on his behalf when he is unable to communicate his wishes himself.

These documents generally have two objectives: first, they speak for the patient when he is unable to make and verbalise decisions and second, they give guidance to the medical practitioner and, in so doing, indemnify the practitioner from civil and criminal liability.

While scholars such as Jordaan (*The legal validity of an advance refusal to medical treatment in South African Law, De Jure Law Journal*, 3 and 4 2011) argue that advance directives should be recognised as an expression of consent to treatment and/or refusal of medical treatment, it is clearly not the common law position, nor is there any statutory recognition of either the living will or the enduring power of attorney in our jurisdiction.

The only case in which a living will is mentioned is *Clarke v Hurst NO and Others* 1992 4 SA 630 (D). In a definitive decision, the court expanded the grounds on which active euthanasia may be exercised to include patients in a permanent vegetative state but it did not recognise or rule on the status of a living will.

Dr Clark had suffered a heart attack and would have died had he not been resuscitated. He suffered irreversible brain damage and was diagnosed as being in a permanent vegetative state. He was kept alive by nasogastric feeding. Clark's wife approached the court four years later to be appointed as his *curatrix personae*. The court ruled that she would not be acting unlawfully in authorising the withholding of his life support system. She did so and he died some days later.

However, the court was not prepared to recognise the patient's right to self-determination. The fact that the patient had executed a living will was not determinative in its decision to allow the patient to die. In response to the contention by the patient's curator *ad litem* that effect be given to the patient's advance directive, the court stated at 638 G-H: "the *curator personae* is at all times under a duty to act in the best interest of the patient and not necessarily in accordance with the wishes of the patient". This is in stark contrast to the substituted judgement test where the proxy or medical attendant decides what they believe the patient would have decided if competent.

In the absence of the promulgation of law or the pronouncement of a court of law on the validity of a living will, the status of these documents remains uncertain. Nonetheless it is suggested that individuals with firm views on life-sustaining treatment or the prolonging of life prepare advance directives.

I propose that the following guidelines – which will counter many of the inherent reservations – be adhered to in the absence of statutory rules. The directives should be:

- couched in terms that are clear but that have a general applicability;
- in printed form;
- signed by the grantor;
- dated;
- witnessed by two competent witnesses who have no interest in the grantor's estate;
- reviewed periodically and made known to the next of kin, supervisory authorities and medical attendants.

## Human rights law

### Proxies

Various legal systems recognise a power of attorney that enable a principal to entrust an agent with decision-making powers regarding the principal's medical treatment and care. Such a power may be embellished by wishes not to be kept alive, akin to a living will.

In South African law, however, a power of attorney lapses when the principal becomes incompetent. The South African Law Commission investigated the viability of an enduring power of attorney, but this came to naught. A subsequent investigation by the Law Commission considered the issue afresh (Discussion Paper 105/Project 122, "Assisted decision-making: Adults with impaired decision-making capacity" 2004).

The commission recommended that an enduring power of attorney and a conditional power of attorney be introduced into law. The former would endure the subsequent incapacity of the principal while the latter would come into operation only on the incapacity of the principal. It was specifically mooted that it should be possible to grant such a power not only in respect of property or financial affairs but also in respect of personal welfare, if expressly granted, albeit subject to certain safeguards around execution and supervision. Importantly, further restrictions on an agent's authority proposed that it was not to be exercised while the agent was still capable.

It was not to extend to giving consent in terms of the Mental Health Care Act of 2002, and the powers in respect of consent to accept or refuse medical treatment of the patient in accordance with the National Health Act were to be circumscribed. The recommendations were unequivocal on that score: the power of consent should not extend to refusing consent to carry out or continue life-sustaining treatment.

### National Health Act (62 of 2003)

The promulgation of the National Health Act has arguably introduced an informal method for the appointment of proxies to make health care decisions that may overcome the common law restrictions.

The Act provides in s7 that, subject to s8, a health service may not be provided to a patient without his informed consent or by a person mandated by the patient to give informed consent.

Regrettably, s8 is rather confusing, as it goes on to state in ss1 that, if the informed consent is given by a person other than the patient, that person must, if possible, consult the patient before giving the required consent. The words 'if possible' could indicate the Act's recognition that consultation may not be possible because the patient was mentally incompetent at the time the consent was required.

However, ss3 then goes on to state that, in the event that a patient is unable to participate in a decision affecting his treatment, he must be given full information of the treatment afterwards. In this section, there is no reference to "possible." Clearly, the lack of certainty whether a patient will recover to a state of competency may cause this to be worthless provision. Similarly, this could logically exclude the withholding of treatment, which in all likelihood would undermine the possibility of recovery.

Though the Act is not without problems, the consensus is that a written proxy mandate takes precedence over the wishes of relatives or partners and that is binding, irrespective of whether the patient is temporarily or permanently unable to give consent, unless a court orders otherwise

## Humanrights law

(viz *Mc Quoid - Masson, Advance Directives and the National Health Act*, SAMJ vol 96 no 12 December 2006).

### Health Care Guidelines

Pontification aside, it is the health care professionals who find themselves at the coalface of this inherent dilemma when they are confronted with patients and family at this important crossroad. It is thus instructive to take note that the Health Care Profession published a visionary and definitive document containing the relevant ethical guidelines (viz Health Professions Council of South Africa (HPCSA), *Guidelines for Good Practice in Health Care Professions* (2008), Booklet 12, *Guidelines for Withholding and Withdrawing of Treatment*)

The fundamental basis of the document is recognition of a patient's autonomy, which includes the right to refuse treatment. The guideline is premised on the assumption that the National Health Act grants patients the right to give a written mandate of wishes, and it thus promotes the application and acceptance of both living wills and enduring powers of attorney. The law appears at the rearguard, and is not in harmony with normative medical practice.

### Constitutional arguments

Since the *Clark* decision, the Constitution (Act 108 of 1996) has become the supreme law of the land. and it is thus relevant to consider how the current law in respect of euthanasia weighs up against relevant rights as codified in the Constitution.

Control over one's body as a facet of the right of self-determination – s12 (2) (b) of the Constitution – may be interpreted widely as the right to choose the time and manner of one's own death.

The right to dignity and to have that dignity preserved and protected by the patient may be impaired if physical and mental deterioration result in dependence on family/friends and/or professional caregivers for the patient's basic needs.

A further right that may be relevant is s11, which simply provides that everyone has a right to life. While the obvious focus is the preservation of life, it is contended that this right is more than a right to mere existence but also the right to be treated as a human being with dignity. This signifies a certain quality of life, and implies that, when that quality is absent, it could translate into a right to die.

A right to privacy – s14, grants the patient the right to make certain fundamentally private choices without state interference. The choice of how to lead your life arguably extends to how, in certain circumstances, to end your life.

It appears that the differentiation between a patient who requests withdrawal of treatment and a patient who requests active physician assistance may fall foul of the right to equality, viz s 9. So too may the different recognition of a contemporaneous request against an advance request be unfair discrimination, if it is based on a factor such as the disability of the patient who is no longer competent.

It can be argued that the absence of choice as to whether a patient wishes to consent to a physician-assisted procedure to cause death, on the patient's request to end unbearable suffering and pain, may deprive him of emergency health care guaranteed in s27 of the Constitution.

Religious freedom, as protected in s15, may also be relevant in that the resistance to accede or sanction a request to end life is primarily founded

on the sanctity of life, central to most religions. This view, even if held by the majority, is not universally shared however, and should be a matter of personal conscience.

It is thus not surprising that Jordaan concludes that a blanket prohibition of voluntary active euthanasia is at least *prima facie* unconstitutional (viz "The right to die with Dignity: Considering Constitutional arguments", *Tydskrif vir Heedendagse Romeinse Hollandse Reg*, 2009 (72)). The same reservations are relevant in the case of advance directives.

### Arguments against euthanasia

Arguments against euthanasia founded on different ideologies arise from various quarters and find expression in different disciplines. It is illuminating to juxtapose some of the more common arguments against the constitutional approach.

The core religious argument is that God has allocated a specific time and death for each person. From a secular perspective, the prohibition against intentional killing is the cornerstone of social relationships and the law. The consent granted by a person who is in extreme pain is questionable. Practitioners can make diagnostic and prognostic errors. The so-called slippery slope arguments are that it is difficult to set secure limits and provide adequate safeguards; this situation may consequently lead to abuse and wide-scale indiscriminate application. It is held that the right to refuse medical assistance is far removed from the right to request assistance in dying. A concern exists, however, that vulnerable people, such as the poor and the elderly, would experience pressure and thus request early death.

An aspect of euthanasia that has been largely ignored in the debate is that a person and his estate are intertwined, and that this may bring about complex tensions and influence the choices made. As individuals have to assume greater responsibility for their financial future, particularly given longer life spans, they may not have sufficient funds, or even run out of funds, that would allow them to benefit from advanced medical interventions. The erosion of limited funds by medical expenses might leave surviving dependents with insufficient funds for maintenance. When others become involved in the decision-making process, it must be examined to what extent depletion of potential inheritance by ongoing medical expenses could influence them and what safeguards could be put in place.

### Recommendations

It is recommended that the legislator give impetus to the recommendations of the South African Law Commission, acknowledging the right of a person to give advance directives in respect of refusing medical treatment, and thus placing them on a secure footing.

In the interim, it is advisable for individuals to have open conversations with their significant others and unambiguously communicate their views on these matters. This should be followed up with the prudent step of recording their views in an advance directive and simultaneously appointing a proxy in accordance with the National Health Act.

The groundswell movement advocating assisted euthanasia should be acknowledged and the matter put up for debate. Hopefully this will result in the promulgation of law, which will bring legal certainty. ♦

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