SHOULD PASSIVE EUTHANASIA BE MADE LEGAL IN SOUTH AFRICA?

A MINI-DISSERTATION SUBMITTED TO THE NELSON R. MANDELA SCHOOL OF LAW AT THE UNIVERSITY OF FORT HARE, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF ARTS IN HUMAN RIGHTS (MA IN HUMAN RIGHTS)

BY

RUMBIDZAI ELIZABETH PORTIA CHIDOORI

SUPERVISIOR: PROFESSOR NS REMBE, FACULTY OF LAW

CO-SUPERVISOR: DR SW REMBE, FACULTY OF EDUCATION: SCHOOL OF POST GRADUATE STUDIES

DATE: 04 December 2009

ABSTRACT

In 1999 the South African Law Reform Commission proposed a draft bill on End of Life Decisions and tabled the Bill before Parliament. To date the Bill is still yet to be put up for discussion perhaps due to the sensitive nature of the subject. This mini-dissertation will examine South African people's perception and awareness of passive euthanasia and whether the procedure should be regulated. The research will look at the current position in South Africa, arguments for and against passive euthanasia, and the factors influencing society's reactions to this growing phenomenon.

DECLARATION

I **RUMBIDZAI ELIZABETH PORTIA CHIDOORI, STUDENT NO: 200437682** declare that this dissertation is my work and that it has not been submitted for any degree or examination in any other university. All the sources used or quoted have been duly acknowledged.

Student: RUMBIDZAI ELIZABETH PORTIA CHIDOORI

Signature: ____________________

Date: ____________________

Supervisor: PROFESSOR NS REMBE

Signature: ______________________

Date: ______________________

ACKNOWLEDGMENTS

I could not have achieved the completion of this dissertation without God's love and blessings. I appreciate the love, support, dedication and inspiration from my parents Mr and Mrs Mavunduse and family. I am greatly indebted to my supervisors Professor NS Rembe and Dr SW Rembe for their patience, meticulous guidance, analysis and encouragement throughout this dissertation. I am especially grateful to PPS Insurance for their financial assistance.

I am sincerely indebted to the UNESCO, Oliver Tambo Chair of Human Rights, University of Fort Hare for granting me the opportunity to study in this challenging programme. Thanks to Lindani Ncube, Nokuthula Mbayiwa, Doreen Hove and Garfield Ndlovu, I am grateful for your friendship and encouragement, which motivated me during difficult moments. Many thanks to the MA in Human Rights class of 2008.

TABLE OF CONTENTS

Abstract…..……………………………………..…......................................….i

Declaration……………………………………………………………..………… ii

Acknowledgements……………………….…………………………………..….iii

Table of contents…………………….…………………………………….……..iv

CHAPTER 1: INTRODUCTION

1.1Background of study…..1

1.2 Problem statement 7

1.3 Purpose of study………………..…………………..………..…………….....…12

1.4 Research question and objectives……………………..…………………...….13

1.5 Hypothesis/Assumptions of the study. …………………………… ………..…13

1.6 Delimitations of the Study……...………………………………………………13

1.7 Limitations of the study……………………………………………….......…14

1.8 Significance of study 14

1.9 Overview of the Chapters………………………………………………………..15

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction……………………………………………………….…..….....…16

2.2 The Right to Die. …………… ……………………..……...……….............17

2.3 Human Rights and the Sanctity of life…………..……………………..…….....21

2.4 Living Wills /Advance Directives. ..……………….....……………………………25

2.5 The Slippery Slope..…………………..……………………..…………….25

2.6 Cultural Influences………………………………………………………….........27

CHAPTER 3: RESEARCH METHODS

3.1 Research Method ……………………………..………..…………………29

3.2 Research Design……………………………………….………………..29

3.2.1 Questionnaires………………………………………….…….……….30

3.2.2 In-person and Telephonic Interviews……………………..…………...31

3.3 Methodology……………………………………………………….........32

3.3.1 Sampling Procedure- Questionnaires…………………………….......33

3.3.2 Sampling Procedure-Interviews………………………………………….34

3.4 Ethical Considerations…………………………………………………….34

CHAPTER 4: RESEARCH FINDINGS AND ANALYSIS

4.1 Analysis of Questionnaires……………………………………..……..36

4.2 Responses to open-ended questions……………………………...….40

4.3 Analysis of data……………………………………………………..….40

4.4 Results from Interviews……………………………………..………..42

4.5 Analysis of data……………………………………….…………..42

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion………………………………….………..……………………….. 44

5.2 Recommendations…………………….…………..………………….….47

5.2.1 Legislative regulation of passive euthanasia…………………………..….47

5.2.2 Mechanisms to review decisions of doctors…………………..…………47

5.2.3 Awareness of education…………………………………………………..47

5.2.4 Recommendations of SALRC…………………………..…………………47

APPENDICES

Appendix A - Questionnaires……………………………………………………………49

Appendix B -Interview schedule…………………………………………………...53

Appendix C- Consent Form……………………………………………………..……54

BIBLIOGRAPHY……………………………………………………………………….55

CHAPTER ONE: INTRODUCTION

1.1. Background of the study

Euthanasia is the deliberate termination of a person's life in order to end suffering. It is commonly known as 'mercy killing'. There are two types of euthanasia, namely; active voluntary euthanasia and passive voluntary euthanasia. The former is an action or series of actions intended to terminate a person's life, while the latter is inaction/ withholding/withdrawing treatment, care or assistance with the intention of terminating one's life. Both active and passive euthanasia may also be non-voluntary. The act in active euthanasia and the omission in passive euthanasia may be done without the patient's request.

This study deals mainly with passive euthanasia. Presently, South African common law states that it is unlawful to terminate a person's life in order to end his/her unbearable pain and suffering even if death is inevitable or imminent.[1] The intentional termination of a suffering person's life is considered as murder irrespective of whether such a person expressed the wish to die or even begs to be killed[2]. However, withholding or withdrawing life-sustaining medical treatment from a terminally ill patient may be permissible under specific circumstances and subject to certain conditions.[3] The two positions stated above seem to be contradictory and have brought about some degree of uncertainty about the legal position of terminally ill and dying people. South African statutory law is silent on

---

[1] South African Law Commission Report on ***Euthanasia and the Artificial preservation of life***-Project 86, November 1998 (hereafter referred to as Project 86).
[2] Ibid.
[3] Ibid.

the subject. According to H. Khuse, [4] nearly 40% of all deaths and 54% of all non-acute deaths are the result of a medical end-of-life decision and or euthanasia. This indicates that South African doctors are already performing euthanasia albeit secretly for fear of exposure to civil claims, criminal prosecution or professional censure.

Families and doctors want to act in the best interests of the patient but they are unsure of the scope of their obligation to provide care[5]. Over recent years, there has been much greater emphasis on patient autonomy worldwide and informed consent is required before a doctor can commence a medical procedure with a few exceptions such as where the patient is unconscious. The debate on euthanasia generally has been argued around the principle of autonomy, the distinction between killing and letting die (notion of intent), the relief of pain and suffering, and the 'slippery slope argument'[6] or the arbitrariness of the limits. Greater patient autonomy has brought into play a concept known as a 'living will', also known as an 'advance directive'. The latter often contains a declaration that one does not wish to have one's life prolonged by artificial means[7]. It is generally agreed that the patient's informed consent is what makes the doctor's actions

---

[4] Khuse H, ***No to the Intention/foresight distinction in Medical end-of –life decisions***-Paper Presented at the 11th World Congress on Medicine and Law held at Sun City on July 28-August 1 1996. In a more recent survey conducted by The Ethics Institute of South Africa in 2001, 49 % of the respondents indicated that they would consider ending their lives should they suffer from a terminal illness. (*presentation by Anita Kleinsmidt on* ***Palliative Care: Law & Ethics****, 2008)*

[5] Supra note 1

[6] '*The slippery slope argument states that many people worry that if euthanasia were to be legalised it would not be long before involuntary euthanasia occurs. There is a concern that vulnerable peoples such as the elderly will feel pressure whether real or imagined to request an early death. However those who oppose the slippery slope argument insist that properly drafted legislation may draw a firm barrier across the slippery slope'.* -BBC Religion and Ethics.

[7] Media Statement by the SALC concerning its investigation into Euthanasia and the Artificial Preservation of life.

lawful. Where patients, while 'of sound mind', have given definite instructions regarding the type of treatment they will not accept under particular circumstances, a doctor who is aware of these instructions and disregards them is in the wrong, and may be liable for damages.

In 1999, the South African Law Commission (SALC)[8] completed and submitted a report to the Minister of Health, which contained recommendations regarding end-of-life decisions, the treatment of terminally ill patients and a Draft Bill on Euthanasia. The SALRC carried out an investigation to determine whether there was a need to legislate euthanasia. The results indicated that the majority of respondents recommended that formal legislation be adopted to remove legal uncertainty for doctors, patients and families.[9]

The proposed law specifically provides for the conduct of a medical practitioner in the event of clinical death. A clear distinction is made between palliative care and active and passive euthanasia. Palliative care is defined as the treatment and care of a terminally ill patient, not with a view to curing the patient but rather to relieve suffering and maintain personal hygiene.[10] In the event that the medication causes the death of the patient in the long run but pain relief in the short term, the medical practitioner will escape civil and criminal liability or both

[8] Is now known as South African Law Reform Commission as amended by Judicial Matters Amendment Act of 2002 (hereafter SALRC).
[9] Project 86, page 17.
[10] ***Euthanasia and the law***, Medico-Legal Articles- www.hasa.co.za/generic_article.asp?id=21 Accessed 29/02/2008.

provided there was no intention to kill[11]. The SALRC does in this regard attempt to clear the uncertainties faced by medical practitioners and families of the patient who are involved in euthanasia. The report by the SALRC was tabled before parliament on March 2nd 2000, but is yet to be decided upon. Perhaps the delay may be due to the sensitivity and controversial nature of the subject.

The SALRC did however state that it agrees with the law in terms of active euthanasia and that physician-assisted-suicide should remain criminalized. The Commission reasoned that the arguments in favour of legalizing the aforementioned types of euthanasia are insufficient to weaken society's prohibitions of intentional killing in a manner that would be impossible to establish sufficient safeguards to prevent abuse.[12]

On the international scene countries that have legalized euthanasia are; The Netherlands (2002); Belgium (2002); and Luxembourg (February 2008).[13] In the Northern Territory of Australia it was legalized in 1995 and overturned in 1997 owing mainly to pressure from religious groups.[14] In Colombia the status is still unclear; it was approved by the Constitutional Court in 1997 but never ratified by Congress.[15] The practice in Japan is illegal in the Japanese Criminal Code, but a 1962 court case, usually cited as the "Nagoya High Court Decision of 1962,"

[11] Ibid.
[12] SALC Bulletin, Newsletter of the South African Law Commission, Vol 4 No. 2, July 1999, pg2.
[13] ***International Perspectives Euthanasia and Assisted Suicide***- www.euthanasiaprocon.org –Accessed 24/03/08
[14] Ibid at page 1.
[15] Ibid at page 2.

ruled that one can legally end a patient's life if six specific conditions are fulfilled.[16] The conditions are as follows:

- the patient's situation should be regarded as incurable with no hope of recovery, and death should be imminent;
- the patient must be suffering from unbearable and severe pain that cannot be relieved;
- the act of killing should be undertaken with the intention of alleviating the patient's pain;
- the act should be done only if the patient him or herself makes an explicit request;
- the euthanasia should be carried out by a physician, although if that is not possible, special situations shall be admitted for receiving some other person's assistance, and
- euthanasia must be carried out using ethically acceptable methods.[17]

Although in the UK it is still illegal, according to a British Medical Journal Report, many UK doctors who had been faced with euthanasia have nonetheless acceded to the request.[18]

One must understand that it is not possible to view the euthanasia debate in purely legal and scientific perspectives; religious and moral considerations must also be taken into account as the *boni mores* of society may be an important

---

[16] Ibid at page 2.
[17] http://www.bioethics.jp/licht_adv8.html- Accessed 24/03/08.
[18] British Medical Journal publishes euthanasia opinions-http://www.news-medical.net/?id=13293 Accessed 24/03/08.

phenomenon in determining the law. This study seeks to question South African people's perceptions on euthanasia. Its also provides a critical comment on the Draft Bill submitted by the SALRC. It further discusses the reasons why euthanasia should be legalized. The study also seeks to answer these questions:

- Should Doctors continue to act according to a patient's directive to withhold life support or prescribe drugs, which may alleviate pain but also shorten the patient's life whilst risking civil or criminal liability?
- Should the patient be kept alive as long as medical technology allows and at whatever cost?
- Does his/her family have the right to decide whether medical treatment should be withdrawn or maintained?
- Does a patient or member of the family of the patient have the legal right to decide on how the patient should die?
- Can euthanasia be morally or legally justified within the context of the South African community and if so, will the end justify the means?

1.2 Problem Statement

Society today is grappling with the reality of pain and suffering whilst at the same time trying to remain faithful to the sanctity and inviolability of human life and the integrity of the medical profession. Those who are pro euthanasia argue that euthanasia can be justified especially when motivated by the individual's need for human dignity and freedom from suffering. It is true that the mere prolongation of life by artificial means in cases where death is inevitable can result in

unnecessary suffering not only of the patient but of their family members too. New technologies have already condemned enough people to a limbo between life and death. Such patients who are usually in a persistent vegetative state or in an irreversible coma, devoid of any pleasure, sensation or comprehension, have been referred to as 'prisoners of technology'.[19]

In South Africa it appears that doctors are already practicing euthanasia privately; this implies that South African people are requesting it.[20] However, most of these cases go unreported due to fear of repercussions, civil and or criminal liability. In such situations, the abuse of euthanasia is likely to go unnoticed and unpunished. On the one hand, the common law criminalizes euthanasia, whilst on the other hand the same common law allows a patient to order a doctor to withdraw/withhold life-sustaining treatment should he/she suffer from an incurable disease or enter into a persistent vegetative state. Should people continue to endure costly legal battles every time a euthanasia case happens? Clearly legal intervention is required to clarify this uncertainty. Therefore, the legislature needs to enact appropriate statutory law to deal with such. If passive euthanasia is legalized, then regulation of the practice would be one possible safeguard that can be put in place to prevent medical practitioners from crossing the limits of legalized euthanasia.

[19] Brody B. Eugene, (1993) **Biomedical Technology and Human Rights**, UNESCO Publishing, Paris page 191.
[20] Project 86.

In 2005, a study found out that 70% of adult South Africans were in favour of passive euthanasia of a brain dead-person[21]. According to Landman,[22] a number of doctors in South Africa would be willing to perform euthanasia at the request of their patients once the controversial practice was legalized in the country. Unfortunately, there is no available scientific data to indicate the exact number of doctors in favour of performing euthanasia.[23] However, in general attitudes have indicated positive results.

Furthermore, in the absence of hard and fast rules, it is difficult for medical practitioners to explain the legal position to patients and families concerning the law, since the existing law is inadequate or unclear. Despite the fact that the law does not yet recognize a living will, to date the South African Living Will Society already, has a membership of more than 20 000.[24]

This question was also dealt with in the case of *Clark v Hurst NO*.[25] In this case, the patient had a heart attack which led to serious brain damage and a deep comatose from which he never regained consciousness. His wife, the applicant in this case, applied to the Court for a declaratory order whereby she would be appointed *curatorix persona* to the patient. This would give her the power and

[21] Results of a Telephonic survey conducted by Research Surveys among 493 adults in urban areas.- http://www.news24.com/News24/South_Africa/News/0,,2-7-1442_1761536,00.html- Accessed 07/03/08.
[22] Landman Willem (member of SALRC), "***Many Doctors in South Africa favour mercy-killing,***" Daily Dispatch Online, Thursday, May 17, 2001- Accessed on 0//03/08.
[23] Supra note 12.
[24] ***Planning for Future Medical Treatment***-AIDS Law Project- www.alp.org.za/modules.php?op=modload&name=News&file=article&sid=115 Accessed 07/03/08.
[25] 1992 (4) SA 630 (D).

capacity to authorize the continuance of any further medical treatment or feeding to her husband.

The respondent opposed the application on the grounds that the proposed action would be *prima facie* unlawful and that the Court did not have authority to tie his hands with an order as proposed. Medical evidence was placed before the Court and the Court decided that the Applicant would not act unlawfully by authorizing the cessation of the artificial feeding of the patient, even though this would hasten the patient's death. This decision therefore confirmed the general trend in legal systems that the life of a patient who is in an irreversible vegetative state may be ended by the cessation of life-sustaining mechanisms. However, such situations must be approached cautiously so as to avoid the termination of life for scrupulous reasons such as cashing in on life insurance policies.

In another case, *S v Hartmann*[26], the accused, a medical practitioner, euthanized his 87-year-old father who was suffering from an advanced stage of prostate cancer. At this stage the father had been on symptomatic treatment and there was no longer any question of a cure; he was bedridden, emaciated and in great pain for which pain-killing drugs were administered. On that fateful day he had been given morphine by a nursing sister. An hour after, the accused placed another dosage of morphine into his drip and a few hours later injected him with Pentothal. The deceased died within seconds. The accused was found guilty of murder regardless of the medical evidence adduced that the deceased was in a

[26] 1975 (3) SA 532 (C).

critical condition and that he would have died as little as a few hours later. Although the accused was sentenced to one year imprisonment, he was detained only until the rising of the court and his sentence was suspended for one year subject to the condition that he would not commit an offence involving bodily injury.

Dr Hartmann was subsequently charged before the South African Medical and Dental Council with unprofessional conduct and his name was struck off the roll. However, after a certain period of time he was reinstated.[27] Strauss questions whether these rulings have transformed criminal law into criminal 'non law' in the sense that although murder is a serious crime warranting capital punishment, most euthanasia cases are a class of 'murderers' whom we do not want to punish at all[28]. Is this not evidence that society now realizes euthanasia may in fact do more good than harm in relation to patients for whom death is inevitable and are suffering great pain and/or are in a permanent vegetative state?

Another relevant factor for consideration is that euthanasia will enable the prevention of unnecessary financial burden of families of the patient. It is undeniable that medical costs are one of the highest burdens on society today. When death is inevitable, lingering for months in a nursing home or intensive care unit may leave some families bankrupt and in severe poverty in addition to the emotional and psychological pain that results from the death of a loved one.

---

[27] Strauss SA, (1984), ***Doctor, Patient and the Law: A Selection of Practical Issues***, 2nd ed, L Van Schaik (Pty) Ltd, Pretoria, page 384.
[28] Ibid.

Section 12 of the South African Constitution recognizes the right of an individual to make decisions concerning their medical treatment. It states:

> *Everyone has the right to bodily and psychological integrity including the right to make decisions concerning reproduction, security and control over their body and not to be subjected to medical or scientific experiments without their informed consent.*[29]

An article by George Devenish[30] which was influenced by the international case of *Terri Schavio* suggests the need for legal clarity on the issue of euthanasia in South Africa.[31] Statutory law has the effect of giving greater clarity, whereas the common law is only used of in the case before the court. Presently, the Constitutional Court must decide what constitutes permissible euthanasia. Meanwhile patients continue to suffer whilst the Court has to be approached at a great cost to determine whether a patient should be allowed to live or die. Is it then not logical and humane to have legislation enacted to allow such people to die with dignity and freedom from suffering?

1.3 Purpose of Study

1) To find out peoples' perceptions and awareness of euthanasia having regard to the Draft Bill on Euthanasia before Parliament.

---

[29] Constitution of the Republic of South Africa 1996.

[30] George Devenish, ***Schavio Affair Highlights need for Legal Clarity in South Africa on the Knotty Question of Euthanasia***, Cape Times, March 29 2005, Edition 1.

[31] Terri Schavio a US national had been brain dead for 15 years and was kept on life support. Her husband requested the doctors to remove her feeding tube so that she could be allowed to die and her parents opposed this move arguing that Terri was conscious. The court held in favour of the husband and the parents appealed hence the case dragged on for seven years. Terri died on 31st March 2005 after the feeding tube had been removed on the 18th of March 2005.- http://en.wikipedia.org/wiki/Terri_Schiavo- Accessed 25/05/08.

2) To come up with suggestions as to whether passive euthanasia should be or should not be legalized.
3) To contribute to South African literature and knowledge on the subject, which is currently limited from legal, moral and ethical perspectives.

1.4 Research Questions/Objectives

1) What are people's perceptions on euthanasia?
2) Why do doctors perform euthanasia despite the practice being unregulated?
3) Should euthanasia be legalized and on what basis?

1.5 Hypothesis/Assumptions of the study

1) Euthanasia should be legalized in South Africa.
2) Passive euthanasia is morally justified.

1.6 Delimitations of the study

This study is limited to South Africa, although examples will be drawn from other jurisdictions. The research was undertaken in Alice, in the Eastern Cape, mainly because the researcher is geographically located within this area. The researcher lacked the financial resources and the time to undertake the study on a much larger scale; hence the conclusions may only be suggestive and not definitive. The study sample was small, multi-ethnic, the majority of the respondents were educated and predominantly black. This enabled the researcher to get new perspectives and insights from black South Africans as

euthanasia is mostly deemed a 'western' concept. Only two medical practitioners were interviewed and the reasons are explained in methodology chapter. The researcher had to rely on other research with regard to the perspectives of doctors in South Africa.

1.7 Limitations of the study

There is always a danger of bias particularly during interviews for example the tendency of the interviewer to seek out responses that support preconceived notions. It is quite difficult to eliminate bias completely. However an awareness of the problem will enable one to exert self-control and avoid bias. Time constraints and costs were especially challenging, hence the researcher was limited to a very small sample of the population. Also contemporary literature on the subject of passive euthanasia in South Africa is limited.

1.8 Significance of the study

It is undeniable that the debate concerning euthanasia has gained momentum over the years. It has become imperative to know whether people understand the phenomena and why there have been calls to make it legal. This study shall raise an awareness of the debate surrounding passive euthanasia within the South African context. Investigations have been conducted into the attitudes of the elderly regarding euthanasia and the effect of culture on attitudes towards euthanasia.[32] The study also seeks to show that the proposed Bill on End of Life

---

[32] Thato Ramabele, **Attitudes Of The Elderly Towards Euthanasia: A Cross-cultural Study,** Masters Thesis, University of the Free State.

Decisions is a first step in reducing the uncertainty that currently plagues the issue of passive euthanasia in South Africa. There is very limited literature or studies that have been taken to investigate whether South Africa is ready to legalize euthanasia and this study therefore seeks to complement the work that has already been carried out.

1.8 Overview of the chapters

Chapter One lays down the background to the research and states the problem; it enumerates the objectives and hypothesis of study; and outlines the limitations and significance of the research.

Chapter Two examines the literature on passive euthanasia in South Africa and around the globe. It covers books, journals, internet articles, unpublished theses and print media.

Chapter Three deals with methodology, research design, research findings and analysis of the study.

Chapter Four carries our conclusions and recommendations.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The phenomenal advances in bio-medical science and technology have raised interesting philosophical, legal and moral issues of prolongation of life, euthanasia, and the right to die, among other things. In an attempt to understand these new concepts studies have focused mainly on the moral, religious, social and legal aspects of euthanasia. The word 'euthanasia' is derived from the Greek words '*eu*' (well) and '*thanatos*' (death), which mean a painless and gentle death.[33] Euthanasia is a clear example of the complex legal problems emanating from the extended frontiers of modern medicine. Nevertheless, the law must indeed define the limits in which modern science and medicine must be practiced, and in doing so, endeavor to harmonize conflicting interests.[34]

Strauss appears to agree that phenomenal developments in the field of medicine have vested in the doctor tremendous power which poses difficult problems relating to medical ethics.[35] In the United States, there have been instances in which a brain-dead woman was kept alive by machines in order to save the life of an unborn baby; some consider this to be immoral and heinous while others consider it to be a gift of life.[36] Strauss maintains that there is no neat and clear

---

[33] Strauss SA (1984), ***Doctor, Patient and the Law: A Selection of Practical Issues***, 2nd Edition, L Van Schaik (Pty) Ltd, Pretoria, page 380.
[34] Ibid at page 384.
[35] Ibid at page 385.
[36] Ertelt S, (2005) **Brain-dead Woman Gives Birth to a Baby Girl-** http://www.lifenews.com/nat1507.html - Accessed 12/12/08. Susan Torres a researcher at the American National Institutes of Health was diagnosed with stage four melanoma cancer and declared brain dead after

legal answer to the issue of euthanasia.[37] It is generally agreed that juristic notions of society that are considered to be socially acceptable usually determine the solution to a problem in such instances.[38] However, Strauss does not discuss what happens when there is a conflict between what is acceptable and what is not. Another scholar, David Potter interestingly asks: is it logical to conscript a young man and subject him to the risk of torture and/or mutilation and probable death in war and refuse an old man an escape from an agonizing end?[39] This is a difficult question to answer and the answer may depend on the moral convictions of the decision maker.

Another scholar, Margaret Otlowski,[40] notes that comparative data indicates the prevalence on non-voluntary euthanasia in jurisdictions that have not legalised assisted dying, for instance, Australia as compared to the Netherlands, which has legalised euthanasia.

2.2 The Right to Die

In respect of 'the right to die' Strauss concludes that "as jurists we must strongly support the individual's right to die even though the common law does not recognize the principle that the individual is *dominus membrorum suorum* (owner

---

the tumor hemorrhaged. She was kept on life support for three months in order to facilitate the birth of her child. Her husband and parents indicated that Susan would have wanted the doctors to do everything possible to save her unborn child. On the 2nd of August 2005,the doctors delivered by C-Section a healthy baby two months premature.

[37] Supra note 1, page 385.

[38] Ibid.

[39] Potter David (1982), **Too Soon to Die**, Welwyn, U.K. Evangelical Press, UK page 26.

[40] Otlowski M,**Assisted Dying and Legal Change**, (2007) Medical Law Review 16, page 313.

of his own bodily members)."[41] Elizabeth Ogg[42] contends that no one is chosen to be born hence there can be no right to die. It can therefore be questioned whether there is a right to life in view of the fact that no one is chosen to be born. The author does however argue that euthanasia should be legal and goes further to cite cases in which the family or the patient requested the hospital to discontinue treatment, or signed a declaration to that effect and the hospital refused to comply.[43] In these cases, the process of dying is prolonged unnecessarily and the patient suffers a great deal. Sprung states that, 'the right to die is an integral part of our right to control our destinies so long as the rights of others are not affected'[44].

In a brief but comprehensive comment on the euthanasia debate in South Africa, Strauss maintains that active euthanasia is unacceptable because it involves an intention to kill, whereas with passive euthanasia the patient is 'let' to die. However, many of the cases cited show that the accused are found guilty but only to be given lenient sentences. This gives the impression that society admits that active euthanasia is wrong but if the intention is to ease the patient's suffering and save him/her from the agony of a prolonged death, then it is understandable.

[41] Supra note 1.
[42] Ogg Elizabeth (1980), **The Right to Die with Dignity**, N.Y: Public Affairs Committee, New York.
[43] Ibid.
[44] Sprung L Charles, **Is the patient's right to die evolving into a duty to die? Medical decision-making and ethical evaluations in health care,** Journal Of Evaluation in Clinical Science, Vol 3, Issue 1, February 1997, pages 69-75.

Project 86 [45]reiterates the point that death is no longer a natural event and most patients die in institutional settings. Hence why should it be a problem to allow medical end of life decisions?

Labuschagne points out that medical science is inherently an interference with the process of nature. For instance sterilization, birth control, artificial inseminations fulfil and protect human values and hopes in spite of nature's failures[46]. This argument goes to the root of many of the arguments proposed on religious-moral grounds. If matters of life and death are to be left to nature, then one might ask why do we go to hospitals, why do we even drink pills or make use of wheel chairs or kidney-dialysis machines? In this light, are body–organ/tissue transplants or even caesarian section births also not interfering with the process of nature and is it immoral to do so?

McDougall J and Gorman M provide quite an insightful discussion of the complexities surrounding euthanasia and valuable factual information on end of life issues.[47] In the *Nancy Cruzan* case, the US Supreme court declared that the right to die was a constitutionally protected liberty, maintaining that the right to refuse treatment, including artificial nutrition or hydration is guaranteed in the US Constitution, albeit this right is not absolute[48].

---

[45] Project 86, (1998) SALRC Discussion Paper, page 6.
[46] See discussion by Labuschagne, J MT in ***Frenchay Healthcare NHS Trust v S*** (1994) 2 All ER 403(CA)
[47] McDougall J and Gorman M, (2007) **Euthanasia: A Reference Handbook,** ABC-CLIO, Oxford page 9**.**
[48] *Cruzan v Director*, Missouri Department of Health, June 25 1990 cited in McDougall J and Gorman M, (2007), **Euthanasia: A Reference Handbook,** ABC-CLIO, Oxford page 9**.**

In the above case the patient had been involved in a terrible accident and suffered extensive injuries, oxygen deprivation and lapsed into persistent vegetative state as a result. She was kept alive for four years by a feeding tube and the parents after having tried everything decided the tube be removed. The case went to court and the court ruled in favour of the Department of Health. The Cruzan's appealed and won. Their case led to the introduction of the Patient Self-Determination Act of 1990. McDougall and Gorman view this Act as an attempt to bring a sense of uniformity to advance directive and in turn, introduce greater clarification by delineating the responsibilities of the various parties:- the doctors, families, patients and health-care institutions.[49] Burnell[50] emphasizes the importance of the distinction between acts that encompass euthanasia before public policies are instituted and that is what South African Law Reform Commission (SALRC) has tried to do in Project 86.

The proposed End of Life Draft Bill deals mainly with three situations where the patient is clinically dead; competent to make decisions; or incompetent and has no prospect of recovery or improvement. The Bill allows a practitioner to act upon a request for euthanasia only if the following conditions are met namely, that the patient is suffering from terminal illness; is subject to extreme suffering; is 18 years and above and is mentally competent; has been adequately informed as to the terminal illness that he/she is suffering from and the prognosis of his/her condition and of any treatment or care that may be available; requests

[49] Ibid page 10.
[50] Burnell G, (1993) **Final Choices: To live or to die in an age of medical technology**, New York, N.Y. Plenum page 25.

euthanasia based on an informed and well considered decision; had the opportunity to re-evaluate his/her request and has persisted; and that euthanasia is the only way out for the patient to be released from his /her suffering. One may argue that this Bill is a reasonable legislative measure that could provide clarity for dying patients and their families as well as medical practitioners.

Many of those who are pro-euthanasia have proposed that the right to die should be considered as a human right. Trowell argues that everyone will die at some point and in a sense no one is eventually denied this right.[51] It has been put forward for discussion that the difficulty of recognizing a legal right to die lies in the fact that there is a more fundamental and opposite right namely, the right to life, which is an inherent part of a basic conditions on which every other right is dependent upon. In view of this, one may contend that euthanasia should not be considered as a right to die *per se*, but rather as an exception to the rule to prevent unnecessary prolongation of death.

2.3 Human Rights and the sanctity of life

The case for euthanasia is justified on three fundamental principles: mercy, autonomy and justice.[52] First, in terms of the principle of mercy, one ought to relieve the pain of another and it is more so a doctor's duty to do so for his/her patients. Secondly, the autonomy argument maintains that euthanasia is an individual's choice, as the degree of pain experienced by one can never be fully

[51] Trowell HC, (1973) **The Unfinished Debate on Euthanasia**, London, SCM Press, page 16.
[52] Battin P Margret, **Euthanasia and Physician Assisted Suicide**, Journal of Health Politics, Policy and Law, Vol 25, (2) April 2000.

appreciated by another. Lastly, the principle of justice justifies euthanasia as central to the liberties protected by the Constitution. Thus, every adult human being has the right to determine what should be done with his/her body as part of the freedom to make individual choices. Here Battin raises some strong valid points. She maintains that in the civil rights movements, evolving concepts of autonomy and self-determination have resulted in a major shift in the way we approach death.[53] Humans already play an active role in planning the course of their deaths.

The question of the sanctity of life in the face of euthanasia is explored by Glover[54] (1977). Glover states that the general taboo on killing is absolved in a war situation. Killing in a war is less serious than any other deliberate killing. He admits that the reasons for the difference of attitudes are quite complex but, nonetheless, an important question may be raised, that is, whether war is immune from moral criticism.[55] Why are people ready to accept war and yet are offended by the thought of allowing dying people to pass away in peace?[56] Why must doctors prolong the existence of life at all costs, even if it is of no benefit to the patient?

---

[53] Ibid.

[54] Glover Jonathan (1977), **Causing Death and Saving Lives**, Penguin, Harmondsworth, Middlesex, page 53.

[55] Ibid.

[56] Ibid.

Achtzen states that the Constitutional Court in many of its decisions speaks of a right to life, not of a duty to live, as evidenced in the *Soobramoney*[57] case. In this case, the appellant who was in the final stages of a chronic renal failure, claimed he was entitled to emergency dialysis given the constitutional right to life and the provision that no one may be denied emergency medical treatment. The Court rejected his application on the grounds that withholding life-sustaining treatment or rationing care is compatible with a human rights approach. Hence the right to life is not an unqualified obligation to continue living and therefore people can waive their right depending on circumstances. Another argument is that the right to life is not 'absolute' and can be weighed against other constitutional rights for instance, the right to freedom and security of the person. For instance, it is generally accepted that one may use lethal force in self-defence from unlawful violence, albeit subject to the principle of reasonableness and proportionality.[58] The Choice of Termination of Pregnancy Act 92 of 1996 allows for a mother to terminate the unborn child's life in certain circumstances.[59] This begs the question, whether this procedure still protects the sanctity of life.

Nonetheless the solution proposed by the SALRC is quite sound and relevant. The development of stringent, procedural safeguards and the involvement of the

---

[57] *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696.

[58] In *S v Makwanyane* 1995 CCT 3/94 –killing is justified if in self defence or brought about by necessity; the approach is to balance rights of aggressor against rights of victim and favouring lives of innocents over those who are guilty. In *R V Malott* 1998 1 SCR 123 the accused shot her common law husband of 19 years and raised the defence of self-defence. During trial, expert evidence was led to show that the accused suffered from Battered Wife Syndrome. Although the jury took such evidence into account the accused was found guilty of second-degree murder but the jury recommended that she get the minimum sentence.

[59] Such as (i) if pregnancy poses as a risk to the woman's physical and mental health; (ii) pregnancy resulted from rape or incest; (iii) there is a substantial risk that fetus would suffer severe physical or mental abnormity, only to mention a few.

relevant stakeholders, for example patients, family, medical experts and policy makers, will enable reasonable legislation to be put in place to deal with the uncertainties that currently plague our society. According to Brody (1993), an examination of the needs and values of patients in a context that recognizes the limits of modern medicine and the inevitability of death will be part of the solution [60]. Authors like Strauss indicate they would be willing to support reasonable legislation that allows passive euthanasia, even though the author does not specifically state what he qualifies as 'reasonable'.

Another interesting argument is advanced by Dena Davis[61], who compares choosing death to exercising birth control. A woman in using birth control devices denies her body the natural capacity to reproduce, it follows that not using birth control leaves the woman at the mercy of her body. Similarly, not planning for one's death allows the person to be controlled by the disease, be it cancer or dementia[62]. This analogy makes sense when viewed in the light of the autonomy argument namely, that one should have the freedom of choice with regard to his/her body.

---

[60] Brody B. Eugene (1993), **Biomedical Technology and Human Rights**, UNESCO Publishing, Paris, page 186-210.

[61] Dena S. Davis, **Why Suicide is like Contraception: A Women-Centered View**," cited in M. Battin, R. Rhodes, A. Silvers (eds) (1998), **Physician Assisted Suicide: Expanding the Debate**, Routledge, NY, page 34.

[62] Ibid.

2.4 Living wills / Advance directives

In respect of the living will, Advocate Dieter Achtzehn[63] acknowledges that there is some doubt as to the legality of such a document having regard to the fact that there is no legislative means or procedures in place by which can be tested as true. Hence if legislation is put in place to deal with the issue, it will help lessen the abuse of the process.

Strauss does indicate his support for passive euthanasia and the living will. Where a doctor bona fide decides to terminate treatment of a patient and this act results in death, he/she should not be persecuted. Doctors must respect the wishes of a patient who refuses to be kept alive by artificial means. If a terminally ill person stipulates that they wish to die, then that is their prerogative. Trowell (1973) also states that in many cases regarding the elderly who are terminally ill, where one has collapsed, medical practitioners tend to resuscitate that individual irrespective of the fact that such person may have a living will.[64] He further suggests, that it is actually the living that fear death and not the dying; hence such people's decisions not to be resuscitated should be respected.[65]

2.5 The 'Slippery Slope'

The 'slippery slope' argument is perhaps the most powerful and compelling argument against legal euthanasia. John Keown in his book, *Euthanasia, Ethics*

[63] Advocate Dieter Achtzehn, **What is happening in South Africa with Euthanasia**? http://www.nal.org.za- Accessed 12/08/08.
[64] Trowell HC (1973), **The Unfinished Debate on Euthanasia**, page 58.
[65] Ibid.

and Public Policy[66] offers a sustained argument against the legalization of euthanasia. Keown argues that pragmatically euthanasia cannot be effectively controlled and this would lead to involuntary deaths occurring.[67] Regardless of this statement one may agree with Lillehammer in that Keown's 'slippery slope' argument fails to take into consideration two important factors: the patient's autonomous request for euthanasia and a competent medical judgment by a health care professional that death will benefit the patient.[68] Those who choose to end their life should have their wishes respected in the same way as those who choose to fight their illness until the end. Legalizing euthanasia will ensure that patients will not be forced to prolong their pain and misery due to court hearings or hospital bureaucracies as in the *Schiavo*[69] case. The case for euthanasia is not about getting rid of people which society considered as unwanted but rather about the necessity of choices for those that need it. Those that are hopelessly ill, and are already slowly dying and wish to discontinue painful treatments are a good example.

There are quite a number of opposing viewpoints on the issue of euthanasia and many authors have tried to use logic and examples to support their views. Many appear to agree with the concept of passive euthanasia. However, only a few have broached the subject of legalizing euthanasia mainly because of its complex nature. The 'slippery slope argument simply put is, 'if you give people an

---

[66] J Keown, **Euthanasia, Ethics and Public Policy,** (2002) Cambridge University Press, Cambridge, cited in Lillehammer H **Voluntary Euthanasia and the Logical Slippery Slope Argument**, Cambridge Law Journal 61 (3) November 2002, page 545-550.
[67] Ibid.
[68] Supra note 22.
[69] Supra note 24 in Chapter 1.

inch, they will take a mile.’ Doctors may start killing people without their consent or elderly and lonely people would request an early death. Taking this into consideration, one may agree to a certain extent that perhaps the legalization of euthanasia may endanger the lives of vulnerable patients and threaten the moral integrity of the medical profession. But again it is interesting to note that both the medical institutions and medical practitioners stand to gain more by keeping the patient alive regardless of the patient’s wishes. Hence the question is “whether opposition against passive euthanasia is genuinely based on the moral duty of care towards the patient” This is indeed food for thought.

It is undeniable that in reality every law is subject to abuse, the most that can be done is to ensure strict adherence to guidelines and procedures so as to reduce the risk of abuse. The courts should punish those that cross the boundaries of the law. For instance, there is no logic to argue that we cannot have a law against rape or murder because some people will commit these crimes anyway, whether the law exists or not.

2.6 Cultural Influences

In Africa culture tends to play a very significant role in shaping people’s nature because it helps form the very identity of an individual. In the course of this research the researcher came across some who assert that passive euthanasia is ‘un-African’. Death is a dreaded event, often considered evil, because it is

believed the dead have power over the living.[70] Perhaps this may explain why people would wish for a longer life. However, actions similar to passive euthanasia are not foreign to Africans. In many African traditions when it is clear that death is inevitable, the individual dying is taken to a place of rest where he/she can pass away in peace; many years ago one could be taken to the caves. Nowadays one is taken to his or her rural home. At this point, the family comes together to comfort, perform rites and encourage the dying person to embrace death with dignity.

[70] Onukwugha G**, Death and Dying in the African Context -** http://www.nathanielturner.com/deathanddyingafrican.htm - Accessed 15/12/08.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Research Method

The main purpose of the study is to identify people's awareness and perceptions about passive euthanasia. The study uses both qualitative and quantitative methods. These methods will enable the researcher to find out whether indeed people are aware of the phenomena and what their thoughts and feelings are towards it. Do they feel that there is a need to legalize euthanasia as argued by the SALRC? This Chapter shall discuss the research design and methodology that has been used by the researcher, and how the research was undertaken. Account will also be made of the limitations and validity of findings.

3.2 Research Design

Both qualitative and quantitative approaches were used in the form of in-depth interviews and questionnaires respectively. As the study required an investigation into people's perceptions and awareness, these two research designs provided an appropriate tool for gathering such data. According to Bryman,[71] qualitative research is used to construe the attitudes, beliefs and motivations within a subject and it can also perform a preparatory role in quantitative research. Qualitative findings cannot however, be generalized to a larger population as samples are usually too small to be representative of the larger population.

[71] As cited in Walliman N, (2005) **Your Research Project**, 2nd Ed, Sage Publications, London, page 247.

Quantitative research on the other hand allows a researcher to remain distant as an outsider, collecting hard and reliable data.[72] Questionnaires and interviews are both a means of eliciting information directly from the people/persons who are presumed to have the required information.[73] A combination of qualitative and quantitative research can help to overcome certain limitations, for instance statistical data may complement qualitative interview studies by helping to identify structural constraints the interviewees are not aware of.[74]

3.2.1 Questionnaires

The researcher chose to make use of questionnaires because they allow one to organize questions and receive replies without having to actually talk to every respondent. This is an advantage in that it lessens the amount of bias that a researcher may give to the person being asked the questions. The researcher tried to ask a number of questions on the same topic, from a variety of angles so as to prevent an oversimplification of responses.[75] A few open-ended questions were included so as to give the respondents a chance to express themselves in their own words and give them a sense of control. Open-ended questions also allow for in-depth answers.[76] Questionnaires also have the advantage of being economic both in terms of cost and time. Nonetheless, questionnaires do have their limitations as well. They do not allow for digression from the set format,

---

[72] Ibid.
[73] Hofstee E (2006) **Constructing a Good Dissertation**, EPE, Sandton, South Africa, page 132.
[74] Bryman A (2005): Why do researchers integrate qualitative and quantitative research? Paper presented at the Invitational Conference on "Mixed Method Research Design: Advanced Issues and Debates", University of Basel, August 12 and 13, 2005.
[75] Walliman, **Your Research Project**, page 286.
[76] Supra note 32.

therefore the researcher is not able to interact, observe the participants or probe any particular respondents.

3.2.2 In-person and Telephonic Interviews

The researcher made use of face-to-face interviews. The questions had structured open- ended questions. The researcher identified specific subjects, which are two medical practitioners living within the Alice and East London areas. Initial contact was made to introduce the respondent to the researcher and her research and cultivate confidence and friendliness. The respondents were given a copy of the questions to be asked in the interviews, the consent form and the date for interview was set.

The advantage of in-depth face-to-face interviews is that it allows the researcher to follow up ideas, probe responses and investigate the motives and feelings, which questionnaires can not do. Visual signs such as nods and smiles are valuable tools in promoting complete responses.[77] Initially, the researcher intended to conduct only face-face interviews initially, but circumstances beyond her control forced her to make adjustments and a telephonic interview was conducted with one of the interviewees. On the one hand, telephonic interviews have the advantage of avoiding the necessity of travelling and time delays. On the other hand, visual aids cannot be used to explain questions or gestures such as eye contact.

---

[77] Ibid, page 284.

3.3 Methodology

The questions in the questionnaire were adapted from the Euthanasia Attitude Scale (EAS) [78] and modified to suit the researcher's focus. The EAS was developed by Holloway, Hayslip, Murdock et. al to assess the general attitude a person has towards end of life decisions.[79] The researcher's objectives were to measure people's awareness and perceptions of passive euthanasia, whether it should be made legal or not and on what basis? In view of this it was necessary to modify the research instrument so as to elicit the appropriate information. The questions in the questionnaire were structured and respondents were offered the same options. These were ranked from strongly agree, agree, and disagree to strongly disagree. The Researcher avoided offering a neutral option such as 'don't know' or 'no opinion'. This is because the topic is quite sensitive and controversial and it is possible that respondents would rather choose this option than answer difficult or discomforting questions. Although, the researcher had to be as objective as possible; there is a possibility of some elements of bias as it is extremely difficult to be totally free from bias.

The questionnaires were self-administered and a total of 30 questionnaires were completed. This approach allowed for the researcher to explain to the respondents in instances where they would not understand. The respondents participated voluntarily and no names or any other personal information was recorded.

---

[78] Thato Ramabele, **Attitudes Of The Elderly Towards Euthanasia: A Cross-cultural Study,** Masters Thesis, University of the Free State, page 15.
[79] Ibid.

3.3.1 Sampling Procedure – Questionnaires

Simple stratified sampling combined with cluster sampling was used as the sampling procedure so as to be able to get a sample representing different segments of the overall population. The population in Alice falls into two distinct categories. First is the local population that lives in the various districts in Alice and vary in terms of age, sex, and social status. Second is the multicultural student population at the University of Fort Hare which varies largely in terms of age, sex, nationality and social status. This sample comprises of students from all over the continent of Africa, although the majority are citizens of the Republic of South Africa. These two samples were combined to form a complete sample of respondents from the whole population. The diversity within the sample represented the multi-ethnic character of the South African nation, commonly referred to as 'the rainbow nation'.

The interviews took place by mutual arrangement in a private venue so as to maintain confidentiality. The interviews lasted between 35-45 minutes. The respondents were given a copy of the interview report to enable them to read over the transcribed interview in order to ensure accuracy, avoid misunderstanding and to acquire any additional information or elaboration as necessary. The literature informed the questions along particular themes. A pilot study was not conducted because an extensive survey of the literature was adequate for such a sensitive topic as this. Pilot studies do have the advantage of determining the effectiveness of a research tool, and are usually associated with quantitative research. However, this study is mainly qualitative.

3.3.2 Sampling Procedure - Interviews

The researcher identified specific subjects. The sampling method used is purposive sampling. The advantage of purposive sampling is that it allows the researcher to home in on people or events, which have good grounds in what they believe, will be critical for the research. Hence, the researcher identified medical practitioners, a sample of the population, which is likely to know more about the subject. The researcher had intended to interview five respondents but unfortunately due to factors such as time and cost, this sample was very small, and only two respondents were interviewed. Nevertheless, the strength of purposive sampling lies in the fact that this type of sampling permits the selection of interviewees whose qualities or experiences permit an understanding of the phenomena in question, and are therefore valuable.[80]

3.4 Ethical Considerations

An ethical consideration is one of the fundamental considerations that every researcher has to take into account when conducting research. First and foremost is the principle of honesty and integrity. According to Walliman, honesty is essential, not only to enable a straightforward, above board communication but to engender a level of trust and credibility to promote debate and the development of knowledge.[81]

---

[80] http://www.deenislam.co.uk/midwife/Dis/5.htm -Accessed 11/11/09.
[81] Supra note 70, page 336.

In order to adhere to University guidelines on ethical standards, participants were made aware that the information they gave would be kept strictly confidential. Consent forms were signed by the respondents interviewed to show that they understood the aims of the research. They were also informed that they can withdraw from the research process at any time. The researcher has tried to avoid discrimination by including both male and female respondents. To ensure anonymity, the questionnaires did not contain anything that may identify the respondent, for instance, names or addresses. The respondents participated voluntary in the questionnaire survey. The researcher understands that people have a right to know why they are being asked questions hence, she explained briefly to the respondents the nature and purpose of the research.

Punctuality, brevity and being courteous are essential qualities to help one's efforts to gain information.[82] The researcher employed these techniques so as to enable a relationship of respect and trust. The researcher verbally acknowledged her appreciation to the respondents with a 'thank-you'. The researcher is aware that plagiarism is a serious crime and acknowledged the relevant sources referred to or cited within the text, although it is known that 'other people's work can be an inspiration and guide to one's own' work.[83] However, in order to maintain an honest approach there must be a distinction between one's own and other people's ideas.[84]

---

[82] Walliman N, (2004) **Your Undergraduate Dissertation: The Essential Guide for Success**, Sage Publications, London, page 151.
[83] Ibid, page 146.
[84] Ibid.

CHAPTER FOUR: RESEARCH FINDINGS AND ANALYSIS

4.1 Analysis of questionnaires

A total of thirty (30) questionnaires were completed. There were fifteen (15) male and fifteen (15) female respondents. Eighty-three percent (83%) of the respondents were between the ages of 15-35 and seventeen percent (17%) were between 36-50. Tables 1 and 2 below show the results from the questionnaires.

***Table 1*. Respondents by Ethnic backgrounds**

ETHNIC ORIGIN	TOTAL NO OF
English	5
Xhosa	12
Afrikaans	2
Other	11

Table ***1*** shows the various race groups included in the study. The Xhosa are in the majority (40%), mainly because the geographical area (Eastern Cape) in which the study took place is Xhosa dominated. Next is Other (36%) owing to the diversity present in the student population at the University of Fort Hare.

***Table 2*. Respondents by Religious backgrounds**

RELIGION	**TOTAL NO OF:**
Christian	22
Islam	0
African Tradition	2
Other	4
None	2

Table *2* illustrates that the majority (73%) of respondents subscribe to the Christian religion regardless of race. This is followed by Other (13%), with the least being None and African tradition at (6%) each. The Christians appeared to be quite accommodative of passive euthanasia (*please refer to **para 4.3** for a more detailed discussion on the above findings)*.

Table *3* below shows how participants responded to the questionnaires. The results illustrates that people's perceptions of life appear to have shifted from mere preservation of life to the quality of life. The majority of respondents (56%) seem to support passive euthanasia provided that sufficient safeguards are put in place to prevent abuse (*please refer to **para 4.3** for a more detailed discussion)*.

***Table 3.* Results from Questionnaire on Passive Euthanasia**

		Strongly Agree	Agree	Disagree	Strongly Disagree	
1.	Under any circumstances I believe that medical practitioners should try to prolong the lives of their patients	17	8	5	0	
2.	I believe there is no justification for ending the lives of persons even though they are terminally ill.	10	15	4	1	
3.	Some patients receive "comfort measures" only for example, pain relieving drugs and are allowed to die in peace without further life extending treatment. This practice should be allowed.	2	16	10	2	
4.	I believe that a person with a terminal and painful disease should have the right to refuse life-sustaining treatment.	6	11	11	2	
5.	I bear no ill feeling towards a person who hastens the death of a loved one to spare him/her unbearable pain	5	20	1	4	
6.	An individual who is "brain dead" should be allowed to die in peace.	7	15	3	5	
7.	I would support the decision to reject additional treatments should a dying person contract a secondary disease that is sure to bring about a quick and painless death.	3	12	9	6	
8.	I would support a doctor's decision to withdraw treatment if patient has no chance of survival.	8	10	7	5	
9.	It is an act of mercy for the terminally ill person to turn off the life sustaining machines.	5	13	7	7	
10.	If I were faced with the situation of suffering a slow and painful death, I should have the right to choose to die and not have my life prolonged unnecessarily.	5	10	10	5	
11.	It is cruel to prolong intense suffering for a person who is mortally ill and desires to die.	3	13	12	2	

12.	No one, including medical professionals should be allowed to decide to end a person life who is suffering from a terminal illness/ in an irreversible coma.	2	8	15	5	
13.	Withdrawal of life sustaining treatment is the same as murder.	2	10	9	9	
14.	If a friend of mine were in severe pain, suffering from a terminal illness and begged me to convince the doctors to allow him/her to die, I would ignore his/her plea.	5	10	10	5	
15.	The injection of a legal dose of some drug to alleviate pain whilst simultaneously hastening the death is unethical.	2	10	15	3	
16.	No matter how much a person pleads for death to avoid unbearable suffering, no one should be allowed to assist such person to die.	2	10	14	4	
17.	Inducing death for merciful reason is acceptable.	3	15	7	5	
18.	Everyone should have the right to choose to withdraw or continue life-sustaining treatment if he/she is in unbearable pain.	8	10	5	7	
19.	Terminally ill people who would rather starve themselves to death, to avoid unbearable pain should be forcibly fed to prolong their lives.	10	7	12	1	
20.	It is unethical to allow termination of life when medical technology is able to preserve it, regardless of cost or wish to die.	10	4	10	6	
21.	Medical costs should be taken into consideration when one is faced with a patient/ family member suffering from a terminal illness /in an irreversible coma.	4	11	12	3	
22.	Passive euthanasia is an act of mercy and allows patient who is terminally ill to die with dignity.	6	15	9	1	
23.	There should be strict legislation regulating passive euthanasia procedures.	17	7	6	0	
	TOTALS	**145**	**245**	**209**	**88**	

4.2 Responses to open-ended questions

In response to these questions, the majority of respondents favored the idea that there should be legal avenues by which an individual could pre-authorize his/her death should he/she suffer intolerable terminal illness in future, for instance by way of living wills. These respondents expressed the view that documents like living wills make decision-making easier for both doctors and relatives of the patient. The issue of patient autonomy was also supported by a number of participants. An individual must be able to exercise his/ her choice and be able to refuse or accept life-sustaining medication. Some did make mention of the fact that medical costs are very expensive and unnecessary prolongation of life may result in the family being impoverished. Only a few expressed the view that they do not agree with the concept of euthanasia, passive or active. They argued that on the basis of their religious beliefs, God is the only one who is entitled to give and to take away life, no matter the circumstances.

4.3 Analysis of data

The results from the questionnaires indicated that indeed people are almost evenly split (see Table 3) over the subject of passive euthanasia. Interestingly the results also revealed that seventy percent (70%) of the sample perceived passive euthanasia to be an act of mercy that allows terminally ill patients to die with dignity. Eighty percent (80%) of the respondents were in favour of strict legislation regulating passive euthanasia procedures.

It is commonly accepted that religion and cultural traditions often dictated the patterns and trends of behaviour, attitudes and perception that is observed in societies. Table 1 shows that the majority of respondents were Christians. Christians are also known to be largely conservative. The very fact that this community is even considering passive euthanasia indicates the influence of ideals of enlightenment and human freedoms, the freedom to make one's own choices. The majority of the respondents' ages ranged from 15-35, indicating a different way of thinking of the new generation. According to Rambele's study, religion did not seem to have a significant effect on elderly people's attitudes towards euthanasia, however race seems to have more influence.[85]

According to the Professor Joubert of the University of Free State, 50% of medical practitioners agreed that the decision to end one's life should be made by the patient; 46.9% indicated euthanasia should be performed by an independent doctor specially trained to handle such cases; 49.9 % were of the view that notification should be given to a special committee.[86] These findings are in accordance with the results from the study conducted by the SALRC during Project 86. The Living Will Society in South Africa (SAVES) and other Right to die societies insist that, laws establishing procedure must rigidly control passive euthanasia, as protocols and safeguards put in place to prevent abuse and protect patients.

[85] Supra note 76.
[86] Professor Joubert, **Law, Ethics and Medicine: Opinions of Private Medical Practitioners in Bloemfontein, South Africa, regarding Euthanasia of terminally ill patients**, Journal of Medical Ethics, 2009;35, pages 130-182.

4.4 Results from the interviews

The researcher managed to interview only two medical practitioners. This was mainly due to matters of time and cost. Interviews scheduled with the other three doctors were cancelled because of their unavailability. The researcher is aware that the sample is very small and may be critiqued as unrepresentative of the population. However, the researcher maintains the view that this small sample size is quite in keeping with the nature of qualitative data and therefore representative. The interviewer obtained consent from the doctors before the interviews. Unfortunately, the interviewer did not have a tape recorder and so she took notes during the interviews. A copy of the interview report was given to the participants so they could confirm and verify the contents of the interview report.

4.5 Analysis of data

The interview results also reveal the fact that society is equally divided on the subject of passive euthanasia. This result is also similar to the results obtained by Research Surveys.[87] They revealed that 50% of the population viewed euthanasia as acceptable.[88] The first doctor interviewed indicated that he did not favor the concept. He argued on the basis of the slippery slope argument, religious beliefs and further indicated that the practice is not in line with the Hippocratic Oath, which states that the duty of the medical practitioner is to do no harm to the patient. He also mentioned that the World Medical Association also

---

[87] Support for Passive Euthanasia- http://www.news24.com/News24/South_Africa/News/0,,2-7-1442_1761536,00.html- Accessed 12/03/08.

[88] McDougall J and Gorman M (2007), **Euthanasia: A Reference Handbook,** ABC-CLIO, Oxford, page 79**.**

does not accept the concept of euthanasia. It was also interesting to note that even though the interviewee disagreed with euthanasia, he did agree with the idea of prolonging the life of terminally ill or those in comatose for the purposes of body organ donations.

The second doctor stated that the subject of passive euthanasia should be considered. He noted that it is a fact that medical costs are extremely expensive, resources hard to come by especially for the average man. Therefore in instances where death is inevitable passive euthanasia would be a welcome relief for the patient, the family and the loved ones. Even in war situations help is offered to those who have a better chance of survival, and although it may sound cruel it is a reality.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

If citizens are allowed to avert their eyes and minds from the crude reality surrounding them, they are not pushed to take any affirmative moral, legal, or political action on issues that deserve attention.[89] Indeed the subject of euthanasia is very sensitive and complex. It is one that most people would rather avoid talking about. The subject of passive euthanasia challenges the traditional values and beliefs that people have about life, thus challenging the nature of society, particularly the way in which we deal with matters of life and death.

It has often been revealed that whilst some people embrace change others resist it regardless of whether that change is good or bad. Nevertheless, the fact is that euthanasia is being practised and to avoid abuse of the process, legal directives need to be put in place to regulate the practice. One may argue for instance, the way society views pre-marital and extra-marital sex, people do not want to talk about it, but it is prevalent worldwide. Similarly, with the scourge of HIV/AIDS people now recognise the need to debate such issues to raise awareness and, ultimately, find a way to deal with the pandemic. Society does not have to wait until a problem arises or harm is done so as to deal with an issue. Therefore, the subject of passive euthanasia needs to be dealt with right sooner rather than later. The issue is not only about the morality of a specific decision regarding the

[89] Note: **Rule Porousness and the Design of Legal Directives**, 121 (2008) Harvard. L. Rev. 2134 June, page 10.

care of a specific individual patient, but the ethics of having a particular social policy and practice.[90]

Legal directives give effect to social policy and democracy requires that people take responsibility for their actions. Those against passive euthanasia may argue that those who request euthanasia are in the minority. Nonetheless, in a democracy the minority's view should also be considered. This research and others before have proven that in actual fact at least half the population finds passive euthanasia acceptable, hence, the argument, that in the case of unrecoverable patients, passive euthanasia should be regulated by legislation.

This research has also revealed that quite a substantial portion of the population, medical practitioners included, agree with the proposal to regulate passive euthanasia. Project 86 notes that legislation dealing with euthanasia that is in line with the fundamental values entrenched in the new Constitution would bring about a certain measure of legal certainty.[91] Medical personnel would be able to raise issues of advance directives because they would be doing so in terms of the law as opposed to the fear of suggesting something illegal since there would be no formal regulation by law.[92]

The most compelling argument in favour of legalising passive euthanasia is that of patient autonomy. In democratic countries the individual freedom to choose is

[90] Ibid at page 10.
[91] Project 86 page 18.
[92] Ibid at page 20.

commonly accepted as a fundamental civil right. Patient autonomy includes the right to full disclosure of a patient's condition, for instance, the extent of the illness, treatment recommended, and the consequences of each. In the event that a doctor concludes that treatment is futile and death is inevitable, the informed patient must be allowed to make an informed choice. This allows the patient time and opportunity to make closure with the family and loved ones. Death is never an easy matter to handle but being better prepared for it does make it more bearable.

Arguments such as 'playing God' cease to hold water because the mere prolongation of life by life-sustaining machines is already 'playing God'. It logically follows that if God sanctions prolongation of life by a doctor's determination, then why does it become a problem if a doctor determines that there is no chance of recovery and recommends termination? If we are humane enough to end an animal's suffering through euthanasia, then perhaps it is time society allows patients facing inevitable death to pass on peacefully in a manner that is less painful and dignified. The consequences of prolongation of life compel society to find appropriate solutions for dealing with them.

In conclusion, is passive euthanasia morally justified? Indeed this is a complex question, to which the research did not provide a conclusive answer save to indicate that this depends on the morality of each individual. The researcher would nevertheless like to point out that death in as much as life, is part of

nature, hence death cannot be unnatural. If we can prepare for life it follows logically that we can prepare for death too.

5.2 Recommendations

5.2.1. *Legislation be put in place to regulate passive euthanasia*. If stringent legal rules are put in place it will lessen the risk of abuse of the process. The understanding of the legislature, which represents the wisdom of the people, is a safer and more dependable means of protection against abuse. Additionally changes in the health-care system should also accompany changes in the law. Passive euthanasia should remain the last option for the treatment of a patient.

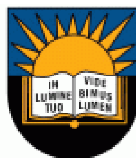
5.2.2. *Establish mechanisms to review the decisions of medical practitioners* in passive euthanasia cases and obtain redress should such practitioners abuse their powers.

5.2.3. *Raising awareness and educating people about passive euthanasia* and such issues could also be included in life orientation at primary and high school level. Death is a taboo in many African communities. However, the reality calls for a culture of openness and transparency so that people can make informed choices about both life and death.

5.2.4. *The legislature take into account the recommendations of the SALRC in respect of the Bill.* The draft Bill on End of Life Decisions contains some valid considerations with respect to passive euthanasia. A fully informed patient has

the legal and ethical right to make direct what happens to his or her body. The proposed legislation provides that mentally competent persons above the age of eighteen and of sound mind and/or above the age of fourteen of sound mind and assisted by their parent or guardian are competent to request termination of life sustaining medical treatment subject to certain conditions. The recommendations of the SALRC confirm the common law position that if the intention is not to kill and merely to provide relief from severe pain or distress, a medical practitioner may prescribe pain relieving and other medications which have the double-effect of relieving pain whilst simultaneously shortening the patient's life.

Appendix A



Questionnaire on Passive Euthanasia

This Questionnaire is designed to measure the attitude and perceptions of persons towards passive euthanasia. Passive euthanasia is withholding/withdrawing treatment, care or assistance with the intention of terminating a person's life, who is in unbearable pain and suffering from a terminal illness or is in an irreversible coma.

Please read each statement carefully, and **select one** of the four responses on the right hand-side which closely represents your own attitude towards the statement comment. **Please note your responses are completely confidential and no names will be required.**

(Please tick in appropriate box)

		Strongly Agree	Agree	Disagree	Strongly Disagree
1.	Under any circumstances I believe that medical practitioners should try to prolong the lives of their patients.				
2.	I believe there is no justification for ending the lives of persons even though they are terminally ill.				
3.	Some patients receive "comfort measures" only for example, pain relieving drugs and are allowed to die in peace without further life extending treatment. This practice should be allowed.				
4.	I believe that a person with a terminal and painful disease should have the right to refuse life sustaining treatment.				
5.	I bear no ill feeling towards a person who hastens the death of a loved one to spare him/her unbearable pain				
6.	An individual who is "brain dead" should be allowed to die in peace.				

		Strongly Agree	Agree	Disagree	Strongly Disagree
7.	I would support the decision to reject additional treatments should a dying person contract a secondary disease that is sure to bring about a quick and painless death.				
8.	I would support a doctor's decision to withdraw treatment if patient has no chance of survival.				
9.	It is an act of mercy for the terminally ill person to turn off the life sustaining machines.				
10.	If I were faced with the situation of suffering a slow and painful death, I should have the right to choose to die and not have my life prolonged unnecessarily.				
11.	It is cruel to prolong intense suffering for a person who is mortally ill and desires to die.				
12.	No one, including medical professionals should be allowed to decide to end a person life who is suffering from a terminal illness/ in an irreversible coma.				
13.	Withdrawal of life sustaining treatment is the same as murder.				
14.	If a friend of mine were in severe pain, suffering from a terminal illness and begged me to convince the doctors to allow him/her to die, I would ignore his/her plea.				
15.	The injection of a legal dose of some drug to alleviate pain whilst simultaneously hastening the death is unethical.				
16.	No matter how much a person pleads for death to avoid unbearable suffering, no one should be allowed to assist such person to die.				
17.	Inducing death for merciful reason is acceptable.				
18.	Everyone should have the right to choose to withdraw or continue life-sustaining treatment if he/she is in unbearable pain.				
19.	Terminally ill people who would rather starve themselves to death, to avoid unbearable pain should be forcibly fed to prolong their lives.				

		Strongly Agree	Agree	Disagree	Strongly Disagree
20.	It is unethical to allow termination of life when medical technology is able to preserve it, regardless of cost or wish to die.				
21.	Medical costs should be taken into consideration when one is faced with a patient/ family member suffering from a terminal illness /in an irreversible coma.				
22.	Passive euthanasia is an act of mercy and allows patient who is terminally ill to die with dignity.				
23.	There should be strict legislation regulating passive euthanasia procedures.				

For the following questions please tick the relevant box and give a reason for your answer.

25. I believe there should be legal avenues by which an individual could pre-authorize his/her death should he/she suffer intolerable terminal illness in future. Yes ☐ No ☐

………
………
………

26. I can envision a medical circumstance in which the termination of life would be merciful.
Yes ☐ No ☐

………
………
………

27. If I were faced with the prospect of having a loved one suffer a slow and painful death, I would support his/her decision to refuse life sustaining treatment. Yes ☐ No ☐

………
………
………

28. I believe it is more humane to end the life of a person who is terminally ill and dying/in an irreversible coma and in severe pain than to allow him/her to continue suffering. Yes ☐ No ☐

………

………
………

Please indicate the following for demographic purposes.

(Please tick in the appropriate box)

Gender

Male	Female

Age

15- 35
36-50
51-70
71+

Ethnic origin

English
Afrikaans
Xhosa
Other

Religion

Christian
Islam
African Tradition
Other
None

THANK YOU FOR YOUR CO-OPERATION!!

Appendix B

Interview Schedule

1. Do you think there is a right to die?
   ………………………………………………………………………………………………………
2. What is your viewpoint on euthanasia? Do you think it should be made legal ?
   ……
3. If a terminally ill patient/family of such patient or patient in an irreversible coma request for withdrawal of life-sustaining medical treatment what are the current procedures if any?
   ……..
4. At the present moment what happens to such patients who have only a limited time to live?
   ……..
5. Can you tell me about advance directives/living wills?
   …….
6. Should a terminally ill person be allowed to reject life-sustaining treatment?
   ……..
7. What do you think could be alternatives to passive euthanasia?
   ……..
8. In your opinion does passive euthanasia go against principles of the Hippocratic Oath?
   ………..
9. What are your views on the slippery slope argument?
   ……….
10. Do you think there is such a thing as dying with dignity?
    ………
11. If one is clinically dead should they be kept on life-support machines?………..
12. What do you think about the Draft Bill on Euthanasia?
    ……..
13. To the best of your knowledge what is the general feeling of the SA Public regarding passive euthanasia?……………………………………………………………………………………………………….
14. Have you encountered a situation were a patient of yours requested euthanasia?

Appendix C

CONSENT FORM

Project Title: Passive Euthanasia

I ____ agree to participate in the above mentioned
(name of participant)
research project, conducted by __Chidoori Rumbidzai E.P____.
(name of researcher)

The Researcher has discussed this research project with me. I have had the opportunity to ask questions about this research and I have received answers that are satisfactory to me. I have read and kept a copy of the introduction letter and understand the general purposes, risks and methods of this research.

I agree to take part because:

1. I know what I am expected to do and what this involves.
2. The risks, inconvenience and discomfort of participating in the study have been explained to me.
3. All my questions have been answered to my satisfaction.
4. I understand that the project may not be of direct benefit to me.
5. I can withdraw from the study at any time.
6. I am satisfied with the explanation given in relation to the project as it affects me and my consent is freely given.
7. I can obtain a summary of the results of the study when it is completed.
8. I understand that my personal information will be kept private.
9. I agree to the publication of results from this study provided details that might identify me are removed, unless otherwise agreed.

Signed by the participant: _________________________________ Date: _________________

Signed by an independent witness: _________________________ Date: _________________

Signed by the researcher: __________________________________ Date: _________________

Should you have any queries concerning this research please contact the Researcher : Chidoori R.E.P- Cell No: 0761509125 c/o Professor N.S Rembe or Dr S.W Rembe at University of Fort Hare, Oliver Tambo Chair of Human Rights, P. Bag X1314, Alice 5700. Tel: 040 6022220.

[A signed and witnessed copy **must** be given to participant.]

BIBLIOGRAPHY

Advocate Dieter Achtzehn, **What is happening in South Africa with Euthanasia**?
http://www.nal.org.za- Accessed 12/08/08.

Battin P. Margret, **Euthanasia and Physician Assisted Suicide**, Journal of Health Politics, Policy and Law, Vol 25, (2) April 2000.

Brody B. Eugene, (1993) **Biomedical Technology and Human Rights**, UNESCO Publishing, Paris.

British Medical Journal Publishes Euthanasia opinions - http://www.news-medical.net/?id=13293 –Accessed 24/03/08.

Burnell G, (1993) **Final Choices: To live or to die in an age of medical technology**, N.Y. Plenum, New York.

Ertelt S, (2005) **Brain-dead Woman Gives Birth to a Baby Girl-** http://www.lifenews.com/nat1507.html - Accessed 12/12/08.

Glover Jonathan, (1977) **Causing Death and Saving Lives, Penguin**, Harmondsworth, Middlesex.

Hofstee Erik, (2006) **Constructing A Good Dissertation**, EPE, Sandton South Africa.

Martin W. Mike**,** (2007) **Everyday Morality, An Introduction to Applied Ethics**, 4th Edition, Thompson Wadsworth, Canada.

McDougall J and Gorman A, (2007) **Euthanasia: A Reference Handbook,** Published by ABC-CLIO, Oxford.

Neuman WL, (1997) **Social Research Methods: Qualitative and Quantitative Approaches**, 3rd Edition, Allyn and Bacon, Boston.

Ogg Elizabeth, (1980) **The Right to Die with Dignity**, N.Y: Public Affairs Committee, New York.

Onukwugha G**, Death and Dying in the African Context** http://www.nathanielturner.com/deathanddyingafrican.htm -Accessed 15/12/08.

Pakes Francis, **The Legalization of Euthanasia and Assisted Suicide: A tale of two scenarios**, International Journal of the Sociology of Law, Issue 2, Vol 33, June 2005 pages 71-84.

Potter David, (1982) **Too Soon to Die**, Welwyn, U.K. Evangelical Press, UK.

Note: **Rule Porousness and the Design of Legal Directives**, 121 (2008) Harvard. L. Rev. 2134 June, page 10.

South African Law Commission Report Project 86, **Euthanasia and the Artificial Preservation of Life,** November (1998).

Sprung L Charles, **Is the patient's right to die evolving into a duty to die?: Medical decision making and ethical evaluations in health care,** Journal Of Evaluation in Clinical Science, Vol 3, Issue 1, February 1997.

Strauss SA, (1984) **Doctor, Patient and the Law**: A Selection of Practical Issues, 2nd Edtn, L Van Schaik (Pty) Ltd, Pretoria.

Support for Passive Euthanasia-
http://www.news24.com/News24/South_Africa/News/0,,2-7-1442_1761536,00.html- Accessed 12/03/08.

Trowell HC, (1973) **The Unfinished Debate on Euthanasia**, SCM Press, London.

Walliman N, (2004) **Your Undergraduate Dissertation: The Essential Guide for Success**, Sage Publications, London.

Walliman N, (2005) **Your Research Project** 2nd Edition, Sage Publications, London.