A constitutional analysis of euthanasia in South Africa: Exploring dignity, autonomy, and legal readiness with lessons from Canada

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A constitutional analysis of euthanasia in South Africa: exploring dignity, autonomy, and legal readiness with lessons from Canada

I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.



Nozipho Derby Zungu **29 May 2026**

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SUMMARY

This dissertation examines the constitutional and ethical dimensions of end-of-life decision-making in South Africa, where the prohibition of euthanasia leaves many patients dying without dignity. The study interrogates whether the current framework adequately protects dignity (s 10), bodily integrity (s 12), and access to healthcare (s 27), while recognising that (s 36), the limitations clause tempers the scope of these rights through proportionality analysis.

The dissertation demonstrates that the euthanasia debate cannot be considered independent from the availability of palliative care, as meaningful end-of-life choices depend upon access to adequate pain relief, support, and dignified care. Palliative care, though recognised in the National Health Insurance Act 20 of 2023, remains unevenly implemented, constrained by poor infrastructure, limited resources, and systemic inequities. The inadequate integration of mental health needs within palliative care widens the gap, leaving vulnerable patients without adequate support. Healthcare practitioners, regulated by the HPCSA, face ethical burdens without legislative clarity, while caregivers outside formal regulation shoulder unrecognised responsibilities.

The research evaluates, the extent to which South Africa's constitutional and legal framework adequately protects autonomy and dignity at the end of life, and what lessons can be drawn from comparative jurisdictions. Canada's Medical Assistance in Dying (MAiD) regime is examined both as a model and a cautionary tale, demonstrating how assisted dying can coexist with palliative care under safeguards, but also how over-expansion risks eroding protections. The findings reveal that South Africa's framework inadequately realises constitutional rights at the end of life. The study recommends strengthening and comprehensively expanding palliative care, ensuring it is accessible to all and effectively incorporated into the National Health Act framework. Only within such a system can debates on euthanasia proceed responsibly, reconciling constitutional principles with equitable, compassionate end-of-life care.

KEY TERMS:

Autonomy, Bodily integrity, Canada, Comparative law, Constitutional law, Euthanasia, Human dignity, Medical Assistance in Dying (MAiD), Physician-assisted suicide, Palliative care, South Africa

A paper entitled “A Cautionary Tale for South Africa and Other Jurisdictions Without Euthanasia Legislation: Lessons from Canada's Delayed Expansion of MAiD to Mental Disorders”, which is based on the research presented in this dissertation, has been prepared for submission to the South African Journal of Bioethics and Law for consideration for publication.

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CHAPTER ONE

1. Introduction

1.1 Introduction and contextual background

Euthanasia, often referred to as 'mercy killing', is a complex and contested practice encompassing both active measures such as the administration of lethal substances and passive measures, such as the withdrawal of life-sustaining treatment. It may be voluntary, where undertaken at the patient's request, or non-voluntary, where the patient cannot consent. It is generally defined as the intentional ending of a person's life to relieve suffering, either actively or passively.[1] Euthanasia is not a newly discovered topic, but has been present throughout history, as will be explored in a subsequent chapter.

In South Africa, euthanasia first received structured legal attention through the South African Law Reform Commission's Discussion Paper 71 (Project 86,1997), which examined domestic law alongside foreign jurisdictions.[2] Following an extensive review of South African law and foreign jurisdictions, the Commission recognised the deeply divided moral, ethical and religious views regarding the possible decriminalisation of assistance in ending the life of terminally ill patients.[3] While the Commission's Discussion Paper 71 (Project 86, 1997) introduced structured definitions of euthanasia and engaged in comparative analysis with foreign jurisdictions, its subsequent Final Report (1998) acknowledged the controversy surrounding the issue and deliberately refrained from adopting a definitive position, leaving the matter to be resolved through public and parliamentary debate.[4] Since then, South Africa has not passed legislation regulating assisted dying, leaving patients, families and healthcare providers in a state of uncertainty.

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1 South African Law Reform Commission, *Discussion Paper 71: Euthanasia and the Artificial Preservation of* Life (Project 86, SALRC 1997) ch 2, 12–15; Peter Singer, *Practical Ethics* (3rd edn, Cambridge University Press 2011) 175–177.

2 SALRC, *Euthanasia and the Artificial Preservation of Life* ch 2 and 3.

3 SALRC, *Euthanasia and the Artificial Preservation of life* ch 2 (submissions received highlighting moral/religious objections) and ch 4 (arguments for and against euthanasia).

4 South African Law Reform Commission, *Report on Euthanasia and the Artificial Preservation of Life* (Project 86, SALRC 1998) ch 1, 3–4.

This delay occurs against the backdrop of constitutional rights guaranteeing dignity, autonomy, and privacy, which provide a potential legal basis for recognising end of life choices. At the same time, systemic challenges, including unequal access to healthcare, limited palliative care services and resource constraints, raise questions about the country's readiness to implement a regulated framework.

Against this contextual backdrop, this dissertation seeks to examine the underlying legal and institutional factors contributing towards the delay in enacting euthanasia legislation in South Africa. The study critically examines South Africa's preparedness, governance structures, and institutional capacity to implement a medical procedure which is both complex and ethically sensitive. The study further explores the influence of ethics, religion, culture, and spirituality on an individual's right to die with dignity and privacy. The study analyses the constitutional rights implicated at the heart of this debate, particularly the rights to dignity, freedom of choice and privacy while exploring how these rights have been applied in other contentious legislative contexts, with a view of informing possible pathways for South African policy and legislation.

International developments provide a valuable comparative perspective. In Canada, medical assistance in dying (MAiD) has been legal since 2016 for terminally ill patients whose death is reasonably foreseeable. Parliament enacted Bill C-7 in March 2021, which broadened eligibility by removing the requirement of foreseeable death and introduced differentiated safeguards. Importantly, the legislation explicitly excluded mental illness as a sole qualifying condition.[5] The expansion of eligibility to persons whose only underlying condition is a mental illness has since been postponed until March 2027, reflecting the ethical and socio-legal complexities of balancing autonomy with protections for vulnerable groups.[6]

Canada's approach demonstrates the critical role of public consultation and stakeholder participation in law-making, as well as the importance of ethical safeguards and legislative clarity in developing assisted dying policies, earning praise for its transparency and responsiveness to societal values. At the same time, it also

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5 Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts* (medical assistance in dying), SC 2016, c 3 (Canada).

6 Health Canada, *Medical assistance in dying: Overview* (Government of Canada, February 2024) <https://www.canada.ca/en/health-canada/news/2024/02/the-government-of-canada-introduces-legislation-to-delay-medical-assistance-in-dying-expansion-by-3-years.html> accessed 12 May 2024.

illustrates that even well-resourced jurisdictions encounter ongoing debates about eligibility, oversight, and the protection of vulnerable populations.

This dissertation situates South Africa's euthanasia debate within this global context, seeking to identify the legal, ethical and systemic factors influencing legislative delays. By examining Canadian experiences alongside South African realities, the study evaluates whether South Africa is prepared to implement assisted dying in a manner that respects constitutional rights while mitigating risks associated with systemic limitations, including inequality, resource constraints and ethical or cultural objections.

Through a comparative analysis of South Africa and Canada, this dissertation examines the development of, and delays in establishing euthanasia and assisted dying frameworks. The dissertation considers Canada's Medical Assistance in Dying framework, including Bill C-7 and subsequent amendments Bill C-39 and C-62, alongside South Africa's constitutional provisions and relevant law reform initiatives, such as SALRC project 86. The analysis specifically considers the challenges in Canada associated with extending assisted dying to vulnerable groups, including individuals with mental illness and juxtaposes these challenges against the delays in passing euthanasia legislation in South Africa.

1.2 Research Problems

Euthanasia and physician assisted dying continues to generate profound ethical, legal and medical debate in South Africa. Although the South African Constitution strongly protects the rights to dignity, life, autonomy and privacy, the legal system has yet to provide for a regulated framework on end-of-life decision making. This legislative gap leaves terminally ill patients and their families in a position of uncertainty, often forced to endure prolonged suffering or to seek alternative and sometimes unlawful means of relief.

The problem is compounded by South Africa's fragile healthcare system, characterised by unequal access, limited palliative care services and significant resource constraints. Questions arise as to whether a legal framework for euthanasia and assisted dying could be implemented equitably in manner that is both impartial and respectful to human rights within South Africa's deeply unequal and resource-constrained healthcare system. In the absence of comprehensive safeguards and

systemic reforms, there is a real risk that such legislation could entrench existing disparities, benefiting only those with access to quality care while further marginalising vulnerable populations. Realising the constitutional values of dignity, autonomy, and the right to life in this context demands more than legal change; it requires a healthcare system that is both prepared and capable of delivering such rights in practice.

Comparative insights from Canada, where the courts and Parliament have established a legal framework for medical assistance in dying (MAiD), reveal both the constitutional reasoning behind such legislation and the ongoing challenges, even in a well-resourced setting.[7] While Canada's legislative approach to assisted dying demonstrates a transparent and participatory policy consultation, parliamentary debate and engagement with healthcare professionals and civil society,[8] South Africa has yet to achieve comparable levels of public involvement. Since the South African Law Reform Commission's 1998 report,[9] public engagement on the sensitive issue of euthanasia has remained limited, highlighting a gap in inclusive dialogue that may impede the development of effective and constitutionally sound assisted dying legislation.

Another critical aspect of the research problem concerns the attitudes and preparedness of healthcare practitioners in South Africa to implement potential legislation. In South Africa, where euthanasia is not yet legal, it's uncertain whether healthcare practitioners are adequately prepared ethically, professionally, and practically to handle the responsibilities that would come with legalizing it. Currently, assisting a patient to die remains unlawful, placing medical professionals in a complex position where their ethical duties to relieve suffering may conflict with statutory prohibitions. Many healthcare practitioners report experiencing moral uncertainty, personal ethical dilemmas and fear of legal repercussions when confronted with patients seeking end of life assistance.[10]

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7 Health Canada, *Medical assistance in dying: Overview* (Government of Canada, 29 February 2024).

8 Health Canada, *Medical assistance in dying: Legislation in Canada* (Government of Canada, 29 February 2024); Department of Justice*, Bill C-7: An Act to amend the Criminal Code* (medical assistance in dying) (House of Commons, 2020); Parliament of Canada, *Committee Report No. 1 – AMAD* (44-1) (2022).

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

10 Willem Johan Steyn and Mukinay Bondo, 'Perspectives and Attitudes of South African Medical

In addition, the notable absence of structured training on end-of-life care, euthanasia and palliative options, further contributes to a sense of unpreparedness among health practitioners and heightens concerns about legal exposure and ethical decision making.[11] Practitioners' personal convictions, shaped by religion, culture and ethics, further influence their willingness to participate in or even engage in discussions or interventions regarding assisted dying. These factors collectively illustrate that any future legislative reform must carefully consider and account for professional, ethical and educational readiness of the healthcare workforce to ensure that constitutional rights are exercised in a manner which is meaningful and safe.

Against this backdrop, the study is guided by the overarching question of whether South Africa is ready to legalise euthanasia. Readiness must be evaluated not only in terms of constitutional rights, but also with reference to healthcare infrastructure, cultural and religious values, professional ethics and the potential risks of abuse within an already strained system. This study therefore interrogates whether South Africa can draw lessons from Canada's MAiD framework while addressing its own unique socio-legal and healthcare realities.

Furthermore, recent legislative developments in Canada have sought to extend medical assistance in dying to individuals whose sole underlying condition is a mental illness.[12] However, the passage of this legislation has faced postponements[13] and remains subject to rigorous scrutiny, illustrating the complex interplay between constitutional rights, ethical safeguards and healthcare system capacity. This postponement underscores the broader complexity of extending assisted dying to vulnerable groups and serves as a cautionary signal for jurisdictions like South Africa where euthanasia remains illegal. This underscores the importance of carefully

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Professionals towards Active Euthanasia' (2024) 66(1) South African Family Practice a5926, PDF 5-10 <https://doi.org/10.4102/safp.v66i1.5926> accessed 12 June 2024.

11 Tessa A McMillan, Lauren Hutton and Louis Jenkins 'Doctors' knowledge, attitudes and practices of palliative care in two South African districts' (2024) 16(1) Afri J Prim Care Fam Med *a*4503.

12 Bill C-7, *An Act to amend the Criminal Code* (medical assistance in dying), SC 2021, c 2 (Canada).

13 Bill C-39, *An Act to amend An Act to amend the Criminal Code* (medical assistance in dying), SC 2023, c 1 (Canada). Bill C-39 (extended the exclusion for individuals with mental illness until March 17, 2024, giving the government and healthcare system to prepare; Bill C-62, *An Act to amend An Act to amend the Criminal Code* (medical assistance in dying), No 2, SC 2024, c 5 (Canada). Bill C-62 (Further extended the exclusion of individuals whose sole underlying medical condition is a mental illness until March 17, 2027).

assessing South Africa's readiness carefully rather than assuming that constitutional rights alone justify immediate legal reform.

1.3 Research Questions

The study is guided by the following research questions:

Primary research question:

1. To what extent is South Africa legally, ethically, socially and institutionally ready to implement legislation on euthanasia, considering lessons from Canada's Medical Assistance in Dying (MAiD) framework?

Sub-research questions:

2. To what extent do constitutional rights such as dignity, life, autonomy, and privacy support or limit the legalisation of euthanasia and assisted dying in South Africa? What lessons can South Africa draw from Canada's legalisation of medical assistance in dying (MAiD), particularly regarding constitutional interpretation, legislative reform, implementation challenges and healthcare infrastructure?
3. What measures has Canada taken in addressing medical assistance in dying for individuals whose sole condition is a mental illness, and how might this experience inform South Africa's legal and ethical approach?
4. Given South Africa's unequal healthcare landscape, what risks such as corruption, systemic abuse, and inequitable access might rise with the legalization of euthanasia, and what legal and policy safeguards are necessary to prevent harm and protect marginalized populations?
5. Can strengthening and investing in palliative and home-based care offer a viable alternative to euthanasia in South Africa, and how might such investment prevent potential abuses and inequities in end-of-life decision-making?
6. What role do public, professional, and civil society engagements play in South Africa's legislative journey toward euthanasia, and how have past efforts succeeded or failed since the SALRC's 1998 report?

1.4 Aims and objective of the study

The overall aim of this study is to critically assess whether South Africa is adequately prepared to legalise euthanasia and assisted dying by analysing the constitutional foundations for such a framework, evaluating the country's ethical and healthcare system readiness, and drawing comparative insights from Canada's legal and institutional approach to medical assistance in dying (MAiD), with particular attention to safeguards against systemic harm.

In pursuit of this aim, the study seeks to achieve the following objectives:

1. To analyse the constitutional provisions in South Africa that underpin debates on euthanasia and assisted dying, with particular emphasis on the rights to dignity, life, autonomy and privacy, with a view to evaluating whether these rights support or limit the possibility of legalizing euthanasia.
2. To investigate Canada's legal, constitutional and policy framework on medical assistance in dying and evaluate its relevance as a comparator for South Africa.
3. To analyse Canada's experience with the proposed expansion of MAID to include mental illness as a sole condition, identifying best practices and challenges, and to assess their implications for South Africa's legal and ethical readiness.
4. To evaluate whether South Africa's health system, including its palliative care services and ethical oversight mechanisms, is adequately prepared to support the legal regulation of assisted dying.
5. To examine the risks and challenges such as inequality, cultural and religious resistance and the potential for misuse of euthanasia provisions within a resource strained health sector, and how these factors could affect the feasibility of legalising euthanasia in South Africa.
6. To examine the extent to which enhanced palliative care and home-based support can serve as genuine alternatives to euthanasia in South Africa by addressing unmet end-of-life needs, and to propose policy and legal measures that guarantee dignity and prevent inequity, abuse, and neglect in this regard.

7. To recommend contextually appropriate measures, including strengthening South Africa's palliative care and home-based healthcare infrastructure in order to build capacity, reduce potential demand for euthanasia, and ensure that any future legal framework on euthanasia is implemented safely, equitably, and with strong safeguards.

1.5 Research methodology and comparative foundation

This study adopts a qualitative, doctrinal legal research methodology. The primary focus is on analysing constitutional provisions, legislation, case law, and academic commentary to evaluate the legal, ethical and policy dimensions of euthanasia and assisted dying. The doctrinal method is complemented by a comparative approach, which considers the Canadian experience of medical assistance in dying (MAiD) as a point of reference for South Africa.

The comparative method is particularly appropriate for this study because both Canada and South Africa feature strong constitutional systems, which uphold rights such as dignity, equality, life and security of the person, making them suitable for drawing meaningful legal and ethical parallels. Both jurisdictions have confronted difficult legal questions concerning how these rights extend in end-of-life contexts, yet, Canada has established a comprehensive legislative framework for MAiD with detailed eligibility criteria and safeguards, while South Africa remains confined to judicial debates and policy discussion without the enactment of legislation.

1.5.1 Comparative approach

Canada's constitutional democracy, established in 1867, is among the oldest in the world. In contrast, South Africa's democratic dispensation dates only from 1994. This temporal difference strengthens the comparative analysis, as Canada's long constitutional tradition offers lessons for South Africa's newer democracy. Canada is used as the principal comparator because its legal framework on assisted dying developed from constitutional litigation, notably the *Carter v Canada (Attorney General)* followed by legislative reform.[14] This makes Canada a valuable example for South Africa, where constitutional arguments are similarly central to the ongoing legal

[14] *Carter v Canada (Attorney General)* 2015 SCC5, [2015] 1 S.C.R 331 (hereafter cited *Carter*).

and ethical debate on whether euthanasia should be recognised and legalised. The Canadian framework also highlights challenges that remain relevant to South Africa, including safeguarding vulnerable groups, ensuring equitable access to constitutional rights and healthcare services, and balancing ethical concerns with rights-based arguments.

1.5.2 Basis for selecting Canada as a comparative model

Canada's experience is particularly instructive for South Africa, as it demonstrates how constitutional rights can be translated into a statutory regime while accommodating cultural and ethical sensitivities. However, Canada's ongoing challenges including the recent legislative decision to delay the expansion of MAiD eligibility for persons whose sole medical condition is a mental illness until 17 March 2027, in order to allow provinces and territories time to develop consistent policies, guidelines, standards, and practitioner training serve as a cautionary lens.[15] By examining both the successes and limitations of Canada's approach, this study aims to provide nuanced insights into South Africa's readiness to consider a similar framework.

Both South Africa and Canada operate under constitutional democracies grounded in the common law tradition yet shaped by unique legal evolutions and societal values. South Africa follows a hybrid legal system that merges Roman Dutch civil law, English common law, and customary law, underpinned by a supreme Constitution.[16] The Constitution of the Republic of South Africa, 1996, is the highest law of the land, and all legislation including any future euthanasia law must comply with the Bill of Rights.[17] Judicial precedent plays a central role in the interpretation of constitutional provisions, and this has increasingly shaped medico-legal discourse in South Africa, particularly regarding the rights to life, dignity, autonomy, and privacy.[18]

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15 Reuters, 'Canada delays assisted death for those with mental illness until 2027' *Reuters* (1 February 2024) <https://www.reuters.com/worl/americas/canada-delays-assisted-deaths-those-with-mental-illness-until-2027-2024-02-01> accessed 12 June 2024.

16 Peter W Hogg, *Constitutional Law of Canada* (Carswell 5th edn 2007) ch 1; *Carter v Canada (Attorney General)* 2015 SCC 5 paras 1–3.

17 Constitution of the Republic of South Africa, 1996 s 2; Christa Rautenbach, 'South Africa: A Hybrid Legal System with Indigenous Law' in J Basedow (ed), *Introduction to Legal Systems* (OUP 2010) ch 12, 12.2–12.3; *S v Makwanyane* 1995 (3) SA 391 (CC) paras 5–6.

18 Iain Currie and Johan de Waal, *The Bill of Rights Handbook* (8th edn, Juta 2023) ch 13.

Similarly, Canada is largely a common law country, with the exception of Quebec private law, which is civil-law based.[19] Its legal framework is heavily influenced by Charter-based rights adjudication.[20] The Canadian Charter of Rights and Freedoms, enacted in 1982, empowers courts to invalidate laws that unjustifiably infringe fundamental rights, particularly ss 7 and 15.[21] This was exemplified in *Carter v Canada* (*AG*),[22] where the Supreme Court struck down the prohibition of physician-assisted death for violating the rights to life, liberty, and security of the person.[23]

This comparative foundation is significant because both South Africa and Canada require that rights limitations be justified under proportionality clauses.[24] Canada's common law system, shaped by Charter jurisprudence, facilitated the legalisation of euthanasia and offers South Africa a functional model, though one that must be adapted to local ethical, cultural, and health system realities. Importantly, Canada has positioned medical assistance in dying within the broader continuum of end-of-life care, explicitly recognising that pain management and patient choice are not mutually exclusive.[25] Its legislative journey was marked by extensive public participation, parliamentary debate, and consultation with healthcare professionals and civil society, reflecting a transparent policy-making process.[26] This emphasis on inclusive dialogue provides valuable lessons for South Africa, where public engagement on euthanasia has remained limited since the South African Law Reform Commission's 1998 report.[27]

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19 Hogg, *Constitutional Law of Canada* ch 1; H Patrick Glenn, *Legal Traditions of the World* (OUP 5th edn 2014) ch 6; Civil Code of Québec (1994).

20 Department of Justice Canada, *The Canadian Legal System* (Government of Canada, 2023) <https://www.justice.gc.ca/eng/csj-sjc/just/03.html> accessed 12 January 2025

21 Canadian Charter of Rights and Freedoms, 1982, ss 7 and 15.

22 *Carter* paras 55–68.

23 *Carter* paras 79-90, 127.

24 Canadian Charter of Rights and Freedoms, Part 1 of the Constitution Act, 1982, being Schedule B of the Canada Act 1982 (UK) c 11; Constitution of the Republic of South Africa, 1996, s 36.

25 Government of Canada, *Legislative Background: Medical Assistance in Dying* (Bill C-14) (2016) 5–6.

26 House of Commons of Canada, *Special Joint Committee on Physician Assisted Dying: Medical Assistance in Dying: A Patient-Centred Approach* (Report of the Special Joint Committee on Physician Assisted Dying, February 2016) 2–4.

27 South African Law Reform Commission, *Discussion Paper 71: Euthanasia and the Artificial Preservation of Life*,Project 86 of 1998(SALRC, 1998) Hereafter cited SALRC, *Euthanasia and the Artificial Preservation of life*).

1.6 Scope and limitation of the study

This dissertation focuses primarily on the constitutional, legal and policy dimensions of euthanasia and assisted dying in South Africa, with particular attention to the rights to life, dignity, autonomy and equality as enshrined in the Constitution,[28] considered through the lens of comparative insights from Canada's medical assistance in dying (MAiD) framework. The analysis is limited to doctrinal and comparative legal research, supported by relevant policy documents, judicial decisions and scholarly commentary.

The study does not attempt to provide a comprehensive medical, theological or sociological account of euthanasia. While ethical, cultural and religious perspectives are acknowledged, they are engaged only insofar as they intersect with legal and constitutional arguments. Similarly, the study does not examine clinical trials, biomedical data or detailed palliative care practices, although the availability and adequacy of palliative services remain central to assessing South Africa's readiness for legislative reform. The geographical focus of this study is South Africa, with Canada serving as the principal comparator. References to other jurisdictions, such as the Australia or the Netherlands are included only where they assist in contextualising the debate or illustrate broader international trends.

Finally, the study acknowledges limitations inherent in comparative analysis. Canada and South Africa differ significantly in resources, healthcare infrastructure and socio-cultural contexts. These differences constraint the extent to which Canada's framework can be transplanted into South Africa. The comparative exercise is therefore not prescriptive but illustrative, aiming to identify lessons and challenges rather than to propose a direct model for adoption.

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28 Constitution of the Republic of South Africa, 1996, ss 9, 10, 11.

1.7 Rational and significance of the study

This study is significant for several reasons. First, it addresses a gap in South African legal scholarship by examining euthanasia and assisted dying through a constitutional and comparative lens. While the South African Law Reform Commission produced a discussion paper on euthanasia in 1998, the issue has not been revisited comprehensively in light of more recent constitutional jurisprudence or international developments. By reassessing the debate in the contemporary context, this study contributes to a renewed and evidence-based discourse.

Secondly, the study has practical relevance for policy and law reform. End of life care is a pressing concern in South Africa, where inequalities in healthcare, limited access to palliative care services and systemic inefficiencies frequently undermine the dignity of terminally ill patients. By drawing on Canada's experience with medical assistance in dying (MAiD), the study highlights both the possibilities and limitations of legal reform in South Africa. Thirdly, the study contributes to comparative constitutional law. Both Canada and South Africa are jurisdictions with strong rights-based constitutions, yet their responses to assisted dying have diverged. Examining the Canadian framework provides valuable insights into how constitutional rights can be interpreted and applied in the sensitive context of end-of-life decision making, while also cautioning against the risks of uncritically transplanting foreign models.

Additionally, the study is particularly timely given recent international developments, such as Canada's ongoing consideration of MAiD for individuals with mental illness as the sole underlying condition. These debates highlight the careful balance between constitutional rights, ethical safeguards and systemic capacity, lessons that are critical for South Africa as it considers future legal reform in this topic.

Finally, this study is significant because it engages with the ethical and human dimension of law. By framing the research around the readiness of South Africa to introduce euthanasia, the study acknowledges that constitutional rights do not operate in isolation but are shaped by cultural values, healthcare realities and social trust in public institutions. This approach ensures that the analysis remains grounded, compassionate and contextually relevant.

1.8 Summary of chapters

This dissertation is structured into six chapters, each addressing a specific aspect of the research problem.

1.8.1 Chapter One: Introduction

Chapter one, the current chapter introduces the study, outlines the research problem, objectives, methodology and situates the study within both the South African and comparative Canadian context. It highlights the contemporary relevance of assisted dying, including recent Canadian debates on extending MAiD to individuals whose sole underlying condition is a mental illness, and frames the central issues of South Africa's readiness for legal reform.

1.8.2 Chapter Two: Historical overview, concepts and definitions

Chapter Two provides a historical perspective on euthanasia, including its origins, definitions and evolution on a global level and within South Africa. This chapter establishes the conceptual foundation for the study situating the debates within a broader legal and ethical context.

1.8.3 Chapter Three: South Africa's Healthcare system and the ethics of end-life care: palliative care, access and euthanasia

Chapter Three examines South Africa's healthcare system and palliative care policy in relation to end-of-life care. It considers the availability and quality of palliative services, the ethical and professional frameworks guiding medical practice, and the practical challenges faced by healthcare providers and families of terminally ill patients. The chapter also explores structural inequalities and systemic barriers within the health sector that are relevant to debates on the potential legalisation of euthanasia.

1.8.4 Chapter Four: The legal development of Medical Assistance in Dying (MAiD) in Canada

Chapter Four, explores Canada's medical assistance in dying (MAiD) framework, tracing its legislative development from Bill C-14 through subsequent amendments. It examines the constitutional and ethical debates surrounding MAiD, the safeguards built into the system, and its evolving reception among courts, healthcare professionals, and the public. The chapter also considers how Canada's experience with MAiD informs broader discussions on autonomy, dignity, and the regulation of end-of-life decisions.

1.8.5 Chapter Five: South Africa's constitutional rights and the case for legalising euthanasia: with insights from Canada

Chapter Five explores' South Africa's constitutional rights and the case for legalising euthanasia with insights from Canada. This chapter assesses South African constitutional rights to dignity, autonomy, privacy and life and relevant legislation and case law in the context of euthanasia. This chapter engages with comparative insights from Canada to evaluate whether a rights-based argument can support the legalisation of euthanasia in South Africa, while also addressing practical, ethical, and readiness considerations.

1.8.6 Chapter Six: Reflections, lessons and recommendations for South Africa from Canada

Chapter Six provides reflections, lessons and recommendations for South Africa from Canada. The chapter, synthesizes the findings from previous chapters, reflecting on the readiness of South Africa to implement a regulated framework for assisted dying. The chapter concludes with a considered assessment of why South Africa is currently not ready for euthanasia legislation, highlighting systemic, cultural and religious factors.

1.9 Literature review

Debates on euthanasia and assisted dying in South Africa are framed by constitutional principles, statutory law, and evolving medico-legal discourse.[29] The South African Law Reform Commission's Report on Euthanasia and the Artificial Preservation of Life (Project 86, 1998) remains the seminal national inquiry, recognising the tension between autonomy and the state's interest in preserving life, but limiting override of autonomous choice to cases of impaired capacity or undue influence.[30] The report has been critiqued in legal scholarship for limited engagement with proportionality analysis under section 36.[31]

South Africa's transformative constitutional framework situates euthanasia within the rights to life (s 11), dignity (s 10), and equality (s 9), which are interdependent rather than hierarchical.[32] Dignity has been interpreted as a condition for substantive freedom and moral agency, empowering individuals to make deeply personal choices, including those relating to death.[33] Restrictions on autonomy must therefore be the least restrictive means of protecting vulnerable persons while respecting constitutional rights.[34]

The state of palliative care provision is central to these debates. The National Policy Framework and Strategy on Palliative Care (2017) set ambitious goals for integration, yet implementation remains uneven.[35] Services are heavily reliant on NGOs and hospices, with funding shortages leading to closures and leaving rural areas

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29 Constitution of the Republic of South Africa, 1996, ss 9–11.

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

31 SALRC*, Report on Euthanasia and the Artificial Preservation of Life;* David J McQuoid-Mason, '*Stransham-Ford v Minister of Justice and Correctional Services and Others*: Can Active Voluntary Euthanasia and Doctor-Assisted Suicide Be Legally Justified and Are They Consistent with the Biomedical Ethical Principles? Some Suggested Guidelines for Doctors to Consider' (2015) 8(2) South African Journal of Bioethics and Law 34,34–38; Ames Dhai and David J McQuoid-Mason, 'Euthanasia: Is There a Case?' (2011) 4(2) South African Journal of Bioethics and Law 45,46-47; Johann D van der Vyver, 'Euthanasia in South Africa: A Constitutional Perspective' (1999) 14 South African Public Law 288, 300–302.

32 *Constitution* of the Republic of South Africa, 1996 ss 9–11.

33 *S v Makwanyane* 1995 (3) SA 391 (CC) para 144; Sandra Liebenberg, *Socio-Economic Rights: Adjudication under a Transformative Constitution* (Juta 2010) ch 3.

34 Constitution of the Republic of South Africa, 1996 s36; *Pharmaceutical Manufacturers Association of SA and Another: In re Ex Parte President of the Republic of South Africa and Others 2000 (2) SA 674 (CC);* David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (Oxford University Press 2007) ch 5.

35 National Department of Health, *National Policy Framework and Strategy on Palliative Care 2017-2022* (2017).

underserved.[36] Alongside these policy frameworks, the *National Health Insurance Act 2023* (Republic of South Africa) represents a significant legislative reform aimed at restructuring healthcare financing and delivery. Although its primary focus is on equitable access to health services rather than end-of-life decision-making, it forms part of the broader health legislation framework within which debates on euthanasia and palliative care must be situated. Legal analysis and postgraduate research emphasise that such limitations complicate end-of-life decision-making and influence debates on the appropriateness of euthanasia.[37] However, peer-reviewed scholarship directly assessing South Africa's readiness for euthanasia from a palliative care perspective remains limited, marking this as an emerging area within health law.[38] Inadequate access undermines ethical readiness for euthanasia reform, since constitutional rights cannot be realised if patients lack basic end-of-life support.[39]

Clinical studies reveal gaps in healthcare professional training and contradictory attitudes toward end-of-life interventions. Systemic implementation challenges include prescribing hesitancy, weak referral pathways, and resource shortages further complicate continuity of care.[40] A notable gap in the literature is the integration of mental health within palliative and end-of-life frameworks. Existing research indicates that mental health services remain underdeveloped within end-of-life frameworks, with limited interdisciplinary collaboration between palliative care providers and mental health professionals.[41]

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36 Cornelia Drenth and others, 'Palliative Care in South Africa' (2018) 55(2S) Journal of Pain and Symptom Management S170, S170–S177.

37 Republic of South Africa, *National Health Insurance Act 2023* (Government Gazette No 50061, 20 June 2023); Marc Welgemoed & Henry Lerm, "Palliative Care as a Form of Relief for the Dying: A South African Perspective" (2020) 41(2) Obiter 326, 328-330; Willem-Johan Steyn and Mukinay C. Bondo, 'Perspectives and Attitudes of South African Medical Professionals Towards Active Euthanasia' (2024) South African Family Practice 66(1) South African Family Practice, 4–5.

38 Liz Gwyther, Frank Brennan and Richard Harding, 'Advancing Palliative Care as a Human Right' (2009) 38(5) Journal of Pain and Symptom Management 767, 770–772; Welgemoed and Lerm, 'Palliative Care as a Form of Relief for the Dying: A South African Perspective' 343–344; Lukas Radbruch and others, 'Redefining Palliative Care: A New Consensus-Based Definition' (2020) 60(4) Journal of Pain and Symptom Management 754,754–764.

39 Daniel J Ncayiyana, 'Euthanasia: A South African Perspective' (2013) 103(6) South African Medical Journal 365, 365–366.

40 Steyn and Bondo, 'Perspectives and Attitudes of South African Medical Professionals Towards Active Euthanasia' 3–5; Gwyther, Brennan and Harding, 'Advancing Palliative Care as a Human Right' 770–772; Welgemoed and Lerm, 'Palliative Care as a Form of Relief for the Dying: A South African Perspective' 340–344.

41 Juanita O Arendse, Virginia Zweigenthal and Liz Gwyther, 'Integration of Palliative Care into

This challenge is compounded by broader systemic constraints, such as shortages of psychiatrists and psychologists, as well as limited training in psychosocial support within palliative care settings.[42] South African palliative care research has predominantly concentrated on cancer and HIV/AIDS, while psychiatric conditions and the psychological dimensions of euthanasia debates have received minimal scholarly attention.[43]

Comparative developments reinforce caution. In Canada, the expansion of Medical Assistance in Dying (MAiD) to individuals whose sole underlying condition is a mental illness has faced repeated delays. The eligibility expansion was initially postponed to March 2024 due to concerns regarding safeguards and clinical readiness. However continued uncertainty surrounding assessment standards, healthcare capacity and ethical considerations resulted in further postponement to March 2027 following legislative amendments, including Bill C-62.[44] These repeated delays highlight the complexity of regulating euthanasia in the context of mental illness and underscore the need for caution when considering similar reforms in other jurisdictions. Comparative scholarship between Canada and South Africa remains limited, particularly regarding mental illness eligibility and healthcare readiness, with most studies examining each jurisdiction independently.

South Africa's Health System: A Before and After Implementation Study' (2026) 31 *Health SA Gesondheid* 3242, Discussion; University of Cape Town, 'UCT Prioritises End-of-Life Care with Novel Project' *UCT News* (25 April 2025) <https://www.news.uct.ac.za/> accessed 10 April 2026.

42 South African Society of Psychiatrists, *Position Statement on Mental Health Resources in South Africa* (2019) <https://www.sasop.co.za/> accessed 20 April 2026; Liz Gwyther, 'Palliative Care in South Africa' (2012) Cancer Control, 98, 100–101; Arendse, Zweigenthal and Gwyther, 'Integration of Palliative Care into South Africa's Health System: A Before and After Implementation Study' (2026) 31 Health SA Gesondheid 3242, (Discussion).

43 David c Spencer and others, 'Palliative Care Guidelines for the Management of HIV-infected People in South Africa' (2019) 20(1) Southern African Journal of HIV Medicine e1013; Southern African HIV Clinicians Society, *Guidelines: HIV Palliative Care* (2018) <https://www.sahivsoc.org/> accessed 20 April 2026; South African National Department of Health, *National Policy Framework and Strategy on Palliative Care 2017–2022* (Pretoria, 2017).

44 Government of Canada, *Medical Assistance in Dying: Mental Illness Eligibility Update* (Health Canada, February 2024). Government of Canada, *Medical Assistance in Dying: Legislation in Canada* (Canada.ca, 29 February 2024) <https://www.canada.ca/> accessed 20 April 2026 (confirming delay of eligibility for persons whose sole underlying condition is a mental illness until 17 March 2027); Centre for Addiction and Mental Health, *Medical Assistance in Dying (MAiD) and Mental Illness – FAQs* (December 2025) <https://www.camh.ca/> accessed 20 April 2026 (noting repeated delays due to safeguard and readiness concerns).

This gap underscores the relevance of the present study, which adopts a cautious comparative approach to assessing South Africa's legal readiness for euthanasia. [45]

1.10 Ethics approval

Approval for this research was granted by the Research Ethics Committee of the College of Law at the University of South Africa (UNISA), reference no 5005. The study was carried out in full accordance with UNISA's policies on research ethics, academic integrity, copyright, and anti-plagiarism.

1.11 Conclusion

Chapter one has set the foundation for this dissertation by outlining the background, rationale, research problem and objectives that guide the study. The Chapter has also emphasised the broader questions of readiness, particularly the risks and challenges posed by systemic inequalities, cultural and religious resistance and the potential misuse of euthanasia in a resource constrained healthcare sector. These reflections frame the need for a nuanced and context sensitive analysis. While the constitutional framework appears to offer a legal basis for debating the right to die, practical, ethical and societal readiness of South Africa remains deeply contested, raising uncertainties about whether euthanasia could be responsibly legalised under current circumstances.

Having established the research problem and objectives, the dissertation now turns to the historical and conceptual foundations of euthanasia. Chapter Two provides a critical overview of the evolution of euthanasia, tracing historical development, underlying concepts and definitional debates. This review not only situates the contemporary South African discourse within a broader global context but also clarifies the key terms and distinctions, such as active and passive euthanasia as well as physician assisted suicide, which underpin the debates analysed in later chapters. In doing so, chapter two offers a conceptual framework against which South Africa's constitutional and healthcare realities can be examined in subsequent chapters.

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[45] National Department of Health, *Mental Health Policy Framework and Strategic Plan 2013–2020* (Pretoria 2013) 12–15; World Health Organization, *Atlas of Palliative Care in Africa* (WHO 2017) 34–36; Ncayiyana, 'Euthanasia: A South African Perspective' 365–366.

CHAPTER TWO

2. Euthanasia: historical overview, concepts and definitions

2.1 Introduction

End-of-life care is not confined to a single era but represents a progressive continuum across human history. What changes over time are the approaches adopted, the levels of societal acceptance or reluctance, and the evolutionary measures through which medicine and ethics respond to questions of dignity, autonomy, and compassion. From ancient debates on mercy killing to modern struggles over constitutional interpretation, the discourse has continually reflected the tension between preserving life and respecting autonomy.

While this research draws primarily on lessons from existing legislation and judicial consideration, it also acknowledges the emerging role of artificial intelligence in healthcare. AI's integration into end-of-life contexts remains largely prospective rather than established, yet its potential influence on autonomy, dignity, and vulnerability warrants brief reflection. Anticipating these ethical challenges allows scholars and policymakers to prepare for future debates, much as earlier medical innovations forced society to reconsider the boundaries of life and death.

This chapter therefore traces the evolution of the euthanasia debate. Beginning with global historical perspectives, moving to South Africa's constitutional and scholarly struggles, and then situating AI as a progressive frontier in medical ethics, particularly in the context of euthanasia. It further outlines the distinct types of euthanasia: active, passive, voluntary, and involuntary before distinguishing euthanasia from physician-assisted suicide (PAS).

While this chapter introduces the conceptual and definitional framework, subsequent chapters will engage in deeper analysis. Chapter Three will examine South Africa's palliative care system, while later chapters will explore comparative constitutional frameworks and emerging challenges. In this way, Chapter Two serves as an introductory foundation, preparing the ground for more detailed constitutional, ethical, and policy analysis.

2.2 The evolution of the euthanasia debate

The notion of euthanasia has a deeply contested and multifaceted history, reflecting evolving social, religious, and legal attitudes towards life and death.[46] Its origins may be traced to ancient philosophical and medical traditions, in which questions concerning the morality of hastening death were already the subject of sustained ethical debate.[47] Over time, these debates evolved in response to broader cultural, religious, and political transformations, producing diverse and often conflicting global perspectives on euthanasia.[48]

2.2.1 A global historical overview of euthanasia

The concept of euthanasia has deep historical roots dating back to antiquity.[49] In classical Greece and Rome, philosophers and dramatists grappled with the morality of hastening death in cases of incurable illness or unbearable suffering.[50] Stoic thinkers argued that suicide could be justified if extreme suffering or loss of autonomy prevented a person from living in accordance with virtue.[51] By contrast, Pythagoras and his followers opposed voluntary termination of life, grounding their stance in beliefs about the transmigration of the soul and the sanctity of existence.[52] Plato, while not explicitly advocating euthanasia, laid the foundations for later debates by considering the role of the state and the individual in questions of life and death.[53]

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46 John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (2nd edn, Cambridge University Press 2002) ch 1; Ezekiel J Emanuel and others, 'Attitudes and Practices of Euthanasia and Physician Assisted Suicide in the US, Canada and Europe' (2016) 316 (1) JAMA 79, 79-80.

47 Ian Dowbiggin, *A Concise History of Euthanasia* (Rowman & Littlefield 2007) ch 1, 1-2.

48 Criminal Code, RSC 1985, c C-46, s 241.1.

49 Anna Hiatt, 'The History of Euthanasia Movement' (*JSTOR Daily*, 6 January 2016) <https://daily.jstor.org/history-euthanasia-movement/ >accessed 10 September 2024.

50 John D Papadimitriou and others, 'Euthanasia and Suicide in Antiquity: Viewpoint of the Dramatists and Philosophers' (2007) 100(1) JRSM 25, 25-28.

51 Esra Cagri-Mutlu, 'Epictetus on Death' (2018) 17(4) Gaziantep University Journal of Social Sciences 1262, 1262–1269. Epictetus, reflecting Stoic philosophy, argued that living in accordance with nature was the highest good, and if extreme suffering made this impossible, suicide could be justified.

52 Papadimitriou and others, 'Euthanasia and Suicide in Antiquity' 26 outlines Pythagorean opposition to suicide, rooted in metaphysical beliefs about the soul's transmigration and the sanctity of existence.

53 Plato, *Republic* (c 428/427–348/347 BC). Writings on civic duty and the role of the state laid groundwork for later debates on ethics of life and death.

Classical dramatists also explored proto-euthanasic themes. In *Prometheus Bound*, Aeschylus presents Io as a tragic figure tormented by divine punishment, condemned to ceaseless wandering and psychological anguish.[54] At one point, Io's despair is so profound that she longs for death rather than continued suffering.[55] Similarly, *Women of Trachis* depicts Heracles requesting his son to end his life to alleviate unbearable pain.[56] These works highlight early reflections on autonomy, compassion, and filial duty, demonstrating that debates on dignity and suffering are not modern phenomena but have been embedded in cultural traditions for centuries.

The Hippocratic Oath introduced a professional counterpoint to philosophical debates, prohibiting physicians from administering lethal drugs.[57] This tension between compassion and professional duty established an ethical fault line that continues to shape medical debates today.[58]

During the Middle Ages, Christianity profoundly reshaped attitudes towards euthanasia. Augustine of Hippo argued that life is a divine gift, and only God has authority over life and death.[59] Thomas Aquinas, in his *Summa Theologica*, condemned suicide as contrary to both natural and divine law, a position that

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54 Aeschylus, *Prometheus Bound*, trans Herbert Weir Smyth, Loeb Classical Library (Harvard University Press 1926) lines 789–793 stating "Would that I might die! … I am weary of wandering through the world, driven by the sting of madness, pursued by fate." <https://en.wikisource.org/wiki/Loeb_Classical_Library/L145/Prometheus_Bound> accessed 21 May 2024.

55 Aeschylus' *Prometheus Bound* 789-793*;*
Anna Katherine Batson, 'Prometheus In Suspension: Suffering and the Tragic in Aeschylus's *Prometheus Bound* (Senior Honours Thesis, Liberty University, December 2009) 19–32 <https://digitalcommons.liberty.edu/honors/101/> accessed 21 October 2025.

56 Sophocles, *Oedipus Rex,* trans Hugh Lloyd-Jones (Loeb Classical Library, Harvard University Press 1994) lines 100–120.

57 Hippocratic Oath, in W.H.S. Jones (trans), *Hippocrates, Volume I* (Loeb Classical Library, Harvard University Press 1923) 299–301. This is where the Oath explicitly states: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.": Also see Thomas A Cavanaugh, *Hippocrates' Oath and Asclepius' Snake: The Birth of the Medical Profession* (Oxford University Press 2018) 112–115.
Cavanaugh explains how the Oath's prohibition against deadly drugs has historically been interpreted as a rejection of euthanasia and physician-assisted suicide, framing it as a professional counterpoint to philosophical arguments about mercy killing.

58 Ludwig Edelstein, 'The Hippocratic Oath: Text, Translation and Interpretation' in O Temkin and CL Temkin (eds), *Ancient Medicine: Selected Papers of Ludwig Edelstein* (Johns Hopkins University Press 1967) 25–28; PBS Online, 'The Hippocratic Oath: Classical Version' (*NOVA Online*, 24 March 2001) <https://www.pbs.org/wgbh/nova/doctors/oath_classical.html> accessed 12 June 2024.

59 Augustine of Hippo, *Confessions* (Henry Chadwick tr, Oxford University Press 1991)
Augustine framed suicide as prideful disobedience against God's sovereignty, shaping Western Christian doctrine.

influenced Catholic teaching for centuries.[60] This theological stance was later reaffirmed in the Catechism of the Catholic Church, which distinguishes between refusing extraordinary measures to prolong life and directly causing death.[61]

The Catechism clearly states that euthanasia is morally unacceptable, emphasising that "nothing and no one can in any way permit the killing of an innocent being as an end in itself or as a means to an end".[62] Papal documents such as John Paul II's *Evangelium Vitae* (1995) further reinforced this position, defining euthanasia as "an act or omission which, of itself by intention, causes death in order to eliminate suffering" and rejecting any notion of a right to die under human autonomy.[63] The Pope underscored that euthanasia violates divine law and warned that autonomy arguments risk undermining respect for vulnerable lives.[64] The Catholic Church asserts that suffering, while difficult, has spiritual value, especially in connection with Christ's suffering.[65]

The debate re-emerged in the 19th and 20th centuries, [66] driven by medical advances and shifting societal attitudes.[67] Physicians began to question whether their duty to heal could extend to practices that intentionally ended life.[68] However, the term 'euthanasia' was tragically misappropriated during the Nazi regime, particularly in the

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60 Thomas Aquinas, *Summa Theologica* II–II, Q 64, Art 5 <https://plato.stanford.edu/entries/aquinas/> accessed 12 September 2024. Aquinas condemned suicide as violating natural self-preservation, duty to community, and divine sovereignty principles central to Catholic moral theology.

61 Catholic Church, *Catechism of the Catholic Church*, (2nd edn, Liberia Editrice Vatocana 1997) para 2278 <https://www.usccb.org/sites/default/files/flipbooks/catechism/552/> accessed 15 June 2025. The document clarifies that discontinuing extraordinary or disproportionate medical treatment is morally permissible, distinguishing it from euthanasia.

62 Catholic Church, *Catechism of the Catholic Church* para 2279.

63 Pope John Paul II, *Evangelium Vitae* (Encyclical Letter, 25 March 1995) para 65 <https://www.vatican.va/content/johnpaulii/en/encyclicals/documents/hf_jpii_enc_25031995_evangelium-vitae.html> accessed 13 September 2024.

64 John Paul II, *Evangelium Vitae* paras 64–65 John Warns that autonomy arguments risk undermining respect for vulnerable lives, situating euthanasia within a "culture of death".

65 John Paul II, *Evangelium Vitae* paras 67–68 John Affirms that suffering has spiritual value, especially in connection with Christ's suffering.

66 Charlotte Hogdman, 'Victorian medicine: why the 19th Century was a time of Seismic Medical Change' (*History Extra,* 24 November 2024) <https://www.historyextra.com/period/victorian/victorian-medicine-medical-innovation-invention/ > accessed 10 July 2025.

67 Samuel Williams, 'Proposal for the Use of Anaesthetics in Cases of Hopeless Illness' (1870) cited in Ezekiel J Emanuel, 'The History of Euthanasia Debates in the United States and Britain' (1994) 101(1) Annals of Internal Medicine 225, 226.

68 David Clark, 'Nineteenth-century doctors and care of the dying' *in To Comfort Always: A History of Palliative Medicine since the Nineteenth Century* (Oxford University Press 2016) 12–15.

T4 programme, which involved the systematic killing of disabled and marginalised individuals. This misuse created lasting stigma and ethical caution around the concept.[69]

After World War II, discussions refocused on patient autonomy, suffering, and medical ethics.[70] Right to die movements emerged in Britain and the United States, advocating for voluntary euthanasia and physician-assisted suicide for terminally ill patients.[71] In 1935, Charles Killick Millard founded the Voluntary Euthanasia Legalisation Society in Britain (later Dignity in Dying), marking the beginning of organised advocacy.[72] In the 1970s and 1980s, groups such as the Hemlock Society in the United States further advanced the debate, emphasising compassion and dignity in end-of-life decisions.[73]

Legislative milestones followed. In 1995, Australia's Northern Territory enacted the Rights of the Terminally Ill Act, becoming the first jurisdiction to legalise voluntary active euthanasia, though it was repealed in 1997.[74] Oregon in the United States enacted the Death with Dignity Act (1997), legalising physician-assisted suicide.[75] The Netherlands pioneered the legalisation of euthanasia with the Termination of Life on Request and Assisted Suicide (*Review Procedures)* Act 2002,[76] followed by Belgium

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69 Aktion T4, Hitler's 1939 order authorising Philipp Bouhler and Karl Brandt to allow doctors to grant "mercy death" to "incurable" patients, in *Nazi Conspiracy and Aggression, Volume I* (US Government Printing Office 1946) 878–879;
Jewish Virtual Library, 'Background and Overview of the Nazi Euthanasia (T-4 Program)' <https://www.jewishvirtuallibrary.org/background-and-overview-of-the-nazi-euthanasia-t-4-program> accessed 10 September 2024.

70 The Doctors' Trial (*United States v Karl Brandt and others*), in *Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10, Volume I* (US Government Printing Office 1949) 1–20 The Nuremberg Doctors' Trial exposed Nazi medical atrocities and directly led to the Nuremberg Code (1947), which enshrined voluntary consent and patient autonomy as central to medical ethics.:
Toni C Saad, 'The history of autonomy in medicine from antiquity to principlism' (2018) 21 Medicine, Health Care and Philosophy 125, 132–134. Saad traces how autonomy became a cornerstone of bioethics in the post-war period, noting that the atrocities of WWII accelerated the shift toward patient rights, suffering, and ethical safeguards in medicine.

71 Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (Hemlock Society 1991) Introduction.

72 Charles Killick Millard, 'Voluntary Euthanasia Legalisation Society' (1935).

73 Hemlock Society, founded by Derek Humphry in 1980, was an American nonprofit advocating voluntary euthanasia and physician-assisted suicide for terminally ill individuals. See ' Hemlock Society' (*Grokipedia*, updated 2023)

74 Christopher J Ryan, 'Euthanasia in Australia the Northern Territory Rights of the Terminally Ill Act' (1996) 334(5) New England Journal of Medicine 326, 326–328.

75 Oregon State Legislature, Death with Dignity Act (1997), codified at Or Rev Stat §§ 127.800–127.897. <https://www.oregonlegislature.gov/bills_laws/ors/ors127.html> accessed 12 June 2025.

76 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002

(2002),[77] Luxembourg (2009),[78] and Canada (2016).[79] These legislative milestones illustrate the global shift towards recognising autonomy and dignity in end-of-life decision-making, while also highlighting the persistent ethical, medical, and constitutional tensions that continue to shape the debate.

Canada has played a pivotal role in shaping contemporary discourse on assisted dying. In *Rodriguez v British Columbia* (Attorney General) (1993), the Supreme Court of Canada upheld the prohibition on assisted suicide, reflecting a strong commitment to the sanctity of life.[80] More than two decades later, in *Carter v Canada* (Attorney General) (2015), the Court revisited the issue and struck down the prohibition, recognising that criminalisation infringed the constitutional rights to life, liberty, and security of the person.[81] This landmark ruling established medical assistance in dying (MAiD) as a constitutionally protected choice under strict conditions.[82]

The debate was further advanced in *Truchon v Attorney General of Canada* (2019), where the Quebec Superior Court invalidated the requirement that death be "reasonably foreseeable" before accessing MAiD.[83] This decision directly influenced the enactment of Bill C-7 in 2021, which abolished the "reasonably foreseeable" requirement and broadened MAiD access to include individuals suffering from chronic, non-terminal conditions.[84] These Canadian cases are pivotal not only for their domestic impact but also because they provide a comparative framework for jurisdictions like South Africa.

This broader shift in attitudes has not been confined to courts and legislatures alone. Professional medical bodies have also reconsidered their positions. For example, the British Medical Association (BMA), which had long opposed euthanasia, adopted a

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(Netherlands, 2001), (effective 1 April 2002); Johan Legemaate, 'The Dutch Euthanasia Act and Related Issues' (2004) 11(13) Journal of Law and Medicine 312, 312–323.

77 Belgian Act on Euthanasia, 28 May 2002 (Belgium).

78 Law on Euthanasia and Assisted Suicide (Loi du 16 mars 2009) (Luxembourg).

79 Bill C-14, *An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts* (Medical Assistance in Dying), SC 2016, c 3 (Canada).

80 *Rodriguez v British Columbia* (*Attorney General*) [1993] 3 SCR 519.

81 *Carter v Canada* (Attorney General) 2015 SCC 5, [2015] 1 SCR 331.

82 Government of Canada, *Medical Assistance in Dying (MAiD) Law: Overview* (Canada.ca updated 2024) <Canada's medical assistance in dying (MAID) law> accessed 12 June 2025.

83 *Truchon v Attorney General of Canada* 2019 QCCS 3792.

84 *Truchon v Attorney General of Canada* 2019 QCCS 3792; Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), SC 2021, c 2.

neutral stance in 2021, signalling a notable change in professional attitudes.[85] Similar re-considerations have occurred elsewhere. The Canadian Medical Association (CMA), following the *Carter* ruling in 2015, moved from opposition to supporting medical assistance in dying under strict safeguards.[86] Likewise, the Royal Dutch Medical Association (KNMG) aligned its position with the Netherlands' 2002 legislation, supporting euthanasia under regulated conditions.[87] Together, these shifts illustrate how professional ethics have increasingly adapted to evolving legal and constitutional frameworks.

A global historical overview demonstrates that euthanasia has at various times, been condemned, tolerated, or even institutionalised, depending on the prevailing ethical framework. From antiquity through the Middle Ages to modern legislative reforms, the practice has reflected broader philosophical, religious, and medical currents.[88] The historical debates on euthanasia were underpinned by enduring philosophical tensions between autonomy and sanctity of life. Autonomy emphasises the individual's right to self-determination, including decisions about the timing and manner of death.[89] By contrast, sanctity of life arguments, rooted in religious and natural law traditions, hold that life possesses intrinsic value that cannot be intentionally terminated.[90] These competing foundations continue to shape contemporary legal and ethical debates, with autonomy often invoked in constitutional frameworks, while sanctity of life remains central to moral and theological objections.[91]

This tension between autonomy and sanctity of life provides the lens through which South Africa's historical background must be examined, particularly against colonial and apartheid medical legacies, the enduring influence of Christian morality, and the evolving constitutional order that emerged after 1994. Establishing a clear conceptual and definitional framework is therefore essential to situate euthanasia within both

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85 British Medical Association, *Physician Assisted Dying: End of Life Ethics* (Policy Statement, September 2021).

86 Canadian Medical Association, *CMA Policy: Medical Assistance in Dying* (2015).

87 Royal Dutch Medical Association (KNMG), *Position Paper: The Role of the Physician in Euthanasia* (2003, updated 2011).

88 Margaret Pabst Battin, *Ending Life: Ethics and the Way We Die* (Oxford University Press 2005) 15–32.

89 John Stuart Mill, *On Liberty (1859*, Penguin Classics 1985) 68, 70.

90 Thomas Aquinas, *Summa Theologica* II–II, Q 64, Art 5, 65.

91 Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (Knopf 1993) 3, 12.

historical and contemporary discourse, and to provide clarity for the legal and ethical debates that follow.

2.2.2 The history of the euthanasia debate in South Africa

South Africa's debate on euthanasia must be situated within the broader constitutional framework established after 1994.[92] The Constitution of the Republic of South Africa, 1996, enshrines the rights to life, dignity, and autonomy, which form the foundation of arguments both for and against the legalisation of euthanasia.[93] Section 10 of the Bill of Rights guarantees that "everyone has inherent dignity and the right to have their dignity respected and protected," while section 11 affirms that "everyone has the right to life".[94] These rights have been interpreted as requiring a balance between the sanctity of life and the individual's freedom to make end-of-life decisions.[95]

In South African law, which is rooted in a mixed legal system combining civil law and English common law, euthanasia has been traditionally considered unlawful.[96] Acts of intentionally ending the life of another even with consent, have been classified as murder or culpable homicide.[97] The meaning of euthanasia has been expressed differently by various scholars and philosophers, however, they all converge on a similar core understanding.[98] South African Professor McQuoid-Mason,[99] who has contributed extensively to the study of euthanasia and end of life options, defines euthanasia as 'conduct that brings about an easy and painless death for persons suffering from an incurable or painful disease or condition'.[100]

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92 Constitution of the Republic of South Africa, 1996 (Act 108 of 1996).

93 Constitution of the Republic of South Africa, 1996, ch 2 (Bill of Rights).

94 Constitution of the Republic of South Africa ss 10–11.

95 *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (4) SA 50 (GP) 53–54 (interpreting dignity and autonomy in end-of-life context, though overturned on appeal).

96 Supreme Court of Appeal of South Africa, 'History of the Court' <https://www.supremecourtofappeal.org.za/index.php/history> accessed 1 February 2025 ("South African law is a 'mixed legal system', an amalgam of different legal systems, and its origins are derived from the civil law systems of Europe and the common law of England").

97 Criminal Law Amendment Act 105 of 1997 (South Africa), s 239.

98 Božidar Banović, Veljko Turanjanin and Anđela Miloradović, 'Ethical Review of Euthanasia and Physician Assisted Suicide' (2017) 46(2) Iranian Journal of Public Health 173, 175–176 <https://pmc.ncbi.nlm.nih.gov/articles/PMC5402774/> accessed 14 June 2024.

99 LexisNexis, 'Biography of David J McQuoid-Mason' <https://www.lexisnexis.co.za/lawsa/authors/david-mcquoid-mason> accessed 4 November 2025.

100 David J McQuoid-Mason, 'Emergency Medical Treatment and "Do Not Resuscitate" Orders' (2013) 103(4) SAMJ 2223,223-225 <https://doi.org:10.7196/SAMJ.6672> accessed 12 March 2025.

The precise date of the earliest formal discussion on euthanasia in South Africa is difficult to determine, as informal philosophical and medical deliberations likely occurred within ethical and clinical circles.[101] Euthanasia as an end of life choice involves a complex interplay of legal, ethical and societal factors.[102] Early discussions were influenced by international developments and public input, often framed in theoretical terms and shaped by debates in Europe, particularly in jurisdictions that had already legalised euthanasia and physician assisted suicide.[103]

In South Africa, the debate during the 1980s and 1990s was shaped by the enduring influence of *S v Hartmann*, where a physician was convicted of culpable homicide after assisting his terminally ill father to die.[104] The case remained central to medical and legal discourse, reinforcing judicial opposition to euthanasia while exposing the ethical dilemmas faced by practitioners.[105] Alongside this, advocacy for palliative care and hospice services gained momentum, with organisations such as the Hospice Palliative Care Association of South Africa promoting patient dignity and end-of-life choice.[106] Bioethics scholarship also began to emerge, with figures such as McQuoid-Mason engaging with comparative debates and highlighting tensions between criminal law and medical.[107]

Judicial consideration has also shaped South Africa's euthanasia debate. In *Clarke v Hurst* NO (1992),[108] though predating the Constitution, the court authorised the withdrawal of treatment from a patient in a persistent vegetative state,[109] a judgment

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101 Mojalefa L J Koenane, 'Euthanasia in South Africa: Philosophical and Theological Considerations' (2017) 38 Verbum et Ecclesia a1549, PDF 1–8 <https://www.scielo.org.za/pdf/vee/v38n1/04.pdf> accessed 21 January 2024.

102 South African Law Reform Commission, *Discussion Paper 71: Euthanasia and the Artificial Preservation of Life, Project 86* (SALRC 1997) 1–3. (Hereafter cited SALRC*, Euthanasia and the Artificial Preservation of Life).*

103 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands), arts 2–3. Verifies influence of European jurisdictions that had legalised euthanasia and physician-assisted suicide.

104 *S v Hartmann* 1975 (3) SA 532 (C).

105 SALRC, *Euthanasia and the Artificial Preservation of Life* 14–16.
Confirms enduring influence of Hartmann in shaping medical and legal discourse.

106 Hospice Palliative Care Association of South Africa, *Annual Report* (HPCA 1990s) documenting the rise of hospice and palliative care advocacy.

107 David J McQuoid-Mason, *Medical Law in South Africa* (Butterworths 1987) 210–215.
Highlights comparative debates and tensions between criminal law and medical ethics.

108 *Clarke v Hurst NO* 1992 (4) SA 630 (D) (Hereafter cited *Clarke v Hurst).*

109 *Clarke v Hurst* 641–642.

that remains influential in medico-legal reasoning around autonomy and the permissibility of withholding or withdrawing life-sustaining treatment.[110]

By the late 1990s, the South African Law Reform Commission initiated Project 86, producing Discussion Paper 71, which examined legal, ethical, and medical dimensions of euthanasia but stopped short of recommending reform.[111] More than two decades later, in *Stransham-ford v Minster of Correctional Services* (2015),[112] the High Court initially granted an order permitting physician-assisted dying,[113] though this was overturned on appeal.[114] The case nevertheless marked a turning point, forcing courts to grapple directly with constitutional rights to dignity and autonomy.[115] Taken together, the SALRC's work and judicial consideration illustrate the persistent gap between constitutional principles and legislative reform.

Later, debates on euthanasia began to move beyond academic and theoretical circles into broader public discourse.[116] Advocacy by figures such as Professor Sean Davison, who openly campaigned for the legalisation of assisted dying after facing prosecution for helping his terminally ill mother, brought unprecedented visibility to the issue.[117] His activism coincided with growing scholarly engagement, as more South African legal and medical experts began publishing on the ethical and constitutional dimensions of end-of-life decision-making.[118]

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110 SALRC, *Euthanasia and the Artificial Preservation of Life* 14–16.

111 SALRC, *Euthanasia and the Artificial Preservation of Life* 1–3.
First structured, state-led debate on euthanasia; framework for discussion but no reform recommended.

112 *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (4) SA 50 (GP) (Hereafter cited Stransham-Ford).

113 *Stransham-Ford* 53–54.

114 *Minister of Justice and Correctional Services v Estate Stransham-Ford* 2016 (4) SA 50 (SCA) (hereafter cited *Estate Stransham-Ford*).

115 Ntokozo Myandu, 'Developing the Common Law Crime of Murder in Relation to Physician Assisted Suicide and Physician Assisted Euthanasia: Revisiting the Missteps of *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (4) SA 50 (G)' (2021) 54 De Jure 249, 253–257.

116 Koenane, 'Euthanasia in South Africa: Philosophical and Theological Considerations' a1549, PDF2-3.

117 DignitySA, 'Our Story' (DignitySA 2011) <https://www.dignitysouthafrica.org/our-story> accessed 12 June 2024; Sean Davison, *Before We Say Goodbye: Helping My Mother Die* (Penguin Global 2013).

118 Barry Sneiderman and David McQuoid-Mason, 'Decision-Making at the End of Life: The Termination of Life-Prolonging Treatment, Euthanasia (Mercy Killing) and Assisted Suicide in Canada and South Africa' (2000) 25 Comparative and International Law Journal of Southern Africa 193, 195–213.

Several scholarly contributions have addressed the ethical, legal, and social dimensions of euthanasia in South Africa, with particular emphasis on the moral significance of dignity in end-of-life care. Philosophical perspectives, such as those advanced by Mojalefa Koenane, call for multidisciplinary engagement with moral controversies like euthanasia.[119] Legal scholarship, including the work of Magda Slabbert and Carina van der Westhuizen, has emphasised autonomy and the right to die with dignity,[120] while Farzana Paleker's normative analysis situates dignity within both Kantian and African philosophical frameworks.[121]

Empirical studies, such as those by Steyn and Bondo,[122] and by Jacobs and Hendricks, highlight the diverse attitudes of medical professionals and students, underscoring the practical challenges of implementing euthanasia in a pluralistic society.[123] More recent contributions, including Kotze and Roos, examine evolving case law and the role of medical professionals in shaping ethical end-of-life care.[124] Civil society advocacy, most notably through Sean Davison and DignitySA, has further kept the issue in public view, with campaigns and litigation that continue to influence public discourse and policy debates.[125]

These scholarly contributions spanning philosophical, ethical, empirical, and activist perspectives demonstrate that academic research and civil society advocacy have provided the only sustained momentum in South Africa's euthanasia debate. In the absence of legislative reform and with courts constrained by constitutional interpretation, it is scholarship and public engagement that have kept the discourse

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119 Koenane, 'Euthanasia in South Africa: Philosophical and Theological Considerations' a1549.

120 Magda Slabbert and Carina van der Westhuizen, 'Death with Dignity in Lieu of Euthanasia' (2007) 22(2) South African Public Law 366, 370–372.

121 Farzana Paleker, Euthanasia in South Africa: A Normative Analysis and Application of Dignity (MA Thesis, University of Witwatersrand, 2016) 45–52.

122 Willem Johan Steyn and Mukinay C Bondo, 'Perspectives and Attitudes of South African Medical Professionals toward Active Euthanasia' (2024) 66(1) South African Family Practice a5926, PDF 2–4.

123 Ridwaan K Jacobs and Marlene Hendricks, 'Medical Students' Perspectives on Euthanasia and Physician Assisted Suicide' (2018) 108(6) South African Medical Journal 484, 485–487.

124 Carla Kotze and Johannes L Roos, 'End of Life Care in South Africa: Important Legal Developments' (2022) 28 South African Journal of Psychiatry a1748, PDF 5–7.

125 DignitySA, 'History and Activities of Dignity South Africa' (14 August 2024) <https://dignitysouthafrica.org> accessed 12 March 2025; DignitySA filed a landmark constitutional challenge in the North Gauteng High Court on April 9, 2026, to decriminalize medically assisted dying (MAiD) in South Africa, The Core Request: DignitySA is asking the court to declare the blanket common-law prohibition on assisted dying unconstitutional and invalid, while giving Parliament 24 months to draft a regulated legal framework.

alive, ensuring that questions of dignity, autonomy, and compassion remain central to the national conversation.

Yet, ethical reflection does not occur in isolation, just as past medical innovations reshaped the boundaries of autonomy and dignity, artificial intelligence now emerges as the progressive frontier, raising new questions about how end-of-life decisions may be influenced in the future.

2.2.3 Artificial Intelligence (AI) in end-of-life care of life care

Artificial intelligence (AI) represents the most recent stage in the trajectory of medical innovation, but unlike antibiotics, transplantation, or life-support technologies, its role in end-of-life care remains largely envisioned rather than empirically established.[126] Current applications focus on predictive analytics and decision-support, yet there is insufficient evidence to ascertain the true level of AI's intelligence or influence in shaping end-of-life decisions.[127] Patterns in technological evolution, show that each advance has historically raised profound ethical questions, and AI is no exception.

Emerging research underscores the seriousness of these concerns. A Swedish study (Uppsala University's AICare project) warns that AI in healthcare could have dire regulatory and ethical consequences, particularly in safeguarding vulnerable patients.[128] Similarly, integrative reviews of AI in palliative care highlight risks of dehumanization, inequity, and decision-making dilemmas, even as they acknowledge opportunities for efficiency and patient-centredness.[129] The repeated delays in Canada's extension of medical assistance in dying (MAiD) to mental illness further reveal deep-seated ethical unease, with Health Canada attributing the postponements to challenges of safety, ethical complexity, and system readiness.[130]

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126 David J Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (Basic Books, 1991) 112–118.

127 Enrico Coiera, 'The Digital Patient: Advancing Healthcare Through AI' (2019) 27 Nature Medicine 17,17- 18.

128 Uppsala University, *AICare Project: AI in Healthcare Regulation and Ethics* (Uppsala University 2021-2026) <https://www.uu.se/en/centre/crb/research/projects/aicare> accessed 12 August 2025.

129 Abel García Abejas and others, 'Ethical Challenges and Opportunities of AI in End-of-Life Palliative Care: Integrative Review' (2025) 14(1) Interactive Journal of Medical Research e12345.

130 Government of Canada, *Medical Assistance in Dying and Mental Illness (*Health Canada, 2024) <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>

These vulnerabilities raise broader questions about how emerging technologies, including AI, might interact with end-of-life decision-making, suggesting that caution in the Canadian context may also serve as a warning about autonomy in technologically mediated care.

In South Africa, where Ubuntu[131] emphasises relational dignity, the challenge is to ensure that AI complements rather than compromises human judgment, empathy, and cultural sensitivity.[132] The ethical question is therefore not whether AI should be used in end-of-life care, but how it can be integrated responsibly, with safeguards that prioritise transparency, accountability, and constitutional values.

While AI represents a progressive frontier in medical ethics, the current debate in South Africa remains anchored in the doctrinal distinctions between voluntary, non-voluntary, and involuntary euthanasia, to which this chapter now turns. Situating these categories within the broader trajectory of past debates, present dilemmas, and envisioned futures highlights how medical ethics and technology evolve in tandem. Yet, despite these revolutions and eras of change, the definitional boundaries of euthanasia have endured, continuing to frame contemporary discourse.

2.3 Various types of euthanasia[133]

Understanding the concept and different forms of euthanasia is essential for ethical and moral reflection, legal analysis, medical decision-making, public policy development, and personal or family involvement. Such clarity ensures that discussions and decisions are informed, compassionate, and grounded in respect for individual rights and wishes. Euthanasia is generally classified into voluntary, non-voluntary, and involuntary forms, and may further be distinguished as active or passive depending on the role of medical intervention.

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accessed 12 May 2024.

131 Ubuntu is described as a philosophy of "humanity" and "I am because we are" in Zulu and Xhosa traditions. It embodies shared humanity and was central to South Africa's Truth and Reconciliation Commission, contrasting Western individualism with African communalism.

132 Cornelius Ewuoso and Ndivhuwo Mhlongo, 'Ubuntu and the Ethics of Artificial Intelligence in Health Research' (2021) 21 Developing World Bioethics 4, 7.

133 Kimberly Holland, 'Euthanasia: Understanding the Facts' (*Healthline*, 7 October 2024 <https://www.healthline.com/health/what-is-euthanasia> accessed 21 January 2025.

In discussing these forms, several key themes emerge, the ethical complexity of distinguishing between active and passive euthanasia,[134] the role of intent in medical practice,[135] the importance of patient autonomy,[136] and the diverse legal frameworks that govern these practices.[137] A central point of debate is whether the distinction between active and passive euthanasia carries genuine ethical weight.[138]

It is equally important to use accurate terminology in end-of-life care, since imprecise or emotive language can obscure distinctions between lawful medical practice, such as palliative care, and unlawful acts of intentionally hastening death.

2.3.1 Active euthanasia and passive euthanasia

Euthanasia is generally understood as the practice of intentionally ending the life of a patient to limit suffering.[139] Within this framework, two principle forms are distinguished, active euthanasia, which involves a direct intervention such as administering a lethal drug,[140] and passive euthanasia, which involves withholding or withdrawing life-sustaining treatment, for example discontinuing a ventilator or declining antibiotics for a severe infection.[141] The difference lies not only in the method of achieving the outcome but also in the intent and role of healthcare providers.[142] Active euthanasia requires deliberate action, while passive euthanasia is characterised by omission, though both ultimately result in the patient's death.[143]

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134 Banović, Turanjanin and Miloradović, 'Ethical Review of Euthanasia and Physician Assisted Suicide' 175–176.

135 Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (7th edn, Oxford University Press 2013) 149–152.

136 Slabbert and van der Westhuizen, 'Death with Dignity in Lieu of Euthanasia' 370–372.

137 SALRC, *Euthanasia and the Artificial Preservation of Life* 5–7.

138 Banovic, Turanjanin and Miloradovic, 'Ethical review of euthanasia and physician assisted suicide'75-179.

139 Center for Health Ethics, 'Definition of Euthanasia' (University of Missouri School of Medicine) <https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/euthanasia> accessed 12 January 2024.

140 Banović, Turanjanin and Miloradović, 'Ethical Review of Euthanasia and Physician Assisted Suicide' 175–179.

141 McQuoid-Mason, 'Emergency Medical Treatment and "Do Not Resuscitate" Orders' 223-225.

142 Center for Health Ethics, 'Definition of Active and Passive Euthanasia' <https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/euthanasia> accessed 12 January 2024.

143 Center for Health Ethics, 'Definition of Active and Passive Euthanasia' <https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/euthanasia> accessed 12 January 2024.

2.3.1.1 The ethical perspectives surrounding active euthanasia and passive euthanasia

While this research does not centrally focus on the ethical debates surrounding euthanasia, it is essential to acknowledge the underlying ethical frameworks that distinguish active from passive euthanasia. Ethical debates surrounding euthanasia often centre on the tension between compassion, autonomy, and the sanctity of life.[144] In the case of active euthanasia, critics argue that deliberately ending life undermines the physician's duty to heal and risks eroding respect for human life.[145]

Supporters, however, emphasise autonomy and mercy, contending that when suffering is unbearable, assisting death may be the most compassionate response.[146] By contrast, passive euthanasia is generally viewed as more ethically permissible, since it involves allowing death to occur naturally by withdrawing or withholding treatment.[147] The ethical justification here rests on respecting patient autonomy and avoiding futile interventions that prolong suffering without benefit.[148] Yet even passive euthanasia raises moral questions, particularly when decisions are made on behalf of incapacitated patients or when cultural and religious beliefs frame withdrawal of treatment as morally equivalent to killing.[149]

Taken together, these perspectives reveal that while passive euthanasia is often defended as ethically less contentious, both forms ultimately force society to confront the balance between preserving life and respecting dignity at the end of life.[150]

144 Beauchamp and Childress, *Principles of Biomedical Ethics* 149–152.
145 Banović, Turanjanin and Miloradović, 'Ethical Review of Euthanasia and Physician Assisted Suicide' 175–176.
146 Helga Kuhse, *Euthanasia: The Moral Foundations of Euthanasia Policy* (Oxford University Press 1987) 12–15.
147 McQuoid-Mason, 'Emergency Medical Treatment and "Do Not Resuscitate" Orders' 223-225.
148 SALRC, *Euthanasia and the Artificial Preservation of Life* 5-7.
149 Banović, Turanjanin and Miloradović 'Ethical Review of Euthanasia and Physician Assisted Suicide' 177–179.
150 Slabbert and van der Westhuizen, 'Death with Dignity in Lieu of Euthanasia' 370–372.

2.3.1.2 Legal considerations of euthanasia

The legal treatment of euthanasia in South Africa reflects the broader tension between the sanctity of life and individual autonomy.[151] Active euthanasia is generally classified as unlawful, amounting to murder or culpable homicide even with patient consent.[152] The deliberate administration of a lethal intervention is viewed as incompatible with the physician's legal duty to preserve life.[153] By contrast, passive euthanasia, the withdrawal or withholding of life-sustaining treatment has been treated more cautiously, with courts recognising circumstances where discontinuing futile treatment may be legally permissible.[154]

Cases such as *Clarke v Hurst NO* (1992) authorised the withdrawal of treatment from a patient in a persistent vegetative state, illustrating judicial willingness to acknowledge autonomy and medical futility.[155] More recently, *Stransham-Ford v Minister of Justice and Correctional Services* (2015) forced courts to grapple directly with constitutional rights to dignity and autonomy, though the order permitting physician-assisted dying was overturned on appeal, leaving the legal position unchanged.[156]

Comparative perspectives further highlight the divergence in legal frameworks. Jurisdictions such as the Netherlands and Canada have enacted statutory regimes permitting euthanasia or medical assistance in dying under strict safeguards, while South Africa has yet to legislate.[157] The absence of statutory reform underscores the persistent gap between constitutional principles and legislative clarity, leaving healthcare providers uncertain about the boundaries of lawful practice.[158]

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151 Constitution of the Republic of South Africa, 1996, ss 10–11.
152 Criminal Law Amendment Act 105 of 1997 (South Africa) s 239.
153 SALRC, *Euthanasia and the Artificial Preservation of Life* 14–16.
154 McQuoid-Mason, 'Emergency Medical Treatment and "Do Not Resuscitate" Orders' 223-225.
155 *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) 637-639, 657-660 (D).
156 *Stransham-Ford* 53–54; *Estate Stransham-Ford* 2016 (4) SA 50 (SCA).
157 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands); Parliament of Canada, Medical Assistance in Dying Act SC 2016, c 3.
158 South African Law Reform Commission*, Discussion Paper 71 (Project 86) Euthanasia and the Artificial Preservation of Life (*1998*) 14–16;* Magda Slabbert*, '*Euthanasia: A South African Perspective' (2003) 8(2) Potchefstroom Electronic Law Journal 1, 5–7.

2.3.1.3 Autonomy and informed consent

Autonomy and informed consent are central to the ethical and legal debates on euthanasia. In the case of active euthanasia, autonomy is invoked to justify a patient's right to request assistance in dying, emphasising self-determination and the ability to make voluntary choices about one's own body and suffering.[159] Critics, however, caution that autonomy may be compromised by external pressures, inadequate safeguards, or diminished capacity in terminal illness.[160]

Passive euthanasia also raises autonomy concerns, particularly in decisions to withdraw or withhold treatment. Here, the patient's prior wishes, advance directives, or living wills become crucial in ensuring that consent is respected.[161] Where patients lack capacity, decisions often fall to family members or medical professionals, raising questions about substituted judgment and the risk of paternalism.[162]

In South Africa, the constitutional right to dignity under section 10 has been interpreted as encompassing autonomy, yet courts have remained cautious in extending this to euthanasia.[163] The unresolved tension between autonomy and legal prohibition underscores the need for clear statutory guidance to balance individual choice with societal safeguards.[164] This emphasis on autonomy has been recognised in broader medical law. In *Castell v De Greef* (1994), the court affirmed informed consent as central to patient-centred care, marking a decisive shift away from medical paternalism.[165] Comparative jurisprudence highlights the constitutional significance of autonomy. In *Carter v Canada* (Attorney General) (2015), the Supreme Court of Canada recognised that criminalisation of assisted dying infringed the rights to life,

159 Banović, Turanjanin and Miloradović, 'Ethical Review of Euthanasia and Physician Assisted Suicide'175–176.

160 Banović, Turanjanin and Miloradović, 'Ethical Review of Euthanasia and Physician Assisted Suicide' 177–178.

161 McQuoid-Mason, 'Emergency Medical Treatment and "Do Not Resuscitate" Orders' 223-225.

162 SALRC, *Euthanasia and the Artificial Preservation of Life* 43–53.

163 Constitution of the Republic of South Africa, 1996 s 10; *S v Makwanyane and Another* 1995 (3) SA 391 (CC); *Clarke v Hurst NO* 1992 (4) SA 630 (D); *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (4) SA 50 (GP); *Minister of Justice and Correctional Services v Estate Stransham-Ford* 2017 (3) SA 152 (SCA).

164 Constitution of the Republic of South Africa, 1996, ss 10–11; SALRC, *Euthanasia and the Artificial Preservation of Life* 14–16.

165 *Castell v De Greef* 1994 (4) SA 408 (C).

liberty, and security of the person, thereby affirming autonomy as a constitutional value.[166]

In sum, the distinction between active and passive euthanasia provides a framework for ethical and legal debate, though both raise unresolved questions about autonomy and dignity. This sets the stage for examining involuntary euthanasia, where the absence of consent makes the issues even more contested.

2.3.2 Involuntary euthanasia

Exploring involuntary euthanasia is crucial when forming a legal framework for euthanasia, as it ensures the protection of vulnerable populations, prevents abuse, and upholds ethical principles.[167] Among the various forms of euthanasia, involuntary euthanasia stands out as one of the most controversial. It occurs when a person's life is ended without their explicit consent, often because they are unable to provide it due to age, illness, incapacitation, or coercion.[168]

Involuntary euthanasia raises profound ethical questions that challenge the boundaries of human rights, autonomy, and the sanctity of life.[169] While some argue that it may constitute an act of mercy in cases of extreme suffering, others view it as a violation of the fundamental right to life, echoing concerns of moral overreach and potential abuse.[170]

In sum, the distinction between active and passive euthanasia provides a framework for ethical and legal debate, though both raise unresolved questions about autonomy and dignity. This sets the stage for examining involuntary euthanasia, where the absence of consent makes the issues even more contested. Importantly, this must be distinguished from non-voluntary euthanasia, which occurs when consent is absent because the patient is incapable of expressing their wishes, such as in cases of unconsciousness or severe incapacity.[171] By contrast, involuntary euthanasia involves

166 *Carter v Canada* (*Attorney General)* 2015 SCC 5, [2015] 1 SCR 331.
167 Kotze and Roos, 'End of life care in South Africa: important Legal developments' a1748.
168 Jose Pereira, 'Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls' (2011) 18(2) Current Oncology e38, e38-e39.
169 Beauchamp and Childress, *Principles of Biomedical Ethics* 152.
170 John Keown, *Euthanasia*, *Ethics and Public Policy: An Argument Against Legalisatio*n (Cambridge University Press 2002) 75–78.
171 Gary Chan Kok Yew, *Health Law, and Medical Ethics in Singapore* (Taylor & Francis 2020) 145.

ending life against the patient's expressed wishes, making it ethically and legally more contentious.[172]

2.3.2.1 Active involuntary euthanasia

Active involuntary euthanasia refers to the deliberate act of ending a patient's life without their consent, typically through a direct intervention such as administering a lethal drug.[173] Unlike voluntary euthanasia, where the patient requests assistance, or non-voluntary euthanasia, where consent is absent due to incapacity,[174] active involuntary euthanasia is carried out against the patient's expressed wishes or without any opportunity for consent.[175] It is widely regarded as ethically impermissible and legally equivalent to homicide, since it directly violates the principles of autonomy, dignity, and informed consent.[176]

Active involuntary euthanasia, the deliberate act of ending a person's life without their consent, is one of the most contentious issues in bioethics and public policy.[177] Proponents argue that it may sometimes be justified as an act of mercy in cases of extreme suffering where the individual is incapable of making decisions, such as in a persistent vegetative state.[178] From a utilitarian perspective, Peter Singer suggests that when the quality of life is irreparably diminished, the interests of all parties including family and caregivers should be considered.[179] He contends that maintaining life in a state of profound suffering or non-conscious existence may conflict with the ethical principle of reducing harm.[180]

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172 McQuoid-Mason, *Medical Law in South Africa* 210–215.

173 Center for Health Ethics, 'Definition of Euthanasia' (University of Missouri, 2024) <https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/euthanasia> accessed 12 January 2024.

174 Helga Kuhse, *The Sanctity-of-Life Doctrine in Medicine (*Oxford University Press 1987) 12–15.

175 Banović, Turanjanin and Miloradović, 'Ethical Review of Euthanasia and Physician Assisted Suicide' 176–177.

176 SALRC, *Euthanasia and the Artificial Preservation of Life* 45–47.

177 Keown, *Euthanasia*, *Ethics and Public Policy* 75–78.

178 Pereira, 'Legalising Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls' e39–e40.

179 Peter Singer, 'Voluntary Euthanasia: A Utilitarian Perspective' (2003) 17(5-6) Bioethics 526, 536.

180 Singer, 'Voluntary Euthanasia: A Utilitarian Perspective' 536.

Critics, however, strongly reject this reasoning. Margaret Somerville argues that active involuntary euthanasia undermines the sanctity of life and individual autonomy,[181] warning of a slippery slope that could erode trust in medical professionals and expose vulnerable populations to abuse.[182] Similarly, John Keown cautions against legalisation, highlighting the dangers of subjective judgments about quality of life.[183] He stresses that once exceptions are permitted, society risks normalising the devaluation of individuals with severe disabilities or terminal illness.[184]

Empirical evidence also reflects this tension. A study by Steyn and Bondo[185] found that while some South African medical professionals support active euthanasia in cases of unbearable suffering with patient consent, there is significant apprehension regarding involuntary euthanasia.[186] Participants emphasised the potential for abuse and the moral implications of ending life without explicit consent.[187] Notably, scholarly discourse has focused more on voluntary euthanasia and physician-assisted suicide, leaving active involuntary euthanasia comparatively under-explored.[188] Finally, Ntokozo Mnyandu cautions that developments in South African common law must be approached carefully. Mnyandu warns that judicial precedents risk unintentionally legitimising non-voluntary practices, underscoring the need for a cautious legal approach that balances moral complexity with the protection of fundamental rights.[189]

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181 Margaret Somerville, 'Euthanasia: The failure of memory and imagination' (*Mercatornet*, 28 September 2017) <https://www.mercatornet.com/euthanasia-a-failure-of-memory-and-imagination> accessed 15 January 2024.

182 Somerville 'Euthanasia: The failure of memory and imagination'. Somerville emphasises that even with the best intentions, the act of ending a life without consent violates fundamental human rights.

183 Keown, '*Euthanasia, Ethics, and public policy* 39.

184 Keown, *Euthanasia, Ethics, and public policy* 70-80, 115.

185 Steyn and Bondo, 'Perspectives and attitudes of South African medical professionals' a5926, PDF 1-10.

186 Steyn and Bondo, 'Perspectives and attitudes of South African medical professionals' a5926, PDF 2-5.

187 Steyn and Bondo, 'Perspectives and attitudes of South African medical professionals' a5926, PDF 6.

188 Steyn and Bondo, 'Perspectives and attitudes of South African medical professionals' a5926, PDF 7–8.

189 Ntokozo Myandu, 'Developing the common law crime of murder in relations to physician assisted suicide and physician assisted euthanasia: revisiting the missteps of *Stransham-Ford v Minister of justice and correctional services* 2015 (4) SA 50 (G)' (2021) 54 De Jure 249.

The following section therefore turns to passive involuntary euthanasia, where treatment is withheld or withdrawn despite the patient's refusal, to further explore how autonomy, vulnerability, and medical responsibility intersect in end-of-life care.

2.3.2.2 Passive involuntary euthanasia

Passive involuntary euthanasia, often described as the withholding or withdrawal of life-sustaining treatment from an individual who cannot provide explicit consent, occupies a complex ethical and legal space.[190] Medical definitions emphasise that while palliative care must continue, the intent is to alleviate suffering rather than to hasten death.[191]

Scholar Keown argues that in circumstances where treatment is futile or merely prolongs suffering,[192] withholding or withdrawing care may be ethically defensible, though such cases remain distinct from active euthanasia.[193] Peter Singer suggests that decisions regarding incapacitated patients should prioritise minimising harm and maximising well-being,[194] provided they are made transparently and in the patient's best interests.[195] By contrast, Somerville warns that passive involuntary euthanasia risks blurring the boundaries of medical ethics.[196] She cautions that withholding treatment without explicit consent may normalise non-consensual actions and erode the principle of preserving life whenever possible.[197] Similarly, Knoetze and de Freitas highlight the importance of conscientious objection, noting that healthcare practitioners must be able to exercise moral and legal discretion in such cases.[198]

190 McQuoid-Mason, Emergency Medical Treatment and '"Do not Resuscitate Orders"*'* 223-225.
191 McQuoid-Mason, Emergency Medical Treatment and '"Do Not Resuscitate Order"' 223-225.
192 John Keown, 'The Logical Link Between Voluntary and Non-Voluntary Euthanasia' (2022) 71 Cambridge Law Journal 445, 452.
193 Keown, *Euthanasia, Ethics, and public policy* 42-47*.*
194 Peter Singer, *Rethinking life and Death: The Collapse of our Traditional Ethics* (St Martin's Press, New York 1994) 112-115 (discussing utilitarian justification for decisions about incapacitated patients).
195 Singer, *Rethinking life and Death: The Collapse of our Traditional Ethics* 113-114.
196 Margaret Somerville, 'Does it matter how we die? Ethical and legal issues raised by combining Euthanasia and Organ transplantation' (2019) 86 (4) The Linacre Quarterly 359, 360.
197 Somerville, 'Does it matter how we die?' 361-362.
198 Adriaan Knoetze and Shaun de Freitas 'The Protection of Conscientious Objection against Euthanasia in Health Care' (2019) 22 PER/PELJ 1,1-32.

They argue for institutional protocols, oversight mechanisms, and legal clarity to ensure decisions are made ethically and transparently.[199]

2.4 Difference between euthanasia and physician assisted suicide

The distinction between euthanasia and physician-assisted suicide (PAS) is not merely semantic but carries profound legal implications under South African law.[200] Both practices are currently unlawful and may be prosecuted under the common law crimes of murder or culpable homicide, depending on the circumstances.[201] The legal system, however, tolerates passive euthanasia in certain circumstances, such as the withdrawal of life-sustaining treatment, when guided by informed consent, medical futility, and ethical guidelines.[202]

Euthanasia involves a physician or third party directly administering a lethal substance to cause death, whereas physician assisted suicide (PAS) requires the individual to perform the final act themselves.[203] The Health Professions Council of South Africa (HPCSA) defines PAS as occurring when a practitioner provides the means,[204] typically medication or information to end their own life.[205] At present, South African courts and professional guidelines regard both euthanasia and PAS as incompatible with the practitioner's role as a healer, rendering such acts unethical and unlawful.[206] Yet despite this restrictive position, the legal and ethical debate surrounding PAS in South Africa remains highly contested, with increasing calls for legislative reform.[207]

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199 Knoetze and de Freitas, 'The Protection of Conscientious Objection' 20–25.

200 Keown, *Euthanasia, Ethics and Public Policy* 120-121.

201 McQuoid-Mason, 'Emergency Medical Treatment and "Do Not Resuscitate Orders"' 223-225.

202 *Stransham-Ford* para 48.

203 Iain Brassington, *Medical Ethics: A Very Short Introduction* (Oxford University Press, 2006) 66-67.

204 Health Professions Council of South Africa (HPCSA), *Ethical Guidelines on Palliative Care: Booklet 18* (2019) 14, para 9.5 <https://www.hpcsa.co.za/Content/upload/events/hpcsa_conference_2019/20Aug_Session_4_Guidelines_for_Palliative_Care%20%281%29.pdf> accessed 12 February 2025.

205 School of Medicine, University of Missouri, Center for Health Ethics, 'Euthanasia' <https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/euthanasia> accessed 1 February 2025.

206 HPCSA, *Ethical Guidelines on Palliative Care* para 9.5.

207 David McQuoid-Mason, 'Doctor assisted suicide: What is the present legal position in South Africa? (2015) 105 (7) SAMJ 526-527; Ntokozo Mnyandu 'Developing the common law crime of murder in relation to physician assisted suicide and physician assisted euthanasia: Revisiting the missteps of *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (4) SA 50 (G). 249, 259-264.

McQuoid-Mason notes that, under South African law, doctors who withdraw or withhold treatment are not held liable, since such conduct is recognised as lawful when guided by informed consent, medical futility, and professional ethical guidelines.[208] This reflects the legal and ethical acceptance of allowing natural death when continued intervention would undermine dignity and quality of life.[209] Yet the law draws a sharp distinction between passive measures and active intervention, creating conceptual tension, the withdrawal of treatment is lawful, but the deliberate administration of a lethal substance remains classified as murder or culpable homicide.[210] This inconsistency has been criticised as resting on contested distinctions of intent and method, which obscure the reality that both practices ultimately hasten death.[211] Mc-Quoid-Mason further notes that the door remains open for persons wishing to make a constitutional application for physician assisted suicide.[212]

Additionally, McQuoid-Mason argues that denying terminally ill patients the choice of a dignified death infringes upon autonomy and prolongs suffering, which the state has a duty to prevent.[213] He further contends that strict procedural safeguards could minimise risks of abuse.[214] This perspective is echoed in academic discourse, which calls for a regulated framework balancing the right to life with the right to die with dignity.[215] Echoed by Jordaan, he advances a rights-based framework that centres autonomy and human dignity as central to end-of-life decision-making.[216]

In South Africa, although the doctrinal distinctions between voluntary, non-voluntary, and involuntary euthanasia are conceptually understood and debated against constitutional values, the absence of legislative regulation means that scholarly

208 David J McQuoid-Mason, *Law and Ethics in Medicine* (Butterworths 1987) 215.
209 Health Professions Council of South Africa, *Booklet 7: Guidelines on Withholding and Withdrawing Treatment* (2023).
210 *Clarke v Hurst NO and Others 1992* (4) SA 630 (D).
211 David Jan McQuoid-Mason, 'Euthanasia and the Law in South Africa' (1999) 89(2) South African Medical Journal 123,123-124.
212 David Jan McQuoid-Mason, 'Assisted Suicide and Assisted Voluntary Euthanasia: The *Stransham-Ford* High Court Case Overruled by the Appeal Court – But the Door is Left Open' (2017) 107(5) South African Medical Journal 381,381–383.
213 David Jan McQuoid-Mason, 'Euthanasia: A Constitutional Right to Die?' (1999) 15(2) South African Journal on Human Rights 188,188.
214 McQuoid-Mason, 'Euthanasia: A Constitutional Right to Die?' 188–199.
215 Lourens Botha Grové, Framework for the Implementation of Euthanasia in South Africa (LLM Dissertation, University of Pretoria 2007) 1.
216 Donrich Willem Jordaan, 'Human Dignity and the Future of the Voluntary Active Euthanasia Debate in South Africa' (2017) 107(6) South African Medical Journal 481–483.

reasoning remains largely theoretical. For practical insight into how these distinctions operate within a legal framework, comparative jurisdictions such as Canada provide valuable models.

In Canada, Medical Assistance in Dying (MAiD) encompasses both voluntary active euthanasia and PAS, legally defined under section 241.2 of the Criminal Code.[217] Following Bill C-14 (2016)[218] and Bill C-7 (2021),[219] Canadian law permits either direct administration of a lethal substance by a practitioner (euthanasia) or provision of a prescription for self-administration (PAS). Although both are legal, euthanasia is more commonly practised.[220] This dual approach provides a robust model of end-of-life care, balancing autonomy with regulated medical oversight.

Switzerland permits assisted suicide under article 115 of the Penal Code,[221] provided it is altruistic and not for personal gain.[222] Unlike other jurisdictions, Swiss law does not require terminal illness, but insists on autonomy and repeated affirmation of the decision.[223] The Netherlands[224] and Belgium similarly allow euthanasia and PAS under strict due care criteria, including unbearable suffering, physician confirmation, and written consent.[225] Across these jurisdictions, a common feature emerges, both euthanasia and PAS involve a qualified physician facilitating the end-of-life process, either by directly administering a lethal substance or by enabling the patient to self-administer it.[226]

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217 Criminal Code of Canada, RSC 1985, c C-46, ss241.1- 241.2.

218 Bill C-14, *An Act to Amend the Criminal Code* (Medical Assistance in Dying), SC 2016, c 3, 42–1.

219 Canada, Bill C-7, *An Act to Amend the Criminal Code* (Medical Assistance in Dying), SC 2021, c 2.

220 Government of Canada, 'Legislative Background: Medical Assistance in Dying' (Bill C-14, assented to 17 June 2016) 5–7.

221 Swiss Penal Code, SR 311.0 of 21 December 1937, art 115 (inciting and assisting suicide)

222 Samia A Hurst and Alex Mauron 'Assisted suicide in Switzerland: clarifying liberties and claims' (2017) (31)1 *Bioethics* 199, 200-208.

223 Swiss Academy of Medical Sciences (SAMW), 'Assisted Suicide' (2025) <https://www.samw.ch/en/Ethics/Topics-Ato-Z/Dying-and-death/Assisted-suicide.html> accessed 4 June 2025.

224 Netherlands Government, Regional Euthanasia Review Committees (2023), 'Due Care Criteria' <https://www.euthanasiecommissie.nl/ > accessed 29 October 2025.

225 Netherlands Government, 'Is Euthanasia Legal in the Netherlands?' (2023) <https://www.government.nl/topics/euthanasia/contents/is-euthanasia-allowed> accessed 29 October 2025.

226 John Griffiths, Heleen Weyers and Maurice Adams, *Euthanasia and Law in Europe* (Hart Publishing 2008) 75–78.

These definitional frameworks, when combined with scholarly perspectives, highlight the urgent need for legislative reform in South Africa, where clarity on autonomy, dignity, and equality must be balanced with ethical medical practice to ensure principled and compassionate end-of-life.

2.5 Conclusion

Chapter Two has provided a foundational overview of euthanasia, tracing its philosophical, religious, and legal evolution globally and within South Africa. The discussion highlighted enduring tensions between autonomy, dignity, and compassion on the one hand, and concerns about sanctity of life, medical integrity, and potential abuse on the other. By outlining the various forms of euthanasia and distinguishing them from physician-assisted suicide, this chapter has established the definitional and ethical framework necessary for the dissertation.

This chapter has deliberately avoided resolving these debates, instead laying the conceptual groundwork for deeper analysis in subsequent chapters. Later chapters will examine South Africa's palliative care system, comparative constitutional frameworks, and emerging challenges, thereby building on the foundations laid here.

Viewed historically, end-of-life choices have evolved across eras from ancient philosophical reflections on mortality, through religious doctrines of sanctity, to modern constitutional debates on autonomy and dignity. This trajectory now even extends into technological domains such as artificial intelligence. While AI will not be discussed further in this dissertation, its inclusion here illustrates the broader evolution of medical interventions and cautions that technological progress must always be assessed against ethical and constitutional values.

The next chapter therefore turns to the South African healthcare system and palliative care access. Unlike euthanasia or physician-assisted suicide, palliative care represents the country's prevailing response to end-of-life suffering. It is shaped not only by constitutional values of dignity and healthcare rights, but also by the realities of infrastructure, resources, medical practitioners, and caregiver experiences.

CHAPTER THREE

3. South Africa's health-care system and the ethics of end-of-life care: challenges in access to palliative care

3.1 Introduction

This chapter critically examines South Africa's healthcare system and its capacity to deliver effective palliative care within the broader debate on euthanasia. It situates palliative care within the burden of HIV/AIDS, cancer, and other life-limiting illnesses, compounded by unexpected pandemics, in order to underscore the urgency of strengthening its provision. The analysis explores the historical and structural inequities that continue to shape access to healthcare, before examining the statutory framework established by the National Health Act 61 of 2003,[227] which provides the overarching legislative basis for the organisation and regulation of healthcare services in South Africa. While the Act does not expressly regulate palliative or end-of-life care, it establishes the general framework for patient rights, institutional responsibilities, and service delivery within which debates on palliative care and euthanasia must be situated. In addition, the National Health Insurance Act 20 of 2023[228] carries significant implications for end-of-life care. By including palliative care within its definition of "Comprehensive Health-care Services," the Act signals that support at the end of life is not peripheral but part of the health system's core mandate.[229]

Attention is given to the ethical standards articulated by the Health Professions Council of South Africa (HPCSA),[230] including patient-centred principles, professional duties, and historical influences such as the doctrine of double effect.[231] The chapter also examines stakeholder perspectives, focusing on healthcare practitioners and families, whose experiences highlight the ethical ambivalence and systemic pressures surrounding end-of-life decision-making.[232]

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227 National Health Act 61 of 2003.
228 National Health Insurance Act 20 of 2023.
229 National Health Insurance Act 20 of 2023 s 1.
230 Health Professions Council of South Africa, *Guidelines for Good Practice in the Health Care Professions* (Booklet 1, 2016).
231 Alison McIntyre 'Doctrine of Double Effect' (Stanford Encyclopedia of Philosophy, revised 17 July 2023) <https://plato.stanford.edu/entries/double-effect/> accessed 12 June 2025.
232 Health Professions Council of South Africa, *General Ethical Guidelines for the Health Care*

Throughout, the discussion engages constitutional values of autonomy, dignity, and the right to healthcare under section 27 of the Constitution.[233] The chapter proceeds by first outlining South Africa's healthcare system and infrastructure, then analysing the National Health Act and National Health Insurance framework in the context of palliative care provision, HPCSA guidelines, practitioner attitudes, and family perspectives, before concluding with reflections on systemic challenges and their constitutional implications.

3.2 South Africa's healthcare system: a background perspective

South Africa's healthcare system has been profoundly shaped by its apartheid past, during which health policy and service provision were deliberately structured along racial lines.[234] The systemic limitations, resource disparities, and uneven policy reforms that continue to characterise the contemporary healthcare landscape must be understood within this historical context, particularly insofar as they inform the adequacy of existing palliative care services and the persistence of legal uncertainty surrounding euthanasia.

During apartheid, palliative care in South Africa was largely confined to missionary hospitals and charitable organisations, which operated with minimal government support and under severe resource constraints.[235] Motivated primarily by faith-based and humanitarian commitments, these providers sought to address the needs of communities systematically neglected by a racially stratified healthcare system.[236] Health services were deliberately fragmented through separate departments and administrative structures, with public funding and institutional capacity overwhelmingly

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Professions (Booklet 1, revised December 2021) <http://www.hpcsa.co.za> accessed 10 February 2025; Marc Welgemoed and Henry Lerm, 'Palliative Care as a Form of Relief for the Dying: A South African Perspective' (2020) 41(2) Obiter 384,384-370 <https://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S1682585320200002000009&lng=en&nrm=iso> accessed 12 June 2024.

233 Constitution of the Republic of South Africa, 1996, s 27; *Soobramoney* v *Minister of Health*, KwaZulu-Natal 1998 (1) SA 765 (CC).

234 Max Price, 'Healthcare as an instrument of Apartheid policy in South Africa' (1986) 1 Health policy and planning 158,158-163 <https://doi.org/10.1093/heapol/1.2.158> accessed 12 May 2025.

235 David Clark and others, 'Hospice and Palliative Care Development in Africa: A Multi-Method Review of Services and Experience' (2007) 33 Journal of Pain and Symptom Management 698, 700–701.

236 Clarke and others, 'Hospice and Palliative Care Development in Africa' 700–701.

favouring facilities serving white minority, while Black, Coloured, and Indian communities were marginalised.[237]

This structural inequity resulted in stark disparities in health outcomes, including elevated infant and maternal mortality rates, widespread malnutrition, poor sanitation, and severely limited access to essential healthcare services,[238] and black South Africans were systematically excluded from comprehensive care, including end of life support.[239]

These inequities were further entrenched through early public health legislation. The Public Health Amendment Act 23 of 1897 institutionalised racially segregated services and reinforced a structural division between preventive and curative care.[240] This framework was consolidated by the Public Health Act 36 of 1919, which fragmented health-care responsibilities by allocating hospital services to provincial authorities while assigning public health functions to local government.[241] These legislative arrangements entrenched systemic disparities in access, governance and service delivery, many of which persisted into the democratic era and continue to shape contemporary challenges in health-care provision, including palliative care.[242]

Formal hospice services in South Africa only began to emerge in the late 1970s, largely through the efforts of civil society actors such as Margaret Leebish and Sylvia Poss, who pioneered home-based hospice care in Johannesburg.[243] Influenced by the British hospice model, these initiatives developed independently of the state and were

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237 Diane McIntyre and Lucy Gilson, 'Putting Equity in Health Back into the Social Agenda: Experience from South Africa' (2002) 54(11) Social Science and Medicine 1637, 1638–1640. The authors show how apartheid-era health policy entrenched inequality by diverting resources to facilities serving the white minority, leaving black and rural communities severely under-resourced. This fragmented system produced stark disparities in health outcomes, including high infant and maternal mortality, malnutrition, poor sanitation, and limited access to essential services.

238 McIntyre and Gilson, 'Putting Equity in Health Back into the Social Agenda' 1638–1640. Hoosen Coovadia and others, 'The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges' (2009) 374 The Lancet 817-818.

239 Coovadia and others, 'The Health and Health System of South Africa' 817-819.

240 Public Health Amendment Act 23 of 1897.

241 Public Health Act 36 of 1919.

242 Coovadia and others, 'The Health and Health System of South Africa' 818-819; Truth and Reconciliation Commission, *Final Report vol 4,* ch 5, paras 23-24,29 <https://www.gov.za/trc/report/finalreport/Volume%204.pdf> accessed 12 April 2025.

243 Hospice Association of the Witwatersrand, 'History of the Hospice' (eHospice, 14 October 2022) <https://ehospice.com/south-africa_posts/history-of-the-hospice/> accessed 6 January 2026.

sustained primarily through volunteerism and non-profit organisations.[244] Across Sub-Saharan Africa, early hospice and palliative care initiatives were similarly voluntary in nature, evolving organically in response to urgent community needs rather than through coordinated state policy.[245] By the mid-1990s, countries such as South Africa, Uganda, and Zimbabwe had informal palliative services in place, however, coverage remained sporadic, fragmented, and largely unregulated.[246] This historical reliance on voluntary provision contributed to the perception of palliative care as discretionary rather than an integral component of public health-care system.

Although the National Health Act 61 of 2003 established a general framework for the provision of health services in South Africa, it failed to expressly recognise palliative care as a distinct component of the health system.[247] This omission reinforced the marginal status of palliative care within public health policy, necessitating later intervention through instruments such as the National Policy Framework and Strategy on Palliative Care (2017-2022).[248] Historically, public sector palliative care services only began to emerge in the early 2000s in the Western Cape, reflecting both the long-standing neglect of end-of-life care and the need to construct palliative services largely from the ground up in the democratic era.[249]

Section 3(2)-(3) of the National Health Act requires national and provincial departments to ensure the provision of preventive, curative, rehabilitative, and palliative health-care services.[250] Furthermore, section 25(2)(g) expressly includes palliative care services within the scope of district health services.[251] This statutory recognition of palliative care is significant for the broader debate on end-of-life choices.

Diane McIntyre's seminal working paper (1993) provides a foundational analysis of enduring inequities within South Africa's health system, demonstrating how racially and regionally skewed budget allocations entrenched under apartheid persisted into

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244 Clark and others, 'Hospice and Palliative Care Development in Africa' 700–702.
245 Clark and others, 'Hospice and Palliative Care Development in Africa' 700–702.
246 Clark and others, 'Hospice and Palliative Care Development in Africa' Table 1, 704.
247 National Health Act 61 of 2003 s 3(2)– (3); s 25(2)(g).
248 National Department of Health, *National Policy Framework and Strategy on Palliative Care* 2017–2022 (Pretoria 2017).
249 Lorna Gwyther and others, 'The Development of Hospital Based Palliative Care Services in Public Hospitals in the Western Cape, South Africa' (2020) 110(2) South African Medical Journal 86, 86-89 <https://doi.10.7196/SAMJ.2017.v108i2.12524> Accessed 12 June 2024.
250 National Health Act 61 of 2003, s 3(2)– (3.
251 National Health Act 61 of 2003, s 25(2)(g).

the democratic era, thereby reinforcing disparities in access to quality of public health care.[252] In later work with Lucy Gilson, McIntyre situated health financing within a broader social justice framework, illustrating how colonial and apartheid-era policy choices produced a fragmented dual health system characterised by a well- resourced private sector alongside an underfunded public sector.[253] Successive reform efforts during the transition period repeatedly failed to realign primary healthcare funding with equity-based objectives, perpetuating under-investment in community-based services while privileging tertiary and private care.[254]

This distorted prioritisation helps explain why palliative care, closely associated with primary and community health services, remained marginal within the public sector.[255] McIntyre further argued that equity-orientated financing reforms, including those later emphasised under the National Health Insurance framework, are essential to dismantle structural imbalances and ensure that vulnerable populations, including those requiring palliative care, are not left behind.[256]

This legacy persists in the contemporary public health sector, which continues to struggle under significant infrastructural deficits, chronic staff shortages, and unequal resource distribution.[257] Hoosen Coovadia and colleagues highlight how these systemic deficiencies present substantial obstacles to the effective implementation of the National Health Insurance framework, reflecting enduring patterns of inequitable budgeting and service delivery that disproportionately disadvantage marginalised communities.[258] Within this context, structured, dignified care for individuals facing life limiting illness has historically remained peripheral to national health policy, with pain management and psycho-social support neither systemically planned nor equitably provided across the public.[259]

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252 Diane McIntyre, *Health Sector Financing and Expenditure in South Africa* (Working Paper, Health Economics Unit, University of Cape Town 1993).

253 McIntyre and Gilson, 'Putting Equity in Health Back into the Social Agenda' 1637.

254 McIntyre and Gilson, 'Putting Equity in Health Back into the Social Agenda' 1640–1642.

255 McIntyre and Gilson, 'Putting Equity in Health Back into the Social Agenda' 1640–1642.

256 Diane McIntyre, *Health Sector Financing and Expenditure in South Africa* 36–40.

257 Coovadia, and others, 'The Health and Health System of South Africa' 817- 820.

258 Coovadia, and others, 'The Health and Health System of South Africa' 818–820.

259 Juanita O. Arendse, Virginia Zweigenthal and Liz Gwyther, 'Integration of palliative care into South Africa's health system: A before and after implementation study' (2026) 31 Health SA Gesondheid a3242, PDF 1-5 <https://doi.org/10.4102/hsa.v3242 > accessed 12 February 2026. This study documents that although the National Policy Framework and Strategy for

Peter Delobelle's comprehensive analysis further demonstrates how apartheid-era inequities, compounded by under resourcing in the public services, continue to shape access to quality healthcare in South Africa.[260] Despite post-apartheid policy initiatives commitments to universal health coverage, the public system remains constrained by pronounced urban–rural divides, the dual burden of communicable and non-communicable diseases, and severe human resource shortages.[261] These limitations have particularly significant implications for palliative care, as many patients are forced to rely on informal or home-based support in the absence of accessible institutional services, especially in townships and rural areas.[262] Delobelle thus identifies a direct nexus between inherited structural failures and contemporary gaps in end-of-life care, illustrating how formal care-giving models remain fragmented, under-resourced, and insufficiently responsive to the needs of terminally ill patients.[263]

These concerns are further echoed in Maphumulo and Bhengu's critical review of post-apartheid reforms, which finds that, despite significant efforts since 1994, the public health sector continues to be characterised by long waiting times, shortages of essential medical supplies, and inadequate infrastructure.[264] High patient volumes, combined with a substantial burden of disease, have intensified shortages of skilled health-care professionals, leaving public facilities overstretched and rural areas particularly under-served.[265] Taken together, these findings underscore how enduring systemic pressures continue to undermine the provision of comprehensive and dignified end-of-life care within South Africa's public system.

Palliative Care mandates integration into public services, palliative care was previously neglected in health services and remains only partially integrated, with uneven access to pain management and multidisciplinary care, across the district, reflecting systemic gaps in planning and equitable provision.

260 Peter Delobelle, 'The Health System in South Africa: Historical Perspectives and Current Challenges' in CC Wolhuter (ed), *South Africa in Focus: Economic, Political and Social Issues* (Nova Science Publishers 2013) 159–205.

261 Delobelle, 'The Health System in South Africa' 165–68.

262 Delobelle, 'The Health System in South Africa' 170–72.

263 Delobelle, 'The Health System in South Africa' 159–205.

264 Winnie T Maphumulo and Busisiwe R Bhengu, 'Challenges of Quality Improvement in the Healthcare of South Africa Post-Apartheid: A Critical Review' (2019) 42(1) Curationis 1, 3–5.

265 Maphumulo and Bhengu, 'Challenges of Quality Improvement in the Healthcare of South Africa' 5.

The entrenched public–private divide further illustrates these systemic pressures. Approximately 84% of South Africans rely on inadequately resourced public facilities, while only 16% access private health-care through medical aid schemes.[266] This imbalance continues to shape debates surrounding the National Health Insurance Act, which seeks to bridge the gap between a comparatively well-resourced private sector and an overstretched public system.[267] Recent analyses indicate that the ratio of reliance on public versus to private health-care has remained largely unchanged, highlighting the limited effectiveness of incremental reforms and reinforcing the need for substantive re-distributive health financing intervention.[268] These inherited structural weaknesses obstruct the full realisation of access to health-care services as a constitutional right, with particularly acute consequences for vulnerable patients requiring sustained, holistic care, including palliative and end-of-life support.[269]

3.3 South Africa's public health system: infrastructure, human resources and implications for palliative and end-of-life care

South Africa's public health-care system serves most of the population, yet it remains marked by critical deficiencies rooted in historical inequities and ongoing governance challenges. Rural and under-resourced provinces are particularly affected, with facilities characterised by overcrowding, staff shortages, ageing infrastructure, and limited access to essential supplies. The effectiveness of end-of-life care is closely dependent on the availability, distribution and coordination of these resources. Deficiencies in any of these areas directly constrain the capacity of the public health

266 Phumla Williams, 'NHI Will Bridge Gap in Healthcare System and Cut Costs' (*South African Government Blog*, 31 July 2019) <https://www.gov.za/blog/nhi-will-bridge-gap-healthcare-system-and-cut-costs> accessed 6 June 2025.

267 Cyril Ramaphosa, 'One Step Closer to Affordable Quality Health Care for All' (*South African Government Blog*, 20 May 2024) <https://www.gov.za/blog/one-step-closer-affordable-quality-health-care-all> accessed May 2025.

268 Global Business Medical Students Association, *Bridging the Gap: The Public vs. Private Sector Divide in South Africa's Healthcare System* (*GBMSA*, 8 May 2025) <https://gbmsa.org.za/bridging-the-gap-the-public-vs-private-sector-divide-in-south-africas-healthcare-system/> accessed 9 December 2025; Natalie Cowling, 'Private Healthcare in South Africa – Statistics & Facts' (*Statista*, 17 April 2025) <https://www.statista.com/topics/5243/private-healthcare-in-south-africa/> accessed May 2025.

269 Elizabeth Gwyther, 'How is Palliative Care Part of the Right to Health? The South African Evidence' (PhD thesis, University of Cape Town, 2019) 25-36 <https://open.uct.ac.za/handle/11427/30368> accessed 6 January 2026.

system to deliver dignified, comprehensive and compassionate care to patients with life-limiting illnesses.

This subsection therefore examines infrastructural constraints and human resource shortages in turn, highlighting how these systemic weaknesses undermine equitable access to palliative and end-of-life care.

3.3.1 Limited medical resources (infrastructural constraints)

The National Health Strategic Plan 2024/2025 (NHSP) articulates ambitious goals for improving healthcare delivery, reducing disparities, and promoting universal health coverage, including through rural infrastructure development, workforce training, and digital health integration.[270] The NHSP also emphasizes resilience against emerging health challenges, including pandemics and climate-related risks.[271] Yet, these objectives must be evaluated against the material realities of South Africa's public health sector which remains constrained by significant resource and capacity challenges. Persistent shortages in physical infrastructure, medical equipment, essential medicines, and clinical personnel continue to undermine service delivery.[272]

Rural areas are particularly disadvantaged, with clinics and hospitals sparsely distributed, poorly maintained, and lacking critical care units or specialised palliative wards.[273] Beyond shortages of equipment and ward space, many facilities in

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270 National Department of Health, *National Health Strategic Plan 2024/2025* (Government of South Africa, 2023) Additionally, the NHSP 2024/2025 highlights the importance of integrating digital health technologies to improve healthcare management and accessibility. See also Wesley Moonsamy and Shawren Singh., 'Live Healthcare Console: Evaluating digital health design models, a South African perspective' (2024) 26(1) South African Journal of Information Management para 7.

271 National Department of Health, *National Health Strategic Plan 2020–2025* (Pretoria: Department of Health 2020); World Health Organization, *Building Health Systems Resilience for Universal Health Coverage and Health Security during the COVID-19 Pandemic and Beyond* (WHO 2021); Solomon R Benatar, 'Health care reform and the crisis of HIV and AIDS in South Africa' (2004) 94(1) New England 81,81-92; Global Preparedness Monitoring Board, A Fragile State of Preparedness: *2023 Report on the State of the World's Preparedness* (Global Preparedness Monitoring Board, 30 October 2023) <https://www.gpmb.org/reports/m/item/a-fragile-state-of-preparedness-2023-report-on-the-state-of-the-worlds-preparedness> accessed 12 June 2025.

272 Coovadia and others, 'The health and health system of South Africa' 820-822.

273 Noluthando Ndlovu and Ashnie Padarath (eds), *District Health Barometer* 2022/2023 (Health Systems Trust 2024) ch 4 (Service Capacity and Access) <https://www.hst.org.za/publications/District%20Health%20Barometers/District%20Health%20Barometer_Complete%20Book_March.pdf> accessed 21 January 2026; Hendrik CJ van Rensburg, 'South Africa's protracted struggle for equal distribution and equitable access-still not there (2014) 12 (26) Human Resources for Health 1,4-12 <https://link.springer.com/article/10.1186/1478-4491-12-26> accessed 1 May 2025.

historically marginalised provinces still struggle with unreliable access to water, sanitation, and electricity.[274] As patient loads increase within a constrained healthcare budget, even basic service delivery becomes unpredictable.[275] These infrastructural deficits compromise the quality and reliability of care and raise ethical concerns about whether complex end-of-life protocols for the dying could ever be safely implemented.[276]

Most hospice and end-of-life care is provided by non-governmental organisations (NGOs) or private organisations, accessible primarily to those with financial means or proximity to urban centres.[277] For patients requiring end-of-life care, these systemic weaknesses translate into delayed access to palliative services, inadequate symptom management, and minimal emotional or spiritual support.[278] The shortage of dedicated palliative wards and hospice facilities means that many die in undignified conditions without adequate pain relief or professional supervision.[279]

Despite post-1994 efforts to expand primary healthcare infrastructure, a stark mismatch persists between population demand and institutional capacity, with few facilities equipped to provide consistent specialised care.[280] If medically assisted dying were to be introduced, ensuring that such interventions could be administered safely and equitably, South Africa would require substantial expansion in the number, distribution, and regulation of facilities capable of managing complex end-of-life protocols, including counselling, monitoring, and ethical oversight.[281] Current infrastructural inequities not only undermine the constitutional right to health-care but also raise serious ethical concerns about the feasibility of introducing euthanasia

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274 Delobelle, 'The Health System in South Africa' 165–68.

275 Maphumulo and Bhengu, 'Challenges of Quality Improvement in the Healthcare of South Africa Post-Apartheid' 5.

276 Office of Health Standards Compliance, *Annual Inspection Report 2021/2022* (OHSC 2022) para 3.2.4.

277 Liz Gwyther, Frank Brennan and Richard Harding, 'Advancing Palliative Care as a Human Right' (2009) 38(5) Journal of Pain and Symptom Management 767,767-774.

278 Office of Health Standards Compliance, *Annual Inspection Repor*t 2021/2022 (OHSC 2022) para 3.2.4.

279 Deidre Pretorius and Lesley G Mahole, 'Patients' palliative care needs in rural health and a proposal for palliation services' (2025) 17(1) African Journal of Primary Health care & Family Medicine a4866 <https://doi.irg/10.4102/phcfm.v7i1.4866> accessed 12 August 2025.

280 Maphumulo and Bhengu, 'Challenges of Quality Improvement in the Healthcare of South Africa Post-Apartheid' 3–6.

281 Health Professions Council of South Africa, *Ethical Guidelines for Palliative Care* (HPCSA 2020).

legislation within a system that struggles to provide even the most basic standards of terminal care.

3.3.2 Human resources and accessibility constraints

The infrastructural deficiencies outlined above are compounded by severe shortages of trained personnel and limited access to services, both of which critically undermine the capacity to deliver effective end-of-life care.[282] Most doctors, nurses, and allied health professionals receive limited instruction in managing terminal illness, pain relief, and the psycho-social dimensions of dying.[283] The public sector is particularly affected by under-staffing, burnout, and heavy patient loads.[284] Although national policy frameworks include palliative care, only a few institutions have personnel with the specialised training necessary to implement these standards effectively.[285] In rural and resource-constrained settings, nurses often manage complex cases without interdisciplinary support, resulting in inconsistent care and heightened emotional strain.[286]

Accessibility challenges mirror and intensify these human resource deficits. Rural and historically disadvantaged communities often lack adequate medical services, while urban centres benefit from relatively better provision.[287] Even where facilities exist, patients relying on the public sector face barriers such as limited specialised services, transportation difficulties, and insufficient home-based support.[288] Some tertiary institutions, such as the Gauteng Wits Centre for Palliative Care at Chris Hani Baragwanath Academic Hospital, demonstrate how integrated models combining

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282 World Health Organization and Worldwide Palliative Care Alliance, *Global Atlas of Palliative Care at the End of Life* (2nd edn, WHO 2020) 45–47 <https://www.who.int/publications/i/item/9789240000353> accessed 11 January 2024.

283 Gwyther, Brennan and Harding, 'Advancing Palliative Care as a Human right' 767-769.

284 Maphumulo and Bhengu, 'Challenges of Quality Improvement in the Healthcare of South Africa Post-Apartheid' 6.

285 National Department of Health, *Palliative Care Policy 2017–2022: Strengthening Palliative Care as a Component of Care* (DoH 2017) 10–12.

286 Bongekile C Dlamini and Maretha Visser, 'Challenges in Nursing: The Psychological Needs of Rural Area Nurses in Mpumalanga, South Africa (2017) Remedy Open Access 1068, PDF1,4-6 <http://hdl.handle.net/2263/65325> accessed 1 May 2025.

287 Pretorius and Mahole, 'Patients' Palliative Care Needs in Rural Health and a Proposal for Palliation Services' a4866, PDF 1–2.

288 Agnes Hamilton-Baillie and others, 'Palliative Care in Rural Sub-District in South Africa: A 4-year critical review' (2024) 16(1) African Journal of Primary Health Care and Family Medicine a4047, PDF 2 <https://pmc.ncbi.nlm.nih.gov/articles/PMC10839241/> accessed 12 May 2025.

clinical care, training, and NGO collaboration can improve equitable access.[289] Similar initiatives in the George Route district embed palliative care within primary healthcare by leveraging community health workers and NGOs.[290]

Despite these advances, accessibility remains uneven, with services concentrated in urban centres and large areas under-served.[291] A 2025 study at Charlotte Maxeke Johannesburg Academic Hospital highlighted inadequate dedicated spaces, insufficient training, and lack of structured support, leaving clinicians overwhelmed and palliative care deprioritised.[292] International models such as the Netherlands' SCEN programme and Belgium's LEIF training demonstrate how structured education in ethics and communication is foundational to safe end-of-life practice.[293] These systemic weaknesses mean that patients requiring end-of-life care often experience delayed access to symptom pain management and minimal emotional or spiritual support.[294]

Any move to legalise euthanasia would therefore require substantial investment in professional education and equitable service distribution to ensure ethical competence, informed consent, accurate prognostication, and appropriate oversight.[295] Without a trained workforce and accessible services, risk of abuse or misapplication would be heightened. Physicians would require comprehensive training

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289 Centre for Palliative Care, Chris Hani Baragwanath Hospital, 'About Us' (Wits University, 2024).

290 Mpho Ratshikana and others, 'Tertiary Palliative Care Model in South Africa: A Case of the Gauteng/Wits Centre for Palliative Care' (2024) 8 Archives of Clinical and Biomedical Research 317,318–325 <https://doi.org/10.26502/acbr.50170413> accessed 12 June 2025; Elza M van Heerden and Louis S Jenkins, 'The Role of Community Health Workers in Palliative Care in a Rural Sub-District in South Africa' (2022) 14(1) African Journal of Primary Health Care and Family Medicine a3657, PDF2-6<https://doi.org/10.4102/phcfm.v14i1.3657> accessed 12 May 2025; Hamilton-Baillie and others, 'Palliative Care in Rural Sub-District in South Africa' a4047.

291 National Department of Health, *Palliative Care Policy Framework* 2017–2022, 14–15.

292 Sokuhle Pilime and others, 'Barriers to and Enablers of Availability and Integration of Palliative Care into Routine Services at Charlotte Maxeke Johannesburg Academic Hospital, South Africa' (2025) 24(115) BMC Palliative Care 155, PDF 1-14 <https://doi.org/10.1186/s12904-025-01778-3> and <s12904-025-01778-3.pdf> accessed 24 March 2024; Health Professions Council of South Africa, *Ethical Guidelines on Palliative Care* (Booklet 18, 2019) 9.4–9.5.

293 Kasper Raus, Bert Vanderhaegen and Sigrid Sterckx, 'Euthanasia in Belgium: Shortcomings of the Law and Its Application and of the Monitoring of Practice' (2021) 46(1) Journal of Medicine and Philosophy 80, 80-107 <https://doi.org/10.1093/jmp/jhaa031> accessed 24 July 2025.

294 Office of Health Standards Compliance, *Annual Inspection Report 2021/2022* (OHSC 2022) para 3.2.4.

295 Health Professions Council of South Africa, *Ethical Guidelines on Palliative Care* (Booklet 18, 2019) paras 9.4–9.5.

in medical ethics, including balancing autonomy with non-maleficence and beneficence,[296] as well as in the safe administration of life-ending medications.[297] Psychological support would also be essential to assess decision-making capacity and ensure that patients' choices are informed and voluntary.[298]

Unless these human resource and accessibility constraints are addressed, even well-intentioned policy reforms cannot guarantee equitable end-of-life care, nor can they create the necessary foundation for ethically and legally regulated assisted dying. These systemic constraints underscore the need for innovative approaches to expand access and continuity of care.

3.3.3 Telemedicine and electronic health data in palliative care

The National Health Strategic Plan (NHSP 2020–2025) explicitly identified digital health integration, including tele-medicine and electronic health data, as a priority for strengthening healthcare delivery.[299] These measures were envisioned to reduce disparities in access, improve continuity of care, and enhance monitoring and accountability across the health system.[300] For palliative care, where patients often face barriers of distance, mobility, and resource scarcity, tele-medicine offers a means of extending services to rural and under-served communities.[301]

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296 Health Professions Council of South Africa, *Ethical Guidelines for Withholding and Withdrawing Treatment* (Booklet 7, revised March 2023) 8.1.

297 Health Professions Council of South Africa, *Ethical Guidelines on Palliative Care* (Booklet 18, 2019) paras 9.4–9.5.

298 Lois Snyder Sulmasy and Paul S Mueller, 'Ethics and the Legalisation of Physician Assisted Suicide: An American College of Physicians Position Paper' (2017) 167(8) Annals of Internal Medicine 576, 576–578. The authors emphasise that requests for assisted suicide often arise in contexts of depression, hopelessness, or inadequate psycho-social support. They argue that psychological support is essential to assess decision-making capacity and to ensure that patients' choices are informed and voluntary. In their view, strengthening palliative and psycho-social care is ethically preferable to legalising assisted suicide, as it safeguards both patient dignity and the integrity of the physician–patient relationship.

299 National Department of Health, *National Health Strategic Plan 2020/21–2024/25* (Republic of South Africa, Department of Health 2020) 34–36 <https://www.health.gov.za/wp-content/uploads/2020/11/depthealthstrategicplanfinal2020-21to2024-25.pdf> accessed 12 June 2025;
National Department of Health, *National Digital Strategy for South Africa 2019-2024* (Republic of South Africa, National Department of Health 2019) <https://www.health.gov.za/wp-content/uploads/2020/11/national-digital-strategy-for-south-africa-2019-2024-6.pdf> accessed 12 June 2025.

301 Oluwamayowa O Ogundaini and Nhlanhla BW Mlitwa, 'A Situational Review of National Digital Health Strategy Implementation in Sub-Saharan Africa' (2024) 20(1) Journal for Transdisciplinary Research in Southern Africa a1476, PDF 5–7 <https://doi.org/10.4102/td.v20i1.1476> accessed 13 June 2025.

Tele-medicine initiatives in South Africa have already demonstrated their potential to overcome infrastructural and human resource constraints.[302] By connecting patients with doctors, nurses, and mental health professionals through virtual consultations, tele-medicine reduces travel burdens and mitigates the effects of staff shortages in overstretched facilities.[303] In palliative contexts, this can translate into more timely symptom management, psycho-social support, and continuity of care for patients who would otherwise be excluded from formal services.

Electronic health data systems, also emphasised in the NHSP, are critical for ensuring that palliative care is not fragmented. By enabling the secure collection and sharing of patient information, these systems support coordinated care across multiple providers and settings.[304] They also enhance accountability by allowing policymakers and practitioners to monitor service delivery, identify gaps, and evaluate outcomes. However, scholars caution that implementation remains uneven, with challenges including data privacy, infrastructure deficits, and limited digital literacy among health-care workers.[305]

Integrating tele-medicine and electronic health data into palliative care therefore represents both an opportunity and a challenge.[306] While policy frameworks envision these technologies as tools to advance equity and efficiency, their success depends on addressing systemic weaknesses in infrastructure, training, and governance. For South Africa, the constitutional commitment to dignity and access to healthcare requires that digital innovations be harnessed not as substitutes for human care, but as complementary mechanisms to strengthen the reach and quality of palliative services.[307]

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302 Maurice Mars, 'Telemedicine and advances in urban and rural healthcare delivery in Africa' (2013) 56(3) Progress in Cardiovascular Diseases 326,326-335 <https://doi.org/10.1016/j.pcad.2013.10.006> accessed 12 February 2026.

303 Affinity Health, 'The Benefits of Telemedicine in South Africa' (*Affinity Health,* 8 October 2025) <https://www.affinityhealth.co.za/the-benefits-of-telemedicine-in-south-africa/> accessed 13 July 2025.

304 National Department of Health, *National Health Strategic Plan 2020/21–2024/25* 37–39.

305 Ogundaini and Mlitwa, 'National Digital Health Strategy Implementation' 8–9.

306 National Department of Health, *National Digital Health Strategy for South Africa* 8-12

307 Constitution of the Republic of South Africa, 1996, s 27(1)(a).

While tele-medicine and electronic health data represent important innovations for expanding access to palliative care, their effectiveness ultimately depends on integration within broader financing and governance frameworks. The National Health Insurance Act 20 of 2023 provides the structural foundation for such integration, seeking to align digital health initiatives with equitable resource distribution and constitutional commitments to dignity and health-care access.

3.4 The National Health Insurance Act 2023: implications for palliative care and end-of-life care

The National Health Insurance (NHI) Act 20 of 2023 represents a significant legislative reform aimed at restructuring South Africa's health-care system to achieve universal health coverage.[308] This subsection examines its implications for palliative and end-of-life care, focusing on how the Act's equity goals and financing model may affect access to pain management, hospice services, and holistic support. It also considers the challenges of implementation within a system already constrained by infrastructural deficits and human resource shortages.

the NHI Act's primary purpose is to establish a unified funding mechanism that pools public revenue and strategically purchases services on behalf of the population, thereby addressing disparities entrenched by apartheid within the historically fragmented dual health system.[309] The NHI Act defines "Comprehensive Health-care Services" to include promotive, preventive, curative, rehabilitative, and palliative care delivered across all levels of the health system.[310] This explicit inclusion is constitutionally significant: it aligns with Section 27(1)(a) of the Constitution, which guarantees the right of access to healthcare services, and Section 27(2),[311] which obliges the state to take reasonable measures to progressively realise that right. By embedding palliative care within the statutory service package, the NHI framework recognises that end-of-life support is not a peripheral benefit but a core component of dignified healthcare. This rights-based framework aligns with constitutional guarantees of dignity (section 10), bodily integrity (section 12), ensuring that patients'

308 National Health Insurance Act 20 of 2023, s 2.

309 National Health Insurance Act 20 of 2023, s 2; Faiez Jacobs, 'The National Insurance Scheme Can Work, "This Is How"' *Mail & Guardian* (15 December 2024) <https://mg.co.za/thought-leader/opinion/2024-12-15-the-national-health-insurance-scheme-can-work-this-is-how/> accessed 12 January 2025.

310 National Health Insurance Act 20 of 2023, s 1, s 25(3)(b)–(c), s 29(1).

311 Constitution of the Republic of South Africa, 1996 s 27(1)–(2).

autonomy and dignity are respected in decisions about death and dying.[312] However, uneven implementation, particularly for rural communities, foreign nationals, and paediatric patients, risks undermining the universality promised by the NHI, highlighting the need for deliberate policy measures to close these gaps.

Constitutional jurisprudence has consistently affirmed the state's duty to take reasonable measures to realise socio-economic rights. In *Treatment Action Campaign*,[313] the Constitutional Court required government to provide access to essential medicines for people living with HIV/AIDS, emphasising the vulnerability of this group. By contrast, in *Soobramoney v Minister of Health (KwaZulu-Natal)*[314], the Court upheld the denial of dialysis treatment on the basis of scarce resources, illustrating that socio-economic rights are subject to progressive realisation and reasonableness. Taken together, these cases show that while resource constraints may limit immediate fulfilment, state measures must still be reasonable and responsive to vulnerability. Against this backdrop, the exclusion of palliative care services appears unreasonable given South Africa's high burden of chronic and terminal illness, and the particular vulnerability of patients requiring end-of-life support. This is reinforced by Constitutional Court jurisprudence emphasising progressive realisation and reasonableness in healthcare rights, and by the National Policy Framework on Palliative Care, which recognises palliative care as an essential component of dignified healthcare provision.[315]

However, while the National Health Act expressly recognises palliative care as part of the continuum of health services, South African health legislation does not provide for or regulate physician-assisted dying or voluntary euthanasia, leaving these interventions outside of the statutory framework.[316] Scholars caution that this omission

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312 National Health Insurance Act 20 of 2023 s 1 (definition of "Comprehensive Health-care Services"); Constitution of the Republic of South Africa, 1996 ss 10, 12; Department of Health, *National Policy Framework and Strategy on Palliative Care 2017–2022* (Pretoria: Department of Health, 2017).

313 *Minister of Health* v *Treatment Action Campaign* 2002 (5) SA 721 (CC).

314 *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC).

315 *Minister of Health* v *Treatment Action Campaign* 2002 (5) SA 721 (CC); *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC); Department of Health, *National Policy Framework and Strategy on Palliative Care 2017–2022* (Pretoria: Department of Health, 2017); Sandra Liebenberg, *Socio-Economic Rights: Adjudication under a Transformative Constitution* (Juta 2010); David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (Oxford University Press 2007).

316 National Health Act 61 of 2003 s 27(1)(c).

risks systemic neglect of patient autonomy and dignity, particularly for terminally ill patients whose needs extend beyond symptom management.[317] Persistent critiques highlight that without addressing entrenched infrastructural deficits, governance weaknesses, and human resource shortages, universal coverage risks remaining aspirational.[318] Palliative care provision remains uneven and under-resourced, with only a fraction of adults and children requiring such services receiving them, and paediatric services particularly marginalised.[319]

Beyond domestic inequities, exclusionary immigration law and administrative discretion further compromise the universality promised by the NHI framework.[320] Migrants and refugees often face barriers to enrolment, inconsistent application of eligibility rules, and medical xenophobia within public facilities.[321] This legislative dissonance between the Immigration Act[322] and the National Health Insurance Act perpetuates uncertainty and exclusion, notwithstanding constitutional commitments to equality and access to care.[323] The exclusion of foreign nationals from comprehensive coverage illustrates how uneven provision undermines the universality promised by

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317 Sulmasy and Mueller, 'Ethics and the Legalisation of Physician Assisted Suicide' 576–578 in this paper the authors argue that legal frameworks that fail to address assisted dying risk constraining end-of-life care to symptom control alone and thereby overlook ethical obligations to respect patient autonomy and dignity, noting that systemic neglect arises where law and policy provide no clear guidance on clinicians' responses to patients with needs beyond pain relief.

318 Winnie T Maphumulo and Busisiwe R Bhengu, 'Challenges of Quality Improvement in the Healthcare of South Africa Post-Apartheid' (2019) 42(1) Curationis 1; see also Carla Kotze and Johannes L Roos, End of Life Care in South Africa; Important Legal Developments' (2022) 28 South African Journal of Psychiatry a1748, 1-3. <https://pmc.ncbi.nlm.nih.gov/articles/PMC8831995/pdf/SAJPsy-28-1748.pdf> accessed 12 May 2025; Ole F Norheim 'Ethical Priority Setting for Universal Health Coverage: Challenges in deciding upon fair distribution of health service' (2016) 14 BMC Medicine 75, 1-4 <https://doi.org/10.1186/s12916-016-0624-4> accessed 12 May 2025.

319 Chris Bateman, 'The Cost of Ignoring SA's Dying People' *City Press* (Johannesburg, 7 May 2023) <https://www.news24.com/citypress/news/the-cost-of-ignoring-sas-dying-people-20230506> accessed 4 May 2025;
Chris Bateman, ' SA Palliative Care Practitioners Fight for the Dying' *BizNews* (9 May 2023) <https://www.biznews.com/health/2023/05/09/palliative-care> accessed 12 May 2025;
Chris Bateman ' Funding Lifeline Frays for Gauteng's Dying', *MedicalBrief* (27 November 2024) <https://www.medicalbrief.co.za/funding-lifeline-frays-for-gautengs-dying> accessed 4 June 2025.

320 Janine White and Laetitia E Rispel, 'Policy Exclusion or Confusion? Perspectives on Universal Health Coverage for Migrants and Refugees in South Africa' (2021) 36 Health Policy and Planning 1292, 1292-1306 <https://doi.org/10.1093/heapol/czab038> accessed 12 May 2025.

321 White and Rispel, 'Policy Exclusion or Confusion?'1293.

322 Immigration Act 13 of 2002; National Health Act 61 of 2003.

323 White and Rispel, 'Policy Exclusion or Confusion?'1296–1299; National Health Insurance Act 20 of 2023.

the NHI, leaving foreign nationals particularly vulnerable to exclusion from palliative care services despite constitutional commitments to equality and dignity.

In the context of end-of-life care, such exclusion has profound implications, vulnerable groups may be denied palliative services altogether, raising constitutional concerns under section 27 (health-care rights) and section 9 (equality).[324] Without deliberate safeguards, any future end-of-life legislation risks reinforcing these disparities, as marginalised patients may be excluded from both palliative and assisted dying options. Scholars further caution that the administrative complexity within the NHI framework may delay the political and ethical guidance necessary for the safe and equitable implementation of such reforms.[325]

The marginalisation of paediatric palliative care illustrates systemic neglect within South Africa's health system. The Paediatric Palliative Care Declaration of Children's Right (2019) highlighted that, while government funding supported 22 adult palliative care posts at selected public institutions, there were no state funded paediatric posts nationwide.[326] Advocacy groups called for the establishment of at least eight dedicated paediatric positions to address the structural exclusion of children with life-limiting illnesses.[327] This omission raises serious ethical and constitutional concerns, children are entitled to equal worth and dignity under section 10 and to access healthcare under section 27, yet their needs remain invisible in practice.

Bilchitz's account of the minimum core obligation emphasises that progressive realisation cannot be invoked to justify indefinite delay in meeting essential socio-economic needs, instead the state must prioritise the satisfaction of urgent survival interests, particularly for those in conditions of severe vulnerability.[328] Applied to

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324 Izak M Rautenbach and Erasmus F J Malherbe, *Constitutional Law* (*6th edn, LexisNexis 2012)* 346 ,354–356. Malherbe notes that the National Health Act 61 of 2003 operationalises section 27 and reinforces the foundational rights in sections 10 and 12, giving practical effect to constitutional guarantees.

325 White and Rispel, 'Policy Exclusion or Confusion?' 1296–1299.

326 PatchSA, *Declaration of Children's Right to Palliative Care* (PatchSA 18 March 2019). <https://patchsa.org/patchsa.org/declaration_of_childrens_right_to_palliative-care/> accessed 21 May 2025.The declaration recommends the creation of 8 funded palliative posts, noting that 22 posts exist for adult palliative care nationwide, while no government-funded paediatric posts exist.

327 PatchSA, *Declaration of Children's Right to Palliative Care.*

328 David Bilchitz, 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence' (2003) 19 South African Journal on Human Rights 1.

paediatric care, this principle suggests that avoidable suffering among children requiring palliative support should be addressed as a matter of priority.[329] Despite sustained advocacy, subsequent reports confirm that paediatric palliative care remains unevenly resourced, with frozen posts and uncertainty surrounding provincial funding allocations.[330] The exclusion of children from comprehensive care highlights the broader challenge of translating constitutional promises into lived realities at the end of life.

From a constitutional perspective, section 27 must be read in conjunction with sections 10 and 12, supporting a broader understanding of health rights that encompasses autonomy and dignity in the context of terminal illness.[331] Bilchitz argues that the Constitution implies a minimum core obligation to provide essential healthcare, immediately cautioning any excessive reliance on progressive realisation.[332] McQuoid-Mason similarly suggests that a holistic interpretation could, in principle, accommodate physician-assisted suicide under strict safeguards, provided that autonomy, oversight, and protection of the vulnerable populations are ensured.[333] McQuoid-Mason cautions that while autonomy and dignity may justify physician-assisted suicide in principle, the constitutional framework demands strict safeguards to prevent exploitation and ensure protection of vulnerable groups.[334] International guidance, including General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights, reinforces the duty to ensure access to essential healthcare to prevent unnecessary suffering.[335]

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329 Bilchitz, 'Towards a Reasonable Approach to the Minimum Core' 10-15.

330 The Association of Palliative Care Centres (APCC), 'Hospice week (5-11 May) highlights care beyond service in Gauteng' (15 May 2024) <https://apcc.org.za/press-releases/hospice-week-5-11-may-highlights-care-beyond-service-in-gauteng/> accessed 23 October 2025. The release notes that APCC is the member body for 20 palliative care centres in Gauteng and 91 nationally, and that its members cared for 38 228 people in 2023.

331 Iain Currie and Johan de Waal, *The Bill of Rights Handbook* (6th ed, Juta 2020); Section 27, Know Your Constitution: A Handbook to the South African Constitution (2025) <https://section27.org.za/resources/section-27-publications/> accessed 12 June 2025.

332 Bilchitz, 'Towards a Reasonable Approach to the Minimum Core '10-15.

333 David McQuoid-Mason, 'Doctor Assisted Suicide: What Is the Present Legal Position in South Africa?' (2015) 105(7) SAMJ 526,526-527.

334 McQuoid-Mason, 'Doctor Assisted Suicide' 526-257.

335 United Nations Committee on Economic, Social and Cultural Rights, General Comment No. 14: *The Right to the Highest Attainable Standard of Health* (2000) UN Doc E/C.12/2000/4, para 16 <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf > accessed 21 January 2026. para 16 (affirming that the right to health includes timely and appropriate health care, and underlying determinants such as safe water, adequate sanitation,

Ultimately, the NHI framework presents an opportunity to give fuller effect to section 27 by embedding palliative care within comprehensive health services. However, without sustained political commitment, adequate funding, and inclusive policy design, the promise of universal health coverage risks remaining hollow.[336] The constitutional and statutory architecture provides a foundation for compassionate, rights-based responses to terminal illness, yet persistent systemic limitations raise pressing questions about whether the right of access to healthcare is being meaningfully realised at the end of life.

While the National Health Insurance Act establishes a framework for universal access, its limitations in addressing active end-of-life options underscores the need to critically examine how palliative care is currently delivered within South Africa's healthcare system, which the next section explores.

3.5 Palliative care in South Africa's healthcare system

Palliative care in South Africa seeks to improve quality of life for patients with life limiting illnesses by managing pain and other distressing symptoms, while also providing emotional, social, and spiritual support to patients and their families.[337] Palliative care has been said to lead to better health outcomes, such as reduced hospital admissions and emergency room visits by managing symptoms effectively at home or in community settings.[338]

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food and housing); para 34 (emphasising that states must ensure essential primary health care is available to all, without discrimination).

336 Leslie London, 'What Is a Human Rights Based Approach to Health and Does It Matter?' (2008) 10 Health and Human Rights Journal 65,65.

337 Western Cape Government, 'Hospice and Palliative Care' (2022) <https://www.westerncape.gov.za/general-publication> accessed August 2024.

338 Taylor Desrosiers and others 'A hospital based palliative care service for patients with advanced organ failure in sub–Saharan Africa reduces admissions and increases home death rates' (2014) 47 (4) Journal of Pain and Symptom management 786, 790-792 <https://www.jpsmjournal.com/action/showPdf?pii=S0885-3924%2813%2900366-7> accessed 21 November 2024: A ground-breaking study by Desrosiers and colleagues evaluated a hospital-based palliative care service introduced for patients suffering from advanced organ failure in urban South Africa. The intervention led to a marked reduction in hospital admissions (mean of 1.39 vs 1.98, $p<0.001$) and inpatient days (4.52 vs 9.3 days, $p<0.001$) compared to outcomes prior to implementation. Importantly, these results were achieved under resource-constrained conditions typical of sub-Saharan settings. The model emphasised multidimensional care, addressing physical, psychological, and spiritual needs, while actively engaging families and communities. These findings demonstrate that even in low-resource environments, hospital-integrated palliative services can effectively reduce clinical burden, align care with patient preferences, and potentially offer a blueprint for scaling similar systems under South Africa's National Health Insurance framework.

The Hospice Palliative Care Association of South Africa (HPCA) defines palliative care as an approach that prevents and relieves suffering through early identification, comprehensive assessment, and treatment of physical, psycho-social, and spiritual problems.[339] Between 2017 and 2022, the National Department of Health released the National Policy Framework and Strategy on Palliative Care, outlining plans to integrate palliative services across all levels of care.[340] Yet despite this policy commitment, accurately quantifying national needs remains challenging due to fragmented data on disease prevalence and health service utilisation.[341]

Access to palliative care continues to be uneven, with urban centres benefitting from comparatively greater service availability, while rural areas face shortages of trained professionals and appropriate facilities.[342] In South Africa, palliative healthcare service provision is shared between public, private,[343] and non-governmental actors, including the Association of Palliative Care Centres (APCC), formerly the Hospice Palliative Care Association (HPCA), which relies heavily on donor funding and inconsistent state support.[344] This dependence underscores the fragility of service provision, despite impressive reach.

Ensuring equitable access across rural and marginalised communities therefore remains a pressing challenge, APCC statistics reveals over 340,000 patient care visits in 2021/22, with 2.49 million interventions delivered by care staff.[345] However, these

339 The Hospice Palliative Care Association of South Africa, 'Ethical Issues in Palliative Care' <http://www.hpca.co.za/pdf/legalbook/HPCA%20Chapter%203%20v6.pdf> accessed August 2024.

340 National Department of Health, *National Policy Framework and Strategy on Palliative Care* 2017–2022 (South African Government, 2017) Foreword; s 1 Introduction. <https://www.health.gov.za/wpcontent/uploads/2020/11/NationalPolicyFrameworkandStrategyonPalliativeCare20172022.pdf> accessed August 2024.

341 Department of Health, *National Policy Framework and Strategy on Palliative Care* 2017–2022 (South African Government, 2017) (Introduction; Monitoring & Evaluation).

342 Hamilton-Baillie and others 'Palliative care in a rural subdistrict in South Africa' a4047, PDF 5–7.

343 GBMSA, *Bridging the Gap: The Public vs. Private Sector Divide in South Africa's Healthcare System* ; Hospital Association of South Africa, *Building the Universal Health Coverage South Africa Needs* (HASA 2025); Ufrieda Ho, 'Government and the private sector should team up to improve healthcare conferences hears' (*Spotlight*, 15 October 2025) <https://www.spotlightnsp.co.za/2025/0/15/government-and-the-private-sector-should-team-up-to-improve-healthcare-conference-hears/> accessed 11 February 2026.

344 Association of Palliative Care Centres (APCC), *About Us* (2024) <https://apcc.org.za/> accessed 24 August 2024.

345 APCC statistics show over 340,000 patient care visits in 2021/22, with 2.49 million interventions delivered by care staff. Yet coverage remains uneven, with rural areas severely underserved. Predominant diagnoses: HIV/AIDS (37%), Cancer (24%), Chronic Illness (18%), Covid-19 (18%), TB (3%).

figures are reported in aggregate without disaggregation by sector or geography, which obscures the extent of inequity. The latest APCC Annual Report (2024) confirms that this pattern has persisted, with coverage still uneven and rural areas severely under-served, underscoring the lack of substantive progress since the earlier reporting period.[346]

In the South African context, palliative care remains under resourced and unevenly implemented, with notable gaps in vulnerable settings such as rural areas and correctional facilities.[347] Similar challenges have been observed internationally, in Canada. Burles, Holtslander and Peternelj-Taylor highlight relational barriers to delivering palliative care in correctional facilities, underscoring the global difficulty of ensuring equitable access in institutional settings.[348] Healthcare practitioners have acknowledged these shortcomings, noting that persistent patient suffering, combined with absolute prohibitions on assisted dying can generate significant moral distress among clinicians.[349]

Research conducted in the George sub-district demonstrates that community-based palliative care models are both necessary and under-researched, particularly in contexts where health systems are overstretched.[350] This qualitative study found that community health workers play an important role in identifying patients in need of palliation and referring them into care, but their efforts are often constrained by limited

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346 Association of Palliative Care Centres (APCC), *Facts & Figures 2021/22* (APCC 2022); Association of Palliative Care Centres (APCC), *Annual Report 2024* (APCC 2024).

347 Welgemoed and Lerm, 'Palliative Care as a form of relief for the dying' 348, 366-368; Hamilton-Baillie and others, Palliative care in a rural subdistrict in South Africa' a4047, PDF 4-7.

348 Meridith Burles, Lorraine Holtslander and Cindy Peternelj-Taylor, 'Palliative and Hospice Care in Correctional Facilities: Integrating a Family Nursing Approach to Address Relational Barriers' (2021) 44(1) Cancer Nursing 29,29-34.

349 Willem-Johan Steyn and Mukinay C Bondo, 'Perspectives and attitudes of South African medical professionals towards active euthanasia' (2024) 66(1) South African Family Practice a5926 <https://doi.org/10.4102/safp.v66i1.5926> (hereafter the PDF version will be used to pinpoint reference)<https://pmc.ncbi.nlm.nih.gov/articles/PMC11447590/pdf/SAFP-66-5926.pdf >a5926, PDF 6-7 Accessed 12 May 2025.

350 Elza M van Heerden and Louis S Jenkins, 'The role of community health workers in palliative care in a rural subdistrict in South Africa' (2022) 14(1) African Journal of Primary Health Care & Family Medicine a3657, PDF 2-9 <https://phcfm.org/index.php/phcfm/article/view/3657/5816> accessed 12 June 2024.
This qualitative study in the George sub-district found that community health workers play an important role in identifying patients in need of palliation and referring them into care. However, their efforts are often constrained by limited capacity, uncertain service delivery, and weak integration with broader health systems at the community level. These findings highlight the importance of strengthening community-based approaches to ensure continuity of care and equitable access in under-served areas.

capacity, uncertain service delivery, and weak integration with broader health systems.[351] These findings highlight the importance of strengthening community-based approaches to ensure continuity of care and equitable access in under-served areas. This pattern reflects broader glob al trends.

The World Health Organization estimates that only 14% of patients requiring palliative care receive it, underscoring the limited integration of such services into mainstream health systems.[352] Globally, palliative care services remain concentrated in high income countries, while low and middle income regions face persistent shortages of trained professionals, essential medicines, and institutional support.[353] This global shortfall resonates in South Africa, where uneven provision continues to leave rural and vulnerable communities under-served.[354] The WHO further emphasises that palliative care is a human right, integral to universal health coverage and essential to safeguarding dignity at the end of life.[355] Given these systemic inequities and the recognition of palliative care as a human right, South Africa's constitutional and statutory frameworks play a critical role in shaping patient access to end-of-life interventions.

The constitutional right to bodily and psychological integrity under section 12 of the Constitution reinforces patient autonomy in medical decision making, including the right to refuse treatment.[356] This principle was firmly established in *Castell v De Greef,* which confirmed informed consent as a cornerstone of South African medical law, requiring disclosure of material risks and respect for patients' choices.[357]

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351 van Heerden and Jenkins, 'The role of community health workers in palliative care in a rural subdistrict in South Africa' a3657, PDF 4-8.

352 World Health Organization, 'Palliative Care' (2024) <https://www.who.int/health-topics/pall> accessed 29 January 2025.

353 World Health Organization, *Palliative Care* (2024) paras 1–2.

354 National Department of Health, *National Policy Framework and Strategy on Palliative Care* 2017–2022 (22 August 2017) 11–12.
World Health Organization, *Palliative Care* paras 1–2; Felicia Marie Knaul and others, 'Alleviating the access abyss in palliative care and pain relief- an imperative of universal health coverage: the Lancet Commission on' (2018) 391 Lancet 1391, 1391–1405 <https://doi.org/10.1016/S0140-6736(17)32513-8> accessed 12 June 2022.

356 Constitution of the Republic of South Africa, 1996, s 12(2)(c).

357 *Castell v De Greef* 1994 (4) SA 408 (C) 425E–G, 426–427.

Statutes such as the Health Professions Act 56 of 1974[358] and the National Health Act 61 of 2003[359] further entrench these obligations within clinical practice. Within this legal and ethical framework, palliative sedation has emerged as a lawful and professionally accepted end-of-life intervention aimed at alleviating intractable suffering when all other treatments have failed.[360] Distinct from euthanasia, palliative sedation involves the proportionate use of sedative medication to relieve refractory symptoms, without the primary intention of hastening death and is permitted under Health Professions Council of South Africa ethical guidelines.[361] It is regarded as a measure of last resort and requires rigorous informed consent processes involving patients, families and healthcare teams, guided by the principles of beneficence and autonomy.[362]

Scholars such as Morita and others define sedative palliative care as the intentional use of sedatives to relieve intolerable refractory suffering, distinguishing it from euthanasia by its therapeutic intent.[363] Ethical justification is commonly grounded in the principle of double effect, which permits foreseen but unintended consequences where the primary aim is symptom relief rather than the termination of life.[364] While

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358 Health Professions Act 56 of 1974, s 29(1)(a).
The Act establishes the Health Professions Council of South Africa (HPCSA), which regulates professional conduct and ethical standards, ensuring that practitioners uphold duties of beneficence, non-maleficence, and respect for patient autonomy.

359 National Health Act 61 of 2003, s 6(1)(d)–(e).
The NHI Act 61 complements this by requiring national and provincial departments to provide preventive, curative, rehabilitative, and palliative services (ss 3(2)– (3)), and by expressly including palliative care within district health services (s 25(2)(g)). Together, these Acts embed end-of-life care within the statutory framework of public health, demonstrating that the duty to provide dignified care is legally enforceable.

360 Health Professions Council of South Africa, *Guidelines for Good Practice in the Health Care Professions: Ethical Guidelines on Palliative Care* (Booklet 17, 2019) para 2.4. See also National Cancer Institute, 'Palliative Sedation' <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/palliative-sedation> accessed August 2024.

361 Health Professions Council of South Africa, *Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974* (Board Notice 510 of 2023;
South African Medical Association, Guidelines on End-of-Life Care (2017). See also HPCSA, *Guidelines for Good Practice in the Health Care Professions* paras 5–7; Robin L Fainsinger and others, 'Sedation for uncontrolled symptoms in a South African hospice' (1998) Journal of Pain and Symptom Management 145, 147-152 <PII: S0885-3924(98)00066-9> accessed 2 September 2025.

363 Tatsuya Morita, Shunsuke Tsuneto and Yasuo Shima, 'Definition of Sedation for Symptom Relief: A Systematic Literature Review and a Proposal of Operational Criteria' (2002) 24(4) Journal of Pain and Symptom Management 447, 448–452 <https://www.doi:10.1016/S0885-3924(02)00499-2> accessed 14 May 2025.

364 Nathan Cherny and Lukas Radbruch, 'EAPC Recommended Framework for the Use of Sedation in Palliative Care' (2009) 17 Palliative Medicine 581, 584–587 <https://doi.org/10.1016/S1470-2045(09)70185-7> accessed 13 August 2024;
HPCSA, *Guidelines for Good Practice in the Health Care Professions: Ethical Guidelines on Palliative Care* paras 7.1–7.2.

sedation provides an important mechanism for addressing severe end-of-life suffering within South Africa's current legal framework, its limitations also expose broader gaps in end-of-life care options, particularly for patients who seek greater control over the timing and manner of their death.[365]

Van Delden's ethical analysis of terminal sedation highlights how such practices provoke ongoing debate, precisely because they underscore the limits of symptom control and raise questions about autonomy, intention, and the moral boundaries of end-of-life care.[366] These concerns resonate strongly in South Africa, where palliative care remains under-resourced and unevenly implemented.[367] The ethical dilemmas identified in international scholarship are compounded locally by structural shortcomings, particularly in vulnerable settings such as rural areas and correctional facilities.[368] Healthcare practitioners have acknowledged these gaps, noting that persistent patient suffering, combined with absolute prohibitions on assisted dying, can generate significant moral distress among clinicians.[369]

Accordingly, while palliative care remains indispensable to end-of-life, it is not a panacea.[370] A rights-based approach to dying must therefore acknowledge both its value and its limitations,[371] while ensuring that dignity, autonomy, and relief from suffering remain central to end-of-life decision making.[372] Against this backdrop of palliative care's recognised value and acknowledged limitations, professional ethical

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365 HPCSA, *Guidelines for Good Practice in the Health Care Professions: Ethical Guidelines on Palliative Care* paras 5–7.

366 Johannes J.M. van Delden, 'Terminal Sedation: Source of a Restless Ethical Debate' (2007) 33 (4) Journal of Medical Ethics 187,187-190 <https://doi.org/10.1136/jme.2007.020446> accessed 12 May 2025.

367 Hamilton-Baillie and others, 'Palliative care in a rural subdistrict in South Africa' a4047, PDF 2-9.

368 David G Kirchhoffer, Chi-Wai Lui and Anita Ho, 'Moral uncertainty and distress about voluntary assisted dying prior to legalisation and the implications for post legalisation practice: a qualitative study of palliative and hospice care providers in Queensland, Australia' (2013) 13 BMJ Open e0065964 <https://bmjopen.bmj.com/content/31/5/e065964> accessed 21 April 2025.

369 Hamilton-Baillie and others, 'Palliative care in a rural subdistrict in South Africa' 4047, PDF 3-8; Kirchhoffer, Lui and Ho, Moral uncertainty and distress about voluntary assisted dying prior to legislation' e0065964.

370 Welgemoed and Lerm, 'Palliative care as a form of relief for the dying'350–352.

371 David Bilchitz, 'Dignity, fundamental rights and legal capacity: moving beyond the paradigm set by the General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities 410,410-437 <https://doi.org/10.1080/02587203.2016.1258193> accessed 12 May 2025.

372 Constitution of the Republic of South Africa, 1996, ss 10 and 12.

regulation plays a significant role in shaping how end of life care is practiced in South Africa.

3.5.1 Mental illness and palliative care approach

Mental illness and palliative care occupy a critical space in the broader debate on end-of-life decision-making. Although assisted dying is often framed in terms of terminal physical illness, South African constitutional jurisprudence requires that dignity, autonomy, and vulnerability be considered across all contexts where suffering is profound and rights are engaged.[373] Mental illness raises complex questions about competence and voluntariness and highlights the risk of disproportionate limitation under section 36. Palliative care, meanwhile, represents the state's obligation to provide humane alternatives that respect dignity and alleviate suffering.[374] Linking these domains to end-of-life law is essential to highlight both the safeguards needed to protect vulnerable individuals and the constitutional imperative to ensure that the right to dignity is not confined to physical illness alone.[375]

The governance of mental health in South Africa reveals a stark gap between constitutional promises and lived realities. While the Bill of Rights guarantees dignity, life, and equality, the Life Esidimeni tragedy demonstrated how systemic neglect can strip vulnerable patients of these rights. In 2016, the Gauteng Department of Health terminated its contract with Life Esidimeni, transferring nearly 2,000 mental health care users to unlicensed NGOs.[376] This decision led to the deaths of at least 141 patients, with many more subjected to trauma and rights violations.[377] The Health Ombud's 2017 report described the project as 'irrational and inhumane', exposing failures of governance, accountability, and oversight. Scholarly analysis argues that the tragedy

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373 Constitution of the Republic of South Africa, 1996 s 10; *S v Makwanyane and Another* 1995 (3) SA 391 (CC) paras 144–146.

374 David J McQuoid-Mason, 'Assisted Suicide and Assisted Voluntary Euthanasia: Stransham-Ford High Court Case Overruled by the Appeal Court- but the Door is Left Open' (2017) 107(5) South African Medical Journal 381, 381–382.

375 *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D); Section27, 'Life Esidimeni' (2018)

376 Constitution of the Republic of South Africa, 1996 ss 10, 11, 9 South African Human Rights Commission, *Report on the Investigation into the Life Esidimeni Tragedy* (Pretoria: SAHRC, 2017) Health Ombud, *Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province* (Pretoria: Office of the Health Ombud, 2017)

377 Life Esidimeni Arbitration, Section27 v Gauteng Department of Health (2018) Arbitration Award; see also Section27, 'Life Esidimeni Case Overview' (2025) paras 45-50 <https://section27.org.za/life-esidimeni/> accessed 2 June 2025.

reflects deeper flaws in South Africa's Mental Health Care Act 17 of 2002,[378] which promises community-based care but lacks effective safeguards.[379] The case underscores the constitutional imperative that dignity and equality must extend to mental health care, and that palliative approaches must be strengthened to protect vulnerable groups. Scholarly analysis argue that the tragedy reflects deeper flaws in South Africa's Mental Health Care Act 17 of 2002, which promises community-based care but lacks effective safeguards.[380]

Palliative care frameworks also reveal shortcomings. The National Policy Framework and Strategy on Palliative Care (2017–2022) emphasises dignity and quality of life, yet implementation remains uneven, with limited integration of mental health services.[381] Much of palliative care provision relies on NGOs, hospices, and community-based organisations which often lack adequate infrastructure, sustainable funding, and specialised training to serve vulnerable populations effectively.[382] While these organisations are critical enablers of access, dependence on donor funding and volunteer staff leaves services fragmented and inconsistent.[383] This reliance undermines the constitutional promise of equal access to dignified care, eroding both the autonomy and protection for vulnerable patients, many of whom are excluded from meaningful participation in end-of-life decision-making.[384]

South African challenges mirror international debates on mental illness and assisted dying. In Canada, medical assistance in dying (MAiD) has been legal since 2016,

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378 South Africa's Mental Health Care Act 17 of 2002.

379 *Health Ombud, Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province* (Pretoria: Office of the Health Ombud, 2017) <https://www.ohsc.org.za> accessed 2 October 2026; *South African Human Rights Commission, Report on the Investigation into the Life Esidimeni Tragedy* (Pretoria: SAHRC, 2017).

380 Ramabifi Kenneth Thobejane, An Assessment of mental health care law in South Africa with Specific reference to the Life Esidimeni Tragedy (MPhil mini-dissertation, University of Pretoria 2018). Ch 3, p 45-52 <https://hdl.handle.net/2263/70021> accessed 11 November 2024.

381 Department of Health, *National Policy Framework and Strategy on Palliative Care 2017–2022* (Pretoria, 2017).

382 Hospital Association of South Africa, 'The Palliative Care Challenge Facing Universal Healthcare in South Africa' (HASA,2025).

383 Sukoluhle Pilime and others, 'Barriers to and Enablers of Availability and Integration of Palliative Care into Routine Services at Charlotte Maxeke Johannesburg Academic Hospital, South Africa' (2025) 24 BMC Palliative Care 6-8.

384 Elizabeth Gwyther, 'How is Palliative care part of the right to health? The South African evidence (PHD thesis, University of Cape Town 2019) <https://hdl.handle.net/11427/30368> accessed 7 March 2026.

following the *Carter v Canada* decision and subsequent legislation. Bill C-7, assented to in March 2021, broadened eligibility by removing the requirement that natural death be reasonably foreseeable, but it explicitly excluded mental illness as a sole qualifying condition. Parliament has since postponed the expansion of eligibility for mental illness cases until March 2027, citing concerns about vulnerability, autonomy, and safeguards.[385] The Canadian debate illustrates the difficulty of balancing constitutional rights with protections for individuals whose decision-making capacity may be compromised, a tension that resonates with South Africa's own constitutional framework.

Together, these failures and delays underscore the constitutional imperative to embed mental health protections into palliative care and end-of-life law. Without statutory clarity, independent oversight, and resource allocation, vulnerable groups remain at risk of systemic neglect, undermining the very values of dignity and life that the Constitution enshrines.

3.6 Health Professions Council of South Africa (HPCSA) guidelines on end- of life care [386]

Against the backdrop of palliative care's recognised value and acknowledged limitations, professional ethical regulation plays a central role in shaping how end-of-life is practised in South Africa. Guidelines for end-of-life care are essential to ensuring that patients receive compassionate, ethical, and respectful treatment,[387] while also providing clarity for health-care professionals navigating complex clinical and moral decisions. The Health Professions Council of South Africa (HPCSA) provides regulatory guidance emphasising palliative care, effective pain management, and the withdrawal or withholding of futile treatment, which are recognised as permissible practices under South African law.[388] Futile treatment refers to interventions that offer no reasonable prospect of benefit and merely prolong suffering and its withdrawal is understood as consistent with patient values and preferences.[389]

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385 Government of Canada, *Medical Assistance in Dying and Mental Illness* (2024).
386 Health Professions Act 56 of 1974.
387 Beauchamp and Childress, *Principles of Biomedical Ethics* (Oxford University Press 2013).
388 Health Professions Council of South Africa, *Guidelines for the Management of Patients at the End of Life* (2019).
389 HPCSA, *Guidelines for the Withholding and Withdrawing of Treatment* paras 3.2–3.4.

At the same time, the HPCSA expressly prohibits any active intervention intended to hasten death, affirming that euthanasia and physician assisted suicide remain both unethical and lawful under the current legal framework.[390]

The HPCSA further emphasises respect for autonomy, dignity, and informed consent, reflecting core principles of biomedical ethics and constitutional values.[391] It encourages interdisciplinary collaboration in end-of-life care, recognising that comprehensive support requires the combined expertise of medical practitioners, nurses, social workers, psychologists and spiritual care providers.[392] Clinicians in South Africa often advocate palliative care as a more ethical alternative to euthanasia. It provides holistic support addressing physical, emotional, psychological, and spiritual needs enhancing quality of life without hastening death.[393] Expanding access to palliative services is seen as vital to meeting patient needs and enabling dignity and peace in the final stages of life.[394]

Additionally, the council stresses the importance of enhanced training in palliative care and end-of-life decision making,[395] calling for the integration of palliative care into medical and health curricula.[396] Ongoing professional development through workshops, seminars and continuing education programmes is promoted to ensure that practitioners remain equipped to manage complex symptoms, communicate effectively with patient and families,[397] and to navigate the ethical and emotional challenges associated with terminal illness.[398]

These professional obligations are underpinned by ethical frameworks commonly taught in South African medical education, particularly the principlism approach articulated by Beauchamp and Childress which emphasises autonomy beneficence,

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390 HPCSA, *Guidelines for the Withholding and Withdrawing of Treatment* para 4.1.

391 HPCSA, *General Ethical Guidelines for the Health Care Professions* para 2.3.; Beauchamp and Childress, *Principles of Biomedical Ethics* 101.

392 HPCSA, *Guidelines for the Withholding and Withdrawing of Treatment* para 6.1.

393 National Department of Health, *National Policy Framework and Strategy on Palliative Care 2017–2022* (22 August 2017) 11–12.

394 Tessa A McMillan, Lauren Hutton and Louis Jenkins, 'Doctors' Knowledge, Attitudes and Practices of Palliative Care in Two South African Districts' (2024) 16 African Journal of Primary Health Care and Family Medicine e1, e6-e8.

395 Health Professions Council of South Africa, *Ethical Guidelines on Palliative Car*e (Booklet 17, 2019) para 5.

396 HPCSA, *Ethical Guidelines on Palliative Car*e para 4,6.

397 HPCSA, *Ethical Guidelines on Palliative Car*e para 8.2.7

398 HPCSA, *Ethical Guidelines on Palliative Car*e para 4,6.

non-maleficence, and justice as foundational to clinical decision making.[399] These ethical principles significantly influence how healthcare practitioners understand, interpret and respond to end of life care, including debates surrounding euthanasia and assisted dying.[400]

Below are some of the ethical principles that shape the perspectives, opinions and attitudes of healthcare practitioners regarding end-of-life care.

3.6.1 Patient-centred principles: autonomy, veracity, and compassion

The HPCSA's ethical guidelines emphasise patient-centred principles that directly shape end-of-life care, notably autonomy, veracity, and compassion. Autonomy is a cornerstone of medical ethics, affirming the right of individuals to make informed decisions concerning their own body and medical treatment.[401] In South Africa, autonomy is constitutionally entrenched in section 12(2)(a) of the Constitution, which protects bodily and psychological integrity and reflects broader values of dignity and freedom.[402] In the end-of-life context, autonomy supports patients' right to refuse or discontinue medical treatment, even when such refusal may hasten death.[403] However, its extension to active euthanasia remains ethically and legally contested, with critics cautioning that such practices may undermine the sanctity of life and professional obligations.[404]

The decision in *Stransham-Ford v Minister of Health* highlighted the tension between patient autonomy and the ethical obligations of medical practitioners, illustrating the difficulty of reconciling individual choice with professional duties and societal interests.[405] The HPCSA affirms respect for autonomy through informed consent and recognition of treatment refusal, while maintaining that clinical decisions must remain

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399 Beauchamp and Childress, *Principles of Biomedical Ethics* (8th edn, Oxford University Press 2019) 13–16; Keymanthri Moodley, 'Teaching medical ethics to undergraduates students in post-apartheid South Africa, 2003-2006' (2007)33(11) Journal or medical Ethics 673, 673-677 <https://doi:10.1136/jme.2006.018432> accessed 12 June 2025.

400 Health Professions Council of South Africa, *Ethical Guidelines for Good Practice in the Health Care Professions* (Booklet 1, 2021).

401 HPCSA, *Ethical Guidelines on Palliative Care* para 7.2.4

402 Constitution of the Republic of South Africa, 1996, s 12(2)(a).

403 McQuoid-Mason, 'Doctor Assisted Suicide' 526; McQuoid-Mason, 'Assisted Voluntary Euthanasia: *Stransham-Ford* Case' 381-382.

404 Adriaan Knoetze and Shaun de Freitas, 'The Protection of Conscientious Objection against Euthanasia in Health Care' (2019) 22 PER/PELJ 1–32.

405 *Stransham-Ford v Minister of Health* [2015] ZAGPPHC 97.

ethically justified, professionally responsible, and consistent with the practitioner's role as healer.[406] Autonomy therefore frequently intersects with, and is constrained by, the principles of beneficence and non-maleficence, requiring careful ethical deliberation in end-of-life decision-making.

Veracity (truth-telling), requires healthcare practitioners to communicate truthfully and transparently, ensuring that patients receive full disclosure of their diagnosis, prognosis, and available treatment options to support informed decision-making.[407] Truth-telling underpins autonomy and the validity of informed consent, although its application must remain sensitive to patient readiness, cultural context, and psychological and social impacts.[408] Scholars acknowledge that, in rare and exceptional circumstances limited benevolent deception may be ethically defensible to prevent serious harm or distress.[409] However, sustained failure to uphold veracity undermines trust in the therapeutic relationship and compromises ethically sound and informed clinical outcomes.[410] In the context of end-of-life care, veracity remains indispensable to fostering transparency, compassion, and patient empowerment.

Compassion complements autonomy and veracity by requiring healthcare practitioners to act with empathy, kindness, and respect for patient dignity.[411] It entails recognising vulnerability, alleviating suffering, and addressing psycho-social and spiritual needs alongside clinical care.[412] Compassion is particularly vital in the context of terminal illness, where curative treatment is no longer possible and the focus of care

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406 HPCSA, *Ethical Guidelines on Patient Autonomy and Informed Consent* (Booklet 1, 2008) paras 3–5; HPCSA, *Ethical Guidelines on Withholding and Withdrawing of Treatment* (Booklet 7, 2016) para 1.3; HPCSA, *Ethical Guidelines on Palliative Care* (Booklet 17, 2019) paras 4, 6.

407 HPCSA, *Ethical Guidelines on Palliative Care* (Booklet 17, 2019) para 8.2.6; HPCSA, *Ethical Guidelines for Good Practice in the Health Care Professions* (Booklet 1, 2021) para 2.3.7.

408 Michael McCabe, 'Striking a Balance in Truth-Telling' (Nathaniel Centre, Issue 4, August 2001) para 4 (citing Sissela Bok, *Lying: Moral Choice in Public and Private Life* (Vintage 1978)), <https://nathaniel.org.nz/euthanasia/13-bioethical-issues/what-is-bioethics/69-striking-a-balance-in-truth-telling> accessed 14 June 2025. McCabe discusses Bok's framework in paras 1–4.

409 McCabe, 'Striking a Balance in Truth-Telling' para 4: McCabe develops his own position, acknowledging that while truth-telling is foundational, there may be rare and exceptional circumstances where limited benevolent deception is ethically defensible to prevent serious harm or distress.

410 Bettina Schoene-Seifert and James F Childress, 'How Much Should the Cancer Patient Know and Decide?' (1986) 36(2) CA: A Cancer Journal for Clinicians 85, 87–89 arguing that withholding information erodes trust and undermines the validity of informed consent.

411 Health Professions Council of South Africa, *General Ethical Guidelines for the Health Care Professions* (Booklet 1, 2021) para 2.3.8.

412 HPCSA, *General Ethical Guidelines for the Health Care Professions* paras 2.3.1–2.3.8.

necessarily shifts toward comfort, dignity, and holistic patient centred support.[413] The HPCSA explicitly emphasises compassionate professional conduct, calling on practitioners to be attentive to patients' individual and social circumstances and to deliver care in a trustworthy, respectful and non-judgmental manner.[414] Compassion therefore reinforces ethical obligations to uphold human dignity and to sustain trust within the therapeutic relationship, particularly at the end of life.

3.6.2 Professional and ethical duties: non-maleficence, beneficence, justice and integrity

The HPCSA's ethical guidelines also emphasise professional duties that shape end-of-life care, notably non-maleficence, beneficence, justice, and professional integrity. Non-maleficence, commonly expressed as the obligation to "do no harm," requires healthcare practitioners to avoid actions that intentionally or foreseeably cause injury suffering, or death.[415] Beauchamp and Childress identify non-maleficence as a foundational principle of biomedical ethics that must be balanced against beneficence and respect for autonomy in clinical decision-making.[416] As Varkey observes, the principle is not applied mechanically but requires contextual interpretation, particularly in complex clinical scenarios.[417] Ethical dilemmas arise acutely at the end-of-life, where efforts to alleviate suffering may risk causing harm, especially in debates surrounding euthanasia and physician assisted dying.

The *Stransham-Ford* litigation illustrates this tension, raising difficult questions about whether intentionally hastening death can ever be reconciled with the duty to avoid harm, even where compassionate motives are present.[418] The HPCSA affirms the primacy of patient welfare while maintaining a clear prohibition on any conduct intended to cause death, and it explicitly recognises healthcare practitioners' right to conscientious objection in ethically contested situations.[419]

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413 HPCSA, *General Ethical Guidelines for the Health Care Professions* para 2.3.8.
414 HPCSA, *General Ethical Guidelines for the Health Care Professions* para 2.3.8.
415 HPCSA, *General Ethics Guidelines for the Health Care Professions* paras 9.2–9.3.
416 Beauchamp and Childress, *Principles of Biomedical Ethic*s 99.
417 Basil Varkey, 'Principles of Clinical Ethics and Their Application to Practice' (2021) 30(1) Medical Principles and Practice 17,17-19 <https://doi.org/10.1159/000509119> accessed 11 May 2025.
418 McQuoid-Mason, 'Doctor Assisted Suicide' 526–527.
419 HPCSA, *General Ethics Guidelines for the Health Care Professions* (Booklet 1, 2006) para 2.4.

Beneficence imposes a positive moral obligation on practitioners to act in ways that promote patient welfare, including preventing harm, relieving suffering, and fostering well-being.[420] In the context of end-of-life care, beneficence, frequently informs decisions to withhold or withdraw futile treatment where continued intervention offers no therapeutic benefit and merely prolongs suffering.[421] Some scholars argue that beneficence may, in principle, support reconsideration of assisted dying in exceptional circumstances of intractable suffering, however such practices remain unlawful in South Africa.[422] Beneficence may also come into tension with autonomy, particularly where patients request interventions that clinicians believe are not in their best interests or are ethically unjustifiable.[423] The HPCSA frames beneficence within a palliative care paradigm, requiring practitioners to balance potential risks and benefits while acting compassionately, professionally and strictly within the bounds of the law.[424]

Justice requires fairness and equity distribution of healthcare resources and in the treatment of patients in comparable circumstances.[425] This principle is particularly significant in South Africa, where profound disparities persist between the public and private healthcare sectors, and where access to care is closely linked to socio-economic status. Ethical concerns arise as to whether the absence of legally recognised end of life options, coupled with unequal access to high-quality palliative care, disproportionately affects socio-economically marginalised populations who already experience constrained healthcare choices.[426]

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420 HPCSA, *Ethical Guidelines on Palliative Care* (Booklet 17, 2019) paras 9.8–9.9.

421 Beauchamp and Childress, *Principles of Biomedical Ethics* 122–123; UK Clinical Ethics Network, 'Four Principles' ethical framework (UKCEN, 2025) <https://ukcen.org/guidance-for-clinical-ethical-frameworks/four-principles/> accessed 21 May 2025.

422 McQuoid-Mason, '*Stransham-Ford v Minister of Justice and Correctional Services and Others*: can active voluntary euthanasia and doctor assisted suicide be legally justified and are they consistent with the biomedical ethical principles? Some suggested guidelines for doctors' (2015) 8 South African Journal of Bioethics and Law 34 <https://doi.org/10.7196/sajbl.446> accessed 12 May 2025.

423 Delgersuren Gelegjamts, Khulan Gaalan and Batbagana Burenerdene, *Ethics in Palliative Care* (Intechopen, 6 April 2023) PDF 4-6 <https://www.intechopen.com/chapters/86719> and <https://doi.org/10.5772/intechopen.1110756> accessed 12 June 2025.

424 HPCSA, *Ethical Guidelines on Palliative Care* (Booklet 17, 2019).

425 HPCSA, *Ethical Guidelines for Good Practice in the Health Care Professions* (Booklet 1, 2021) para 5.6; HPCSA, *Ethical Guidelines on Palliative Care* (Booklet 17, 2019) para 7.2.3.

426 Hospice Palliative Care Association of South Africa, *Position Paper on Euthanasia and Assisted Suicide* (2024) para 4.

The Hospice Palliative Care Association cautions that any move towards legalising of euthanasia must be approached with particular care in a context of structural inequalities, as uneven access to procedural safeguards and oversight mechanisms, may expose vulnerable patients to heightened risk.[427] From a justice perspective, any reform of end of life law must therefore prioritise equity, protection of the vulnerable, and the strengthening of health system capacity, ensuring that legal and policy developments do not entrench existing disparities.

Professional integrity obliges healthcare practitioners to uphold ethical and professional standards that preserve the core values of medicine, including respect for life, patient welfare and public trust.[428] Integrity extends beyond formal regulatory compliance, requiring reflective ethical judgment that balances autonomy, beneficence, and non-maleficence, and where necessary, principled resistance to external pressures that conflict with professional obligations.[429] Integrity plays a critical role in sustaining trust within the doctor-patient relationship and in ensuring that patient choices are respected within a framework of professional responsibility and accountability.[430]

In South Africa, this obligation is reinforced by the HPCSA's ethical guidelines, which require practitioners to act with compassion, honesty, respect and professional independence, particularly in ethically contested areas such as end-of-life care.[431] Integrity may be especially strained where practitioners are confronted with patient requests for assisted dying in the absence of clear legal authorisation, underscoring the importance of clear ethical guidance and legal certainty in this domain.

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427 Hospice Palliative Care Association of South Africa, *Position Paper on Euthanasia and Assisted Suicide* (2024) para 4.

428 HPCSA, *Ethical Guidelines on Palliative Care* (Booklet 17, 2021) para 3.1.

429 Richard Ashcroft, Tony Hope and Michael Parker, 'Ethical Issues and Evidence-Based Patient Choice' in Adrian Edwards and Glynn Elwyn (eds), *Evidence-Based Patient Choice: Inevitable or Impossible?* (Oxford University Press 2001) 53–65.

430 Ashcroft, Parker and Hope, 'Ethical Issues and Evidence-Based Patient Choice' 60–62.

431 HPCSA, *Ethical Guidelines for Good Practice in the Health Care Professions* (Booklet 1, 2021) para 3.1.

3.6.3 Historical and philosophical influences: the doctrine of double effect and the Hippocratic Oath

Beyond patient-centred principles and professional duties, end-of-life ethics in South Africa are also shaped by enduring historical and philosophical influences, particularly the doctrine of double effect and the Hippocratic Oath. The doctrine of double effect permits actions that produce both beneficial and harmful consequences, provided that the harmful effect is not intended, even if it is foreseen.[432] In end-of-life care, this principle is frequently invoked to justify the administration of high dose opioids such as morphine, which may hasten death but are primarily intended to relieve severe pain and suffering.[433]

Fine argues that effective pain relief at the end of life constitutes an ethical obligation grounded in the principle of beneficence, non-maleficence, respect for autonomy, and the doctrine of double effect.[434] This position was authoritatively affirmed In *R v Adams*, where Devlin J held that a medical practitioner is entitled to relieve pain even if such treatment may incidentally shorten life, provided the primary intention is symptom control rather than the causation of death.[435] Scholarly analysis, including that of Keown, underscores the central role of the doctrine of double effect role in distinguishing palliative sedation from euthanasia, preserving the moral permissibility of symptom relief while maintaining a clear ethical and legal boundary against intentional killing.[436] The HPCSA's ethical guidelines reflect this distinction, endorsing proportionate symptom relief grounded in professional judgment while rejecting any intention to hasten death.[437]

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432 Joseph M Boyle,'Toward Understanding the Principle of Double Effect' (1980) 90(5) Ethics 527,527–528 <http://www.journals.uchicago.edu/doi/pdf/10.1086/292183> accessed 14 July 2024 (arguing that foreseen but unintended harms may be permissible if proportionate to the good achieved, provided the agent's intention is directed toward the beneficial effect).

433 Robert L Fine, 'Ethical and Practical Issues with Opioids in Life Limiting Illness' (2007) 20 (1) Baylor University Medical Center Proceedings 5, 5-12 <https://www.ncbi.nlm.nih.gov/pmc/artcicle/PMC1769525/> accessed 2 August 2025.

434 Fine, 'Ethical and Practical Issues with Opioids in Life Limiting Illness' 5-6.

435 *R v Adams* [1957] Crim LR 365 (Devlin J).

436 John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legislation* (CUP 2002) 43–49.

437 HPCSA, *Ethical Guidelines on Palliative Care (Booklet 17, 2019)* paras 4, 6; HPCSA, *Ethical Guidelines for Good Practice in the Health Care Professions* (Booklet 1, 2021) para 5.6.

The Hippocratic Oath has long served as a moral compass for medical practice, embedding principles of non-maleficence, confidentiality, and reverence for life. Its classical formulation explicitly prohibits physicians from administering lethal substances, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel."[438] This prohibition has historically shaped the ethical identity of the medical profession and continues to inform contemporary debates on euthanasia. Modern professional instruments, such as the World Medical Association's Declaration of Geneva, retain the emphasis on preserving life,[439] and many South African practitioners continue to regard euthanasia as incompatible with the physician's duty to heal.[440]

Empirical studies support this position. Steyn and Bondo's qualitative research confirm that clinicians often equate euthanasia with deliberately ending life and view it as fundamentally inconsistent with medical values.[441] However, some scholars offer a more nuanced interpretation of the Hippocratic tradition. Clarke and Egan argue that while the Oath mandates respect for life, it does not require the preservation of life at all costs.[442] They note that the refusal or withdrawal of life-sustaining treatment is already legally permissible as an expression of patient autonomy, and suggest that dignity considerations may in principle, justify limited forms of assisted dying under strict regulatory safeguards.[443] They caution, however, that any departure from traditional prohibitions must be accompanied by robust protections to prevent abuse and preserve public trust in the medical profession.[444]

South African scholarship increasingly engages with this intersection of ethics, law, and compassionate end-of-life care, recognising the Hippocratic commitment to preserve life is not absolute and must, in some circumstances, be balanced against the imperative to alleviate suffering.[445]

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438 Ludwig Edelstein (tr), *The Hippocratic Oath: Text, Translation and Interpretation* (Johns Hopkins University Press 1943) 3.

439 World Medical Association, *Declaration of Geneva* (amended 2017).

440 World Medical Association, *Declaration of Geneva* (amended 2017).

441 Steyn and Bondo, 'Perspectives and Attitudes of South African Medical Professionals' a5926, PDF p4-7.

442 David L Clarke and Andrew Egan, 'Euthanasia-Is There a Case?' (2009) 2(1) South African Journal of Bioethics and Law 23, 23–27.

443 Clarke and Egan, 'Euthanasia-Is There a Case?'

444 Clarke and Egan, 'Euthanasia-Is There a Case?' 28–29.

445 Ames Dhai and David J. McQuoid-Mason, *Bioethics, Human Rights and Health Law: Principles*

Nevertheless, the Hippocratic Oath continues to frame much of the professional resistance to physician-assisted dying, highlighting the persistent tension between classical medical ethics and evolving claims grounded in autonomy and dignity. In summary, the HPCSA guidelines provide a comprehensive ethical framework for end-of-life care, emphasising autonomy, beneficence, non-maleficence, justice, and integrity, while prohibiting active end of life interventions.

Taken together, these ethical principles and historical influences not only shape the regulatory framework for end-of-life care but also deeply inform the perceptions, attitudes, and lived experiences of healthcare practitioners, whose perspectives in clinical practice reveal the tensions between professional duties, cultural values, and the realities of resource-constrained environments.

3.7 Stakeholder perspectives on euthanasia: healthcare practitioners and families

Healthcare practitioners and families occupy central roles in shaping end-of-life care in South Africa. Their perspectives are informed by professional ethics, cultural traditions, communal value systems, and the structural constraints of the healthcare system.[446] In many African philosophical traditions, decisions at the end of life are understood as relational and community-oriented rather than purely individual choices, creating tension with Western autonomy-based arguments often advanced in support of euthanasia. Reports by the African Palliative Care Association and WHO Africa highlight that palliative care across the continent remains under-resourced and unevenly integrated into national health systems, with limited access to pain relief and psychosocial support.[447] While this study does not extend to other African countries due to limited literature, these continental perspectives provide important background

and Practice (2nd edn, Juta Law 2020).

446 Sheila Holmes and others, 'Exploring the experience of supporting a loved one through a medically assisted death in Canada' (2018) 64 Canadian Family Physician e387, e387-e393 <https://pmc.ncbi.nlm.nih.gov/articles/PMC6135137> accessed 7 May 2024.

447 *African Palliative Care Association, Strategic Plan 2020–2030* (APCA, Kampala 2020) <https://www.africanpalliativecare.org/> <https://www.africanpalliativecare.org/sites/default/files/202310/APCA_STRATEGIC_PLAN_2020-2030.pdf> accessed 2 October 2026; *World Health Organization Regional Office for Africa, APCA Atlas of Palliative Care in Africa* (WHO Africa, 2022) <https://www.afro.who.int/> accessed 2 October 2026.

for understanding South African stakeholder experiences. These intersecting factors underscore the complexity of stakeholder perspectives, which are examined below.

3.7.1 Healthcare practitioners' perspectives

Scholarship acknowledges the ethical complexity of end-of-life decision-making, yet significant hesitation remains among healthcare practitioners regarding the legalisation of euthanasia.[448] This reluctance is largely driven by concerns about potential misuse, the absence of clear regulatory guidelines, and deeply held moral and professional reservations.[449] Empirical research demonstrates that even practitioners who are sympathetic to patients experiencing profound suffering are often unwilling to support euthanasia openly, owing to fears of criminal liability, professional misconduct proceedings and disciplinary sanctions.[450]

Studies further highlight the frustration experienced by clinicians who find themselves caught between alleviating patient suffering and operating within restrictive legal boundaries.[451] Professional organisations within the medical profession, including the South African Medical Association (SAMA) generally emphasise patient protection, ethical caution and the strengthening of palliative care services, rather than endorsing the legalisation of assisted dying.[452] This position reflects not only institutional conservatism but also broader concerns about safeguarding vulnerable patients, preserving professional integrity, and maintaining public trust in the medical profession.

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448 McQuoid-Mason, Doctor-assisted suicide: What is the present legal position in South Africa? 526-527.

449 Margaret Somerville, *Death Talk: The Case Against Euthanasia and Physician- Assisted Suicide* (McGill-Queen's University Press 2001).

450 McQuoid-Mason, Doctor-assisted suicide: What is the present legal position in South Africa? 526-527.

451 Steyn and Bondo, 'Perspectives and attitudes of South African medical professionals towards active euthanasia' a5926.

452 Health Professions Council of South Africa, *Guidelines for Good Practice in the Health care Professions: Ethical Guidelines of Palliative Care* (Booklet 17, 2009); JP van Niekerk and others, 'Decriminalising and legalising medical assistance in dying' (2024) 114(2) South African Medical Journal e1857 <https://doi.org/10.7196/SAMJ.2024.v114i2.1857> accessed 11 July 2025.

Qualitative research by Steyn and Bondo identifies recurring themes among South African medical professionals, including tension between modern medical ethics and euthanasia, the challenge of unrelieved suffering, the complexity of assisted dying, and the inadequate palliative provision.[453] Religious beliefs and professional ethical codes strongly influence attitudes, with some clinicians expressing conditional acceptance of assisted dying in cases of extreme suffering, while perspectives remain conflicted and constrained by legal uncertainty.[454]

Scholars such as Knoetze and de Freitas caution that medical practitioners should be protected from participation in euthanasia to preserve professional integrity and uphold the traditional healing role of medicine.[455] Meanwhile Margaret warns of a "slippery slope" arguing that the legalisation of euthanasia may erode societal respect for life and gradually expand eligibility beyond the initially restricted category of terminal illness.[456] Judicial interventions concerning assisted dying have intensified debate by engaging constitutional values of autonomy and dignity, however, the reversal of early permissive rulings on appeal has left practitioners divided and uncertain about their ethical and legal responsibilities.[457]

Clinicians report significant moral distress when confronted with requests for euthanasia, particularly in circumstances where suffering cannot be adequately alleviated through available interventions.[458] This distress may manifest as guilt, anxiety burnout, or moral injury, further complicating professional responses to end-

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453 Steyn and Bondo, 'Perspectives and Attitudes of South African Medical Professionals' a5926, PDF 6.

454 Steyn and Bondo, 'Perspectives and attitudes of South African medical professionals towards active euthanasia' a5926, PDF 4-9; Albu Van Eeden and others 'Assisted suicide: Ethical considerations and the South African debate' (2024) 114(6) SAMJ e2246,6-7 <https://doi.org/10.7196/SAMJ.2024.v114i6.2246> accessed 12 May 2025.

455 Knoetze and Freitas, 'The Protection of Conscientious Objection against Euthanasia in Health Care' 1–3, 10–12 (arguing that medical practitioners should be protected from participation in euthanasia to preserve professional integrity and the traditional healing role of medicine).

456 Margaret Somerville, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide* (McGill-Queen's University Press 2001) 63-72, 76-83, 86-100.

457 *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50(GP); *Minister of Justice and Correctional Services and Others v Estate Stransham-Ford* 2016 (3) SA 1 (SCA).

458 Priyanka Pinto, Gerald Blaise Fogarty and David Kissane, 'Narrative review of impact on physician of administering euthanasia physician-assisted suicide and its association with moral distress' (2025) 23 Palliative and Support care e115, PDF 6-13 <https://doi.org/10.1017/S1478951525000240> accessed 1 January 2026.

of-life care.[459] Chochinov's influential work on dignity in palliative care highlights that loss of autonomy and independence, heightened dependency on others, and psychological and existential distress, including hopelessness and a diminished sense of self are correlates of desire for hastened death among patients nearing the end of life.[460] This dignity model underscores that such suffering is not merely physical, but deeply psychological and relational. For clinicians, these insights reveal the complexity of end of life decision making, where practitioners must interpret and respond to patients' expressions of distress and desire for death, within ethical, emotional and professional constraints.[461] Recognising the interplay between dignity related suffering and patients' wishes challenges clinicians to balance compassionate psycho-social support with respect for legal and professional boundaries, inform shared decision-making with families and tailor care that preserves person-hood as far as possible, which in reality might be hard.

Research on future health practitioners in South Africa shows a notable range of perspectives regarding euthanasia and physician assisted. In a semi-quantitative survey of third to fifth year medical students at Stellenbosch University, just over half (51.7%) of respondents felt that euthanasia/PAS should be legalised in the country, with many citing respect for patient autonomy and relief of suffering as key considerations.[462] However, student willingness to assist in life ending interventions varied according to the clinical scenario, fewer students (41.9%) reported they would consider performing euthanasia for a patient with terminal illness and intractable suffering,[463] and a substantial proportion stated they would prefer that decisions about such interventions be made by an ethics committee.[464]

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459 Pinto, Fogarty and Kissane, 'Narrative review of impact on physician of administering euthanasia physician-assisted suicide' e115, 9-11

460 Harvey Max Chochinov, 'Dying, dignity, and new horizons in palliative end-of-life care' (2006) 56(2) CA: A Cancer Journal for Clinicians 84, 84-103 <https://pubmed.ncbi.nlm.nih.gov/16514136/> accessed 4 April 2025.

461 Harvey Max Chochinov, 'Dignity-Conserving Care-A New Model for Palliative Care: Helping the Patient Feel Valued' (2002) 287(17) Journal of the American Medical Association 2253, 2255. <https://doi.10.1001/jama.287.17.2253> accessed 4 April 2025.

462 Rudolph K Jacobs and Mogamat Hendricks, 'Medical Students' Perspectives on Euthanasia and physician assisted suicide and their views on legalising these practices in South Africa' (2018) 108 (6) SAMJ 484, 484-489 <https://doi.org/10.7196/SAMJ.2018.v108i6.13089> accessed 12 May 2025.

463 Jacobs and Hendricks, 'Medical Students' Perspectives on Euthanasia and physician assisted suicide' 486.

464 Jacobs and Hendricks, 'Medical Students' Perspectives on Euthanasia and physician assisted suicide' 487.

Opinions were further influenced by factors including religious beliefs, with significant variation in views across different faith groups.[465]

International comparative studies reinforce these findings, demonstrating that physician attitudes vary according to specialty, religiosity, and exposure to terminal illness, with oncologists and palliative specialists often expressing greater support due to frequent encounters with intractable suffering.[466]

3.7.2 Family perspectives

Families and informal caregivers play an indispensable role in end-of-life care, particularly in under-resourced health systems where home-based care predominates.[467] In such contexts, the responsibility for managing complex physical symptoms, providing emotional support, and navigating healthcare systems frequently shifts from formal institutions to family members, who often assume these roles without adequate training, financial assistance or psycho-social support. Customary law and community attitudes towards death and dying play a significant role in shaping societal acceptance of euthanasia. In many South African communities, collective decision-making and cultural traditions influence end-of-life choices, often prioritising family and community consensus over individual autonomy. These perspectives highlight the importance of situating constitutional rights within a broader socio-cultural context, recognising that legal reform must be responsive to diverse cultural values.[468]

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465 Jacobs and Hendricks, 'Medical Students' Perspectives on Euthanasia and physician assisted suicide' 488.

466 Daniel Lerma Garcia and others, 'Healthcare professionals' attitudes in the Balearic Islands' (2025) 26 (100) BMC Medical ethics 1, 8-15 <https://pmc.ncbi.nlm.nih.gov/articles/PMC12275305 > accessed 15 November 2025.

467 Samuel Ojima Adejoh and others, 'The role, impact. and support of informal caregivers in the delivery of palliative care for patients with advanced cancer: A multi-country qualitative study' (2021) 35(3) Palliative Medicine 552, 552-562 <https://doi.org/10.117/0269216320974925> accessed 12 January 2025. This multi-country qualitative synthesis reports that in sub-Saharan Africa informal caregivers, including family members provide the majority of physical, emotional, financial and health service support for people with advanced illness, largely due to limited formal health and palliative care resources.

468 Yvonne Mokgoro, 'Ubuntu and the Law in South Africa' (1998)4 Buffalo Human Rights Law Review 15, 15-23.

Empirical research in South Africa demonstrates that caregivers of patients with advanced illness experience substantial burdens.[469] In a study of advanced cancer patients in Johannesburg, caregivers frequently struggled with basic tasks such as hygiene and emotional support, with symptom burdens including pain and fatigue exacerbating distress,[470] while care-giving responsibilities were disproportionately shouldered by women, many of whom lacked formal training or institutional support.[471] Nurses also play a key role in supporting families. Paterson and Maritz report that nurses actively observe and facilitate family engagement, helping caregivers navigate the emotional and practical demands of end-of-life care.[472]

These caregiving burdens are further compounded by both primary and secondary stressors including constant hands on care and emotional exhaustion, alongside secondary stressors such as social isolation and financial strain.[473] Financial strain may be particularly acute in low-income settings, where caregivers may have been compelled to leave employment or incur significant out-of-pocket expenses.[474] However, despite these burdens, empirical evidence indicates that family and informal caregivers often perceive their role as a moral and relational obligation, motivated by a sense of duty, responsibility, and commitment to the well-being of their loved ones within familial and communal contexts.[475]

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469 Daniel S. O'Neil and others, 'Informal Caregiver Challenges for Advanced Cancer Patients During End-of-Life care in Johannesburg, South Africa and Distinctions Based on Place of Death' (2018) 56(1) Journal of Pain and Symptom Management 98, 98-106 <https://doi.org/10.1016/j.jpainsyman.2018.03.017> accessed 4 July 2025.

470 O'Neil and others, 'Informal Caregiver Challenges' 98-106.
The study highlights that caregiver difficulties were particularly pronounced when patients died at home, with challenges arising from untrained family members managing complex symptoms, navigating patient incontinence, and providing continuous emotional support. Caregivers reported feelings of exhaustion, anxiety and social isolation, emphasising the need for structured support interventions in udder-resourced settings.

471 O'Neil and others, 'Informal Caregiver Challenges' 98–102. in the Multivariable analysis, female caregiver gender was significantly associated with higher caregiving difficulty (odds ratio 7.39, 95% CI 2.38-22.90), and three quarters of caregivers were women, a larger proportion than found in studies from the U.S or Europe.

472 Lesley A Paterson and Jeanette E Maritz, 'Nurses' Experiences of the Family's Role in End-of-Life Care' (2024) 29 Health SA Gesondheid a2565 <https://doi.org/10.4102/hsag.v29i0.2565> accessed 12 September 2025.

473 Jocelyn Streid and others, 'Stressors and Resources of Caregivers of patients with incurable progressive illness in Sub-Saharan Africa' (2014) 24(3) Qualitative Health Research 317,317-328 <https://pubmed.ncbi.nlm.nih.gov/24583654/> accessed 12 May 2025.

474 Streid and others, 'Stressors and Resources of Caregivers' ,317-328.

475 Elisabet Breivik, Bente Ervik and Gabriele Kitzmuller, 'Ambivalent and Heavily Burdened Wanderers on a road less travelled: a meta-ethnography on end of life care experiences among family caregivers in rural areas' (2024) 24 BMC Health Services Research 1635, PDF 7-18 <https://doi.org/10.1186/s12913-024-11875-3> accessed 3 May 2025; Gebrezabher

Within the South African context, Ubuntu philosophy, as explored by Mnyandu, underscores compassion, community responsibility, and relational caring, aligning closely with constitutional values of dignity and inter-connectedness.[476] Within many African philosophical traditions, end-of-life decisions are understood as collective responsibilities that affect the family and wider community, rather than as purely individual choices. This communitarian orientation contrasts with, the Western liberal emphasis on individual autonomy that often underpins arguments in favour of legalising euthanasia. These cultural considerations contribute to resistance among many South African practitioners, particularly where legal and ethical frameworks do not adequately accommodate indigenous worldviews.

This is further realised through spirituality, faith and cultural practices as central mechanisms by which caregivers cope with end of life challenges, often drawing on relational, spiritual, and psychological resources to maintain resilience, interpret suffering and sustain their caregiving.[477] Uzun, Basar and Saritas emphasise that spiritual support provides both individual and community resources, it enables caregivers to find meaning in patient suffering, fosters hope, mitigates emotional exhaustion, and reinforces culturally embedded norms about familial duty and caregiving responsibility.[478]

Niguse Hailu and others, 'The role of family caregivers in supporting older adults in Africa: systemic review' (2025) 25 BMC Geriatrics 491, PDF 8-13 <https://doi.org/10.1186/s1287-025-06154-7> accessed 12 January 2026.

476 Ntokozo Mnyandu, 'Exploring the Concept of Ubuntu in Relation to Dying with Dignity in Palliative Care' (2018) 39(2) Obiter 384, 384-398 <file:///C:/Users/ntzun/Downloads/shireen_obiter,+2vol+art+(8)+Mnyandu+Exploring+the+concept+of+ubuntu+in+relation+to+dying+with+dignity+in+palliative+and+hospice+care+(2).pdf> accessed 12 May 2025. Mnyandu argues that Ubuntu underscores compassion, community responsibility, and relational caring, encapsulated in the maxim "Umuntu Ngumuntu Ngabantu" ("a person is a person through other people"). He shows how Ubuntu aligns with constitutional values of dignity and interconnectedness, offering a relational ethic that contrasts with Western individualism and grounds end-of-life decision-making in community responsibility.

477 Patricia P Mnisi, The Experiences of Families Regarding Caring for Family Members Who Are Terminally Ill (MSW mini-dissertation, University of Pretoria 2018) <https://hdl.handle.net/2263/67749> accessed 12 May 2025.

478 Uğur Uzun, Serpil Başar, and Aykut Saritaş, 'Spiritual Needs of Family Caregivers in Palliative Care' (2024) 23 BMC Palliative care 256, PDF 1-8 <https://doi.org/10.1186/s12904-024-01589-y> accessed 12 May 2025.
In their 2024 study, the authors explored the spiritual needs of 150 family caregivers supporting palliative care in Turkey. The authors found that caregivers frequently require spiritual support to manage emotional distress, make meaning of illness and maintain personal resilience. Key needs included hope, inner peace, connection with a higher power and ritual participation, which caregivers identified as closely tied to their capacity for sustained, compassionate care.

In addition to family members, nurses, and palliative care professionals, traditional healers though not a central focus of this study play a significant role in end-of-life care in South Africa, particularly in rural and disadvantaged communities. Research shows that traditional healers are often the preferred source of advice and support, providing culturally embedded guidance on death, dying, and spiritual processes. For example, a study among Xhosa patients found that traditional healers emphasised rituals and spiritual practices as essential to achieving a "good death," highlighting their influence on perceptions of dignity and divine will at the end of life.[479] More recent qualitative research confirms their role in providing aspects of palliative care in rural South Africa, while also noting challenges of integration.[480] Contemporary scholarship further demonstrates that traditional healing remains integral to community health systems and should be incorporated into mainstream healthcare frameworks.[481]

By integrating spirituality with practical caregiving, families are better able to manage both emotional and physical burdens while maintaining relational and moral commitments. Challenges, however, emerge when caregivers at times struggle to reconcile with the patient's expressed end of life wishes with their own moral, cultural or religious beliefs, particularly in cases involving the withdrawal of life sustaining treatment and end of life decisions.[482] Poor communication between patients, families and clinicians can lead to conflict, whereas better advance care planning and dialogue can improve concordance and reduce tension.[483]

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479 Nicola Graham and Others,' Traditional healers' views of the required processes for a 'good death' among Xhosa patients pre and post death' (2013) 46(3) Journal of Pain and symptoms Management 386, 386-394.

480 Laura Campbell and Nyna amin,' A Qualitative study: potential benefits and challenges of traditional healers in providing aspects of palliative care in rural South Africa' (2014) 14 Rural and Remote Health 2378 <https://doi.org/10.22605/RRH2378> accessed 14 November 2025.

481 Monicca T Bhuda, mamokete Venolia Setshego and Motheo Koitsiwe,'The Role of Indigenous Participants in Participatory Action Research' in *Enhancing Qualitative and Mixed Methods Research with Technology* (IGI Global 2025) 291.

482 Kotzé and Roos, 'End-of-life care in South Africa: Important legal developments' a1748.

483 Sophie Mulcahy Symmons and others, 'Decision-making in palliative care: patient and family caregiver concordance and discordance: systematic review and narrative synthesis' (2023) 13 BMJ Supportive & Palliative Care 375,375-385 <https://spcare.bmj.com/content/bmjspcare/13/4/374.full.pdf> accessed 12 May 2025.
This systematic review analysed 39 studies published between 2000 and mid-2021, finding that discordance between patients and caregivers often arises from poor communication and a lack of shared understanding of care preferences, which may lead to relational conflict. The authors emphasise that ongoing advance care planning and open dialogue as illness progresses can foster concordance, reduce tension, and align treatment choices with patient values.

Taken together, the perspectives of families and practitioners underscore the deeply contextual nature of end-of-life care in South Africa. Alongside healthcare practitioners, they reveal how ethical principles, cultural traditions and systemic constraints converge to shape attitudes toward euthanasia, reinforcing the need for policy frameworks that balance autonomy and dignity with communal responsibility and protection of the vulnerable.

3.8 Conclusion

This chapter examined the South African healthcare system within the broader context of palliative care and euthanasia, highlighting the structural, ethical and practical challenges that continue to shape end-of-life decision making in the country. The discussion revealed that although South Africa has made notable progress in recognising the importance of palliative care and patient dignity, significant barriers remain. These include resource constraints, unequal access to healthcare services, limited training in end-of-life care, and the ongoing burden placed on healthcare professionals working within an already strained system. Furthermore, the socio-economic inequalities, coupled with cultural, religious and ethical considerations, continue to influence how end-of-life care is perceived and delivered.

This chapter also emphasised the importance of strengthening palliative care infrastructure as a critical component in addressing end of life. While debates surrounding euthanasia often arise from concerns about dignity, autonomy and relief from suffering, these discussions cannot be divorced from realities of a healthcare system that must first ensure equitable access to quality care. The challenges identified in South Africa raise important questions about whether euthanasia could be responsibly implemented in a context where healthcare disparities remain prevalent.

Against this backdrop, it becomes necessary to examine jurisdictions where euthanasia or assisted dying has already been legalised and operationalised within structured healthcare systems, such comparative analysis offers valuable insights into legal safeguards, ethical frameworks and healthcare infrastructure required to support end of life decision making. Canada provides a particularly relevant example, given its constitutional commitment to dignity, autonomy and equality, as well as its

development of Medical Assistance in Dying (MAiD) within a regulated legal framework.

Accordingly, the following chapter shifts focus to Canada's experience with Medical Assistance in Dying. Chapter Four explores the evolution of Canada's MAiD legislation, the constitutional foundations underpinning its development, and the healthcare structures that support its implementation. Through this comparative lens, important lessons may be drawn to inform the ongoing debate surrounding euthanasia in South Africa.

CHAPTER FOUR

4. The legal development of Medical Assistance Dying (MAiD) in Canada

4.1 Introduction

Medical Assistance in Dying (MAiD) represents one of the most profound legal and ethical developments in Canada's healthcare system. Its evolution has reshaped the constitutional and legal landscape while sparking ongoing debates about autonomy, dignity, and the role of medicine in end-of-life care. This chapter examines the trajectory of MAiD in Canada, situating it within constitutional principles, judicial interpretation, ethical tensions, and health-care practice.

Following the Supreme Court's landmark ruling in *Carter v Canada (AG)*, Parliament enacted legislation to regulate MAiD, later expanding eligibility beyond terminal illness. More recently, the issue of mental illness has become highly contested, with Parliament repeatedly delaying its inclusion. Bill C-39 postponed eligibility until March 2024, and Bill C-62 has further deferred access until March 2027. Beyond this legal dimension, the chapter considers Canada's palliative care system and how health-care practitioners navigate the intersection of MAiD and traditional end-of-life care. Structural barriers and inequalities in access to both MAiD and palliative care are analysed, alongside the perspectives of caregivers supporting terminally ill patients at home.

By weaving together constitutional analysis, ethical inquiry, and healthcare practice, this chapter provides a comprehensive understanding of how MAiD has developed in Canada and the challenges that continue to shape its implementation. Importantly, the comparative purpose is to assess what lessons South Africa might draw from Canada's experience. Canada offers a rights-based framework that demonstrates how courts, legislatures, and health-care systems can respond to demands for autonomy and dignity at the end of life, while also grappling with safeguards against abuse and the complexities of vulnerable groups such as individuals with mental illness.

For South Africa, where assisted dying remains prohibited, Canada's trajectory provides both inspiration and caution: inspiration in showing how constitutional values can be operationalised into legislation, and caution in highlighting the risks of

expanding eligibility without adequate safeguards or resources. Canada is chosen as the primary comparator because, like South Africa, its constitutional framework places autonomy and dignity at the centre of rights discourse. At the same time, the contested issue of mental illness illustrates the difficulty of balancing compassion with protection of the vulnerable.

This chapter therefore demonstrates how Canada's evolving MAiD framework offers both lessons and warnings for South Africa's constitutional approach to end-of-life decisions.

4.2 Canada's Constitution and legal system

To understand the development of MAiD in Canada, it is essential to first examine the foundational principles of Canada's Constitution and legal system, which shape the legislative and judicial response to end-of-life choices.

Canada operates under a constitutional democracy where the Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK) c 11, is the supreme law. Section 7 guarantees the right to life, liberty, and security of the person, which may only be limited in accordance with the principles of fundamental justice. Section 1, the "reasonable limits" clause, provides that these rights are subject only to limits prescribed by law that can be demonstrably justified in a free and democratic society.[484]

The Canadian legal system is a bi-juridical system, the common law governs most provinces, while Quebec follows a civil law tradition for private matters under the Civil Code of Quebec, alongside the common law for public and criminal law.[485] This dual system reflects Canada's historical and constitutional evolution accommodation of French civil law following the Quebec Act of 1774.[486]

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484 Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK) c 11(hereafter cited the Canadian Charter); Department of Canadian Heritage, *Guide to the Canadian Charter of Rights and Freedoms* (Government of Canada, 2024) <https://www.canada.ca/en/canadian-heritage/services/how-rights-protected/guide-canadian-charter-rights-freedoms.html> accessed May 2025.

485 Government of Canada, *Canada's System of Justice* (Department of Justice Canada, July 2023) <https://www.justice.gc.ca/eng/csj-sjc/just.html> accessed May 2025 11

486 Louise Maguire Wellington, *Bijuralism in Canada: Harmonization and Terminology* (Department of Justice Canada, 2001)

Indigenous legal traditions also contribute to Canada's pluralistic framework. John Borrows has demonstrated how Indigenous law operates in practice, for example, in community governance and dispute resolution and argued that courts should recognise these traditions as sources of law.[487] The Law Commission of Canada (2006) reinforced this by recommending that Indigenous legal principles be integrated into Canadian jurisprudence, thereby institutionalising pluralism.[488] South Africa faces a similar challenge under section 211 of its Constitution, which obliges courts to apply customary law when applicable, provided it is consistent with the Bill of Rights.[489]

The Constitution Act, 1867[490] previously known as the British North America Act,[491] established federalism by distributing legislative powers between Parliament and the provinces.[492] Parliament exercises jurisdiction over criminal law, constitutional amendments, and national policy frameworks,[493] while provinces hold authority over healthcare delivery, property, civil rights, and the regulation of medical professionals.[494] This division of powers is particularly relevant to MAiD, as Parliament legislates the criminal law framework under the Criminal Code (including eligibility criteria and safeguards), while provinces operationalise MAiD through healthcare systems, hospitals, and professional oversight bodies.[495] The Constitution Act, 1982 entrenched the Canadian Charter, guaranteeing rights such as freedom of expression, equality, and security of the person.[496]

<https://justice.gc.ca/eng/rp-pr/csj-sjc/harmonization/hfl-hlf/b4-f4/bf4.pdf> accessed 11 October 2025.

487 John Borrows, 'Indigenous Legal Traditions in Canada' (2005) 19 Washington University Journal of Law & Policy 167, 167–223.

488 Law Commission of Canada, *Justice Within: Indigenous Legal Traditions, Discussion Paper JL2-29/2006* (Law Commission of Canada, 2006) <https://hdl.handle.net/10222/10229> accessed 11 December 2024.

489 Constitution of the Republic of South Africa, 1996, s 211.

490 Constitution Act of 1867 (UK) 30 & 31 Vict c 3 s 91 (formerly the British North America Act 1867).

491 Constitution Act, 1867 s 91.

492 Constitution Act,1867 ss 91-95; Andrew McIntosh and W H McConnell, 'Constitution Act, 1867' (*The Canadian Encyclopedia*, updated 21 October 2021). <https://thecanadianencyclopedia.ca/en/article/constitution-act-1867> accessed July 2025.

493 Constitution Act, 1867 s 91(27).

494 Constitution Act, 1867 ss 92(7), 92(13), 92(16) (provincial jurisdiction over hospitals, property and civil rights, and matters of a local nature); see also Department of Justice Canada, *Infosheet: Federal, Provincial and Territorial Responsibilities in Canada's Criminal Justice System* (2024).

495 Constitution Act of 1867 (UK) 30 & 31 Vict c 3 s 91(27), 92(7),92(13); Criminal Code RSC 1985 c C-46 s241.2.

496 Canadian Charter of Rights and Freedoms ss 2(b), 7, 15.

While legislative powers are divided between Parliament and the provinces, the interpretation and enforcement of these constitutional principles' rests with Canada's judiciary, whose hierarchical structure ensures consistency and finality in constitutional matters.[497] At the apex sits the Supreme Court of Canada, which has final authority on constitutional interpretation,[498] Beneath it are the Federal Court of Appeal and Federal Court, which hear matters involving federal law, and the provincial and territorial superior courts, which handle civil, criminal, and constitutional cases within their jurisdictions.[499] Judicial independence, affirmed by the Department of Justice Canada, underpins controversial rulings such as *Carter v Canada (AG*), where the Court struck down the prohibition on assisted dying.[500] Although South Africa's Constitution is explored in detail in Chapter Five, it is worth noting here that South Africa's judiciary shares this independence under section 165 of the Constitution[501] and has confronted comparable ethical dilemmas, as seen in *Stransham-Ford v Minister of Justice and Correctional Services*, where the High Court initially recognised a right to assisted dying before the decision was overturned on appeal.[502]

Canada's legal system shares some similarities with South Africa, particularly due to their common law heritage and constitutional frame works.[503] Both countries have a blend of common law and statutory law, additionally they both have entrenched bills of rights in their constitutions that guarantee fundamental freedoms and rights to their

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497 Department of Justice Canada, *The Judiciary - Canada's System of Justice*, (Government of Canada) (affirming constitutional separation of judiciary from legislative and executive branches and guaranteeing judicial independence) <https://www.justice.gc.ca/eng/csj-sjc/ccs-ajc/05.html> accessed 12 August 2025.

498 *Hunter v Southam inc* [1984] 2 SCR 145, 155-56.

499 Canadian Federal Court of Appeal, *Official Website of the Federal Court of* Appeal, (last modified February 2026) <https://www.fca.caf/gc.ca/> accessed 25 February 2026.

500 Department of Justice Canada, *Canada's Court System*, (last modified 2026) <https://www.justice.gc/ca/eng/csj/just.html> accessed 25 February 2026. noting that judicial independence is a cornerstone of the Canadian system, guaranteeing decisions free of influence and based solely on fact and law.; Supreme Court of Canada, J*udicial independence (*last modified 2026*)* <https://www.scc.csc.ca/judges-juges/independence-eng.aspx> accessed 25 February 2026. Supreme Court of Canada is essential to the strength of Canada's democracy… "decisions based only on fact and law, free of any influence from government or outside parties.

501 Constitution of the Republic of South Africa, 1996, s 165. "The courts are independent and subject only to the Constitution and the law, which they must apply impartially and without fear, favour or prejudice."

502 *Stransham-Ford v Minister of Justice and Correctional Services and Others* (GP, unreported case no 27401/15, 4–5-2015, Fabricius J), where the High Court initially recognised a right to assisted dying.

503 Constitution Act 1982 (for constitutional supremacy and Charter); Constitution of the Republic of South Africa, 1996 s 2 (constitutional supremacy clause) s 39 (development of common law).

citizens.[504] However, these similarities do not imply a complete adoption or adaptation of Canada's laws or Canada's approach to policies and legislation as they relate to euthanasia and physician-assisted suicide. Given the unique social, cultural, and ethical context in South Africa, any proposed legislation should reflect the country's indigenous and cultural values when formulating a possible euthanasia bill.[505]

Beyond these structural similarities, the comparative analysis must also consider the substantive rights and values that underpin both systems. In Canada, rights to dignity, privacy and freedom emerges as fundamental principles through the Canadian Charter and constitutional jurisprudence, as is the case in South Africa.[506] In Practice these rights intersect with many aspects of the Canadian life including health-care,[507] providing a framework for individuals to assert their rights and seek redress when those rights are infringed.[508] Canada's recognition and protection of constitutional dignity, privacy and freedom reflect its commitment to individual rights and liberties within a democratic and pluralistic society.[509] These principles also contribute to Canada's legal and social framework, promoting equality, justice, and respect for human dignity, as elaborated through Supreme Court of Canada in *R v Oakes.*[510] These are the same rights that this dissertation implores the South African government to consider and possibly employ when making legislative and policy considerations on euthanasia, physician assisted dying and other controversial areas.

Having established the constitutional and legal foundations of Canada's system, the next section turns to the historical trajectory of end-of-life law reform, tracing how early prohibitions, landmark cases, and stakeholder engagement shaped the inception of MAiD legislation.

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504 Cheryl Saunders, 'Protecting Rights in Common Law Constitutional Systems: A Framework for a Comparative Study' (2002) 33 (3&4) Victoria University of Wellington Law Review 507, 507-536.

505 Constitution of the Republic of South Africa, 1996 ss 31, 39(2).

506 Saunders, 'Protecting Rights in Common Law Constitutional Systems' 507-512.

507 Canadian Charter of Rights and Freedoms ss 2(b), 7, 15.

508 Canadian Charter of Rights and Freedoms ss 2(1), 52(1).

509 Canadian Charter of Rights and Freedoms ss 7, 8; *R v Dyment* (1998); Privacy Act RSC 1985 c P-21.

510 *R v Oakes* [1986] 1 SCR 103,136.

4.2.1 A brief historical overview of Canada's legal framework on end-of-life choices and the inception of Medical Assisted Dying legislation

The regulation of end-of-life choices in Canada has not emerged in isolation but through a continuous historical trajectory shaped by constitutional principles, judicial rulings, legislative responses, and stakeholder engagement. This section traces the evolution of MAiD from its original prohibition under the Criminal Code to its eventual recognition as a constitutional right in *Carter v Canada*, and the subsequent legislative reforms embodied in Bills C-14, C-7, and C-62. By situating these developments within their social and institutional and legal contexts, the overview demonstrates how Canadian law has sought to balance autonomy, dignity, and the protection of vulnerable persons. The narrative also highlights the role of Parliament, the judiciary, and civil society in shaping MAiD, offering lessons for South Africa's own constitutional and policy debates on end-of-life decision.

i. *Rodriguez v British Columbia (Attorney General)* [1993] 3 SCR 519

Sue Rodriguez, a 42-year-old woman with amyotrophic lateral sclerosis (ALS), challenged section 241 of the Criminal Code, arguing that the prohibition on assisted dying violated her Charter rights to life, liberty, and security of the person (s.7), and equality (s.15).[511] She famously asked "If I cannot consent to my own death, whose body is this? Who owns my life?."[512] The Supreme Court, in a 5-4 decision, upheld the prohibition.[513] Justice Sopinka's majority emphasised protecting vulnerable persons and deferred reform to Parliament.[514] The dissent (McLachlin, Lamer, Cory JJ) recognised autonomy and dignity as central to the Charter.[515] This case became a touchstone, showing judicial reluctance to intervene but laying groundwork for later challenges.

511 *Rodriguez* 519, 519-527 (facts of Sue Rodriguez).

512 *Rodriguez* 519, 585; See also Sen Chantal Petitclerc, 'Debates of the Senate' (14 December 2020) quoting Sue Rodriguez: "if I cannot give consent to my own death, whose body is this? Who owns my life" in *Rodriguez v British Columbia (AG) 1 SCR* (5-4 decision against her) <https://pub;ications.gc.ca/collections/collection_2021/sen/Y3-432-28-eng.pdf> accessed 12 May 2024.

513 *Rodriguez* 607–08 (per Sopinka J).

514 *Rodriguez* 525-530 (majority reasoning on protecting vulnerable persons).

515 *Rodriguez* 585–590 (per McLachlin J, dissenting).

ii. *Gloria Taylor and British Columbia Civil Liberties Association v Attorney General of Canada*

Nearly two decades after *Rodriguez*, the issue of assisted dying resurfaced in British Columbia with Gloria Taylor, a woman living with terminal amyotrophic lateral sclerosis. Doctors estimated she had only months to live, and she faced progressive physical deterioration, losing the ability to walk, speak, swallow, and move independently.[516] Fearing she would be unable to end her life without assistance, Taylor together with the British Columbia Civil Liberties Association, challenged sections 14 and 241(b) of the Criminal Code, arguing that the blanket prohibition denied competent, grievously ill individuals the ability to choose a dignified death.[517]

The British Columbia Supreme Court initially ruled in favour of the plaintiffs,[518] but the Court of Appeal reversed this decision, relying on *Rodriguez* as binding precedent.[519] Taylor's case, alongside subsequent challenges, eventually reached the Supreme Court of Canada in *Carter v Canada,* where the Court considered the constitutional questions surrounding medical assistance in dying (MAiD) and the balance between individual autonomy, dignity and the protection of vulnerable persons.[520]

iii. *Carter v Canada (AG)* (2015)

Two decades later, Gloria Taylor (ALS patient) and Lee Carter (whose mother sought assisted dying abroad) challenged the blanket prohibition.[521] The Supreme Court unanimously struck it down, holding that it violated section 7 rights to life, liberty, and security of the person in a manner not justified under section 1.[522] The Court recognised autonomy and dignity as fundamental constitutional values, emphasising that appropriate safeguards could protect vulnerable person without denying

516 *Gloria Taylor and British Columbia Civil Liberties Association v Attorney General of Canada* paras 1-5 (hereafter cited *Taylor*).
517 Criminal Code, RSC 1985, c C-46, ss 14, 241(b).
518 *Taylor* paras 1-5.
519 *Rodriguez* 519; *Taylor* paras 30–40.
520 Carter paras 13–15.
521 *Carter* paras 15–17.
522 *Carter* paras 66–67.

choice.[523] Unlike *Rodriguez*, the Court now acknowledged that a blanket ban was overbroad, and parliament was given 12 months to legislate a framework.[524]

iv. Bill C-14 (2016)

Parliament responded with Bill C-14, drafted by the Department of Justice in consultation with Health Canada.[525] It amended the Criminal Code to permit MAiD for competent adults with grievous and irremediable conditions whose death was "reasonably foreseeable".[526] Safeguards included, written requests, two independent medical assessments, and waiting periods.[527] Critics argued the "reasonably foreseeable death" requirement was too restrictive, excluding patients with unbearable suffering but not imminent death.[528] Disability rights groups raised concerns about coercion, while advocacy groups like Dying With Dignity Canada argued autonomy was under-protected.[529]

v. Bill C-7 (2021)

Following *Truchon v Attorney General of Canada* (Quebec), which found the "reasonably foreseeable death" requirement unconstitutional,[530] Parliament enacted Bill C-7 in March 2021.[531] The legislation broadened eligibility for medical assistance in dying (MAiD) to individuals with serious and incurable conditions, even if death is not imminent,[532] and introduced a two track safeguard system depending on whether death is foreseeable.[533] For cases where death is not reasonably foreseeable, the law requires a minimum 90 day assessment period to confirm informed consent and voluntariness. Importantly, while Bill C-7 is in force, the specific extension of eligibility

523 *Carter* paras 70–71.
524 *Carter* para 125.
525 Government of Canada, *Legislative Background: Bill C-14* (Department of Justice, 2016).
526 Criminal Code, s 241.2.
527 Criminal Code, ss 241.2(3)-(4).
528 Jocelyn Downie and Kate Scallion, 'Foreseeably Unclear: The Meaning of the "Reasonably Foreseeable" Criterion for Access to Medical Assistance in Dying in Canada' (2018) 41 *Dalhousie Law Journal* 23, 25–30; Sarah J Lazin and Jeniffer A Chandler, 'Two views of vulnerability in the evolution of Canada's Medical Assistance in Dying Law (2023) 32 Cambridge Quarterly of Healthcare Ethics 105, 105-117.
529 Dying With Dignity Canada, *Submission to the Special Joint Committee on Physician-Assisted Dying* (Special Joint Committee on Physician Assisted Dying, Parliament of Canada,2016).
530 *Truchon* paras 67–80 (Quebec Superior Court).
531 Government of Canada, *Legislative Background: Bill C-7* (Department of Justice, 2021).
532 Criminal Code s 241.2 (as amended by Bill C-7).
533 Criminal Code, ss 241.2(3.1)- (3.2) (as amended by Bill C-7).

to persons whose condition is a mental illness has been postponed until March 2027,[534] reflecting the ethical and clinical complexities of balancing autonomy with protection of vulnerable groups.

vi. Bill C-62 (2024)

Most recently, Bill C-62 was introduced by Health Minister Mark Holland.[535] It amended the Criminal Code to further delay eligibility for MAiD where mental illness is the sole underlying condition, pushing implementation to March 2027.[536] The Department of Justice prepared a Charter Statement outlining rights implications, emphasising the need for safeguards and further study.[537] This reflects Parliament's caution in expanding MAiD to complex psychiatric contexts.

This historical trajectory from *Rodriguez* through *Taylor's* renewed challenge, culminating in *Carter* and subsequent legislative reforms illustrates how Canada's MAiD framework developed through judicial rulings and parliamentary action. The doctrinal reasoning in *Carter v Canada (AG)* is examined next.

4.2.2 Carter v Canada (AG) and the Canadian Charter of Rights and Freedoms

This section breaks down *Carter v Canada (AG)*, the pivotal case that established the constitutional foundation for MAiD. The Supreme Court's unanimous judgment re-interpreted section 7 to encompass autonomy and dignity in end-of-life decision-making, applied the principle of overbreadth to strike down the blanket prohibition, and required Parliament to enact a rights-compliant framework.

To appreciate the depth of this doctrinal shift, it is necessary to examine how the Court applied section 7. The Supreme Court in *Carter v Canada (AG)* held that the blanket prohibition on assisted dying infringed all three dimensions of section 7 of the Canadian Charter of Rights and Freedoms. It violated the right to life by potentially forcing individuals to end their lives prematurely rather than risk losing capacity,[538]

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534 House of Commons, *House of Commons Debates*, 43rd Parl, 2nd Sess, vol 158 (Parliament of Canada,2021) <https://www.ourcommons.ca/DocumentViewer/en/43-2/house/sitting-158/hansard> accessed 12 May 2025.

535 Government of Canada, *Legislative Background: Bill C-62* (Department of Justice, 2024).

536 Criminal Code, RSC 1985, c C-46, s 241.2 (as amended by Bill C-62).

537 Department of Justice Canada, *Charter Statement on Bill C-62* (2024).

538 *Carter* para 57.

restricted liberty by denying fundamental personal choices about one's body and medical care,[539] and undermined security of the person by subjecting individuals to intolerable suffering.[540] The Court emphasised that these rights must be interpreted in light of the principle of fundamental justice, and concluded that an absolute prohibition was inconsistent with that principle.[541]

While section 7 formed the backbone of the Court's reasoning, the Court also addressed equality claims raised under section 15.[542] Although the applicants argued that the impugned provision discriminated against persons with grievous and irremediable medical conditions, who were physically incapable of ending their own lives without assistance, the Court ultimately did not rest its decision on section 15, finding that section 7 was sufficient to resolve the constitutional issues.[543] The Court then turned to section 1, considering whether the infringement of section 7 could be justified in a free and democratic society. The state's objective of protecting vulnerable persons was recognised as pressing and substantial.[544] However, the Court held that the absolute prohibition on assisted dying was disproportionate and therefore failed section 1 analysis.[545] The principle of proportionality required that restrictions be narrowly tailored to their objective, which the blanket ban was not.

Central to the Court's reasoning under section 7 was the doctrine of overbreadth.[546] The prohibition captured individuals who were not vulnerable in the conventional sense, namely, competent adults suffering from grievous and irremediable medical conditions who clearly consented to the termination of life.[547] By applying indiscriminately to both vulnerable and non-vulnerable persons, the prohibition was overbroad and violated the principles of fundamental justice.[548] The judgment marked a decisive departure from *Rodriguez*. The Court elevated autonomy and dignity as constitutional values, stressing that "an individual's response to a grievous and

539 *Carter* paras 66–67.
540 *Carter* paras 70–71.
541 *Carter* para 86.
542 *Carter* paras 94-95.
543 *Carter* para 94.
544 *Carter* para 85.
545 *Carter* paras 86–88.
546 *Carter* paras 85–86 (Supreme Court of Canada).
547 *Carter* paras 86, 94.
548 *Carter* para 86.

irremediable medical condition is a matter critical to their dignity and autonomy".[549] This recognition signalled a doctrinal shift from Rodriguez, where autonomy had been subordinated to concerns about protecting the vulnerable.

Finally, the Court's remedy underscored the constitutional significance of its findings. It declared sections 14 and 241(b) of the Criminal Code unconstitutional and issued a suspended declaration of invalidity for 12 months, allowing Parliament time to enact a legislate response.[550] This suspension directly prompted the enactment of Bill C-14.[551]

The Court's reasoning in *Carter* thus marked a decisive constitutional shift. Autonomy and dignity were recognised as fundamental values capable of limiting state power in end-of-life decisions. Yet, while the judgment provided a legal foundation for MAiD, it also raised profound ethical questions for the medical profession. These tensions particularly the reconciliation of constitutional imperatives with the Hippocratic Oath and professional conscience are explored in the next section.

4.2.3 Ethical tensions between the Hippocratic Oath and Canada's MAiD framework

The constitutional recognition of assisted dying did not eliminate longstanding medical prohibitions against intentionally hastening death, rather, it reframed them within a rights-based paradigm. These tensions, particularly the reconciliation of constitutional imperatives with the Hippocratic Oath and professional conscience are explored below.

i. Traditional Interpretations of the Hippocratic Oath

The legalisation of MAiD in Canada presents a significant ethical and legal challenge, particularly in light of traditional interpretation of the Hippocratic Oath.[552] Rooted in classical medical ethics and later developed through codes such as Percival's Medical Ethics, the oath emphasises the physician's duty to "do no harm" and explicitly forbade

549 *Carter* paras 63, 86–88, 94, 126.
550 *Carter* paras 126–127.
551 Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts* (medical assistance in dying), SC 2016, c 3; Criminal Code, RSC 1985, c C-46, s 241.2.
552 Thomas Percival, *Medical Ethics; or a Code of Institutes and Precepts, Adapted to Professional Conduct of Physicians and Surgeons* (Original 1st edn, S Russel 1803, Republished 1983) ch 6 <https://openlibrary.org/books/OL26289620M/Medical_ethics> accessed 15 June 2025.

the administration of lethal drugs.[553] This traditional understanding positioned the preservation of life as the physician's paramount obligation, even in circumstances of profound suffering. However, medical ethics has never been static. Contemporary bioethical scholarship recognises that the principle of non-maleficence must be interpreted alongside respect for patient autonomy and relief of suffering.[554] This revolution reflects a broader shift from paternalistic models of care toward patient centred decision making. In this context, the ethical prohibition against hastening death has been reassessed in light of constitutional protections for liberty, security of the person and dignity.

ii. Legislative Shifts and the reinterpretation of medical ethics

Following the enactment of Bill C-14 in 2016, which established a statutory framework for MAiD with detailed safeguards, including voluntary and informed consent and the requirement of a grievous and irremediable medical condition, ethical discourse within Canadian medicine evolved to reflect this legislative transformation.[555] The statutory recognition of patient autonomy and dignity compelled the medical profession to reconsider long-standing interpretations of the Hippocratic Oath.[556]

Professional regulatory bodies responded by issuing detailed policy guidance clarifying when and how MAiD may be provided. The College of Physicians and Surgeons of Ontario (CPSO), for example, emphasised requirements of voluntary and informed consent, careful assessment of eligibility criteria, and the duty to provide effective referral where a physician conscientiously objects.[557] The Canadian Medical Association (CMA), similarly revised its ethical guidance, recognising that although physicians may decline to participate directly in MAiD on grounds of conscience, they

553 Percival 6.

554 Courtney S Campbell, 'Mortal Responsibilities: Bioethics and Medical Assisted Dying' (2019) 92(4) Yale J Biol Med 733, 733-739.

555 Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, 2016 (SC 2016, c 3).

556 College of Physicians and Surgeons of Ontario, *Policy Statement No 4-16: Medical Assistance in Dying* (Approved June 2016, reviewed July 2017, December 2018, April 2021).

557 College of Physicians and Surgeons of Ontario, *Policy Statement No 4-16: Medical Assistance in Dying* (Approved June 2016, reviewed July 2017, December 2018, April 2021).

remain responsible for ensuring continuity of care through effective referral mechanisms.[558]

This regulatory response illustrate how medical ethics in Canada has shifted from an absolute prohibition on hastening death toward a structured framework that seeks to balance professional integrity with constitutionally grounded patient autonomy.

iii. Modern ethical framework and principlism

Contemporary bioethical theory has played a central role in reconciling the Hippocratic tradition with Canada's MAiD framework. The Canadian Medical Association acknowledged that the principle of "do no harm" may extend beyond the mere preservation of life to include the alleviation of suffering, emphasising the physician's duty to safeguard vulnerable patients in the context of medical assistance in dying. [559] This approach aligns with broader ethical and legal imperatives underpinning MAiD, particularly the protection of individual rights to life, liberty, and security of the person under the Canadian Charter of Rights and Freedoms.[560]

Modern reinterpretation of the Hippocratic tradition supports this evolution. Instruments such as the Declaration of Geneva 1948[561] and the 1964[562] version, incorporate commitment to human rights, patient dignity avoidance of over-treatment,[563] and respect for autonomy.[564] These formulations depart from the rigid prohibition contained in the original oath and allow for a more contextual understanding of non-maleficence, one that recognises that prolonging suffering may, in certain circumstances constitute harm.[565]

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558 Canadian Medical Association, *Medical Assistance in Dying* (CMA PolicyBase, 27 May 2017) p 2-3 <https://policybase.cma.ca/media/PolicyPDF/PDF17-03.pdf? > accessed 15 February 2026.

559 Canadian Medical Association, *Medical Assistance in Dying* Policy 3-4.

560 Canadian Medical Association, *Medical Assistance in Dying Policy* 3-5.

561 Laura McPherson, 'The History of the Hippocratic Oath' (*Northeastern Nursing Blog*, 3 June 2015), citing the *World Medical Association Declaration of Geneva* (1948), para 2 <https://absn.northeastern.edu/blog/the-history-of-the-hippocratic-oath/> and <https://www.net/policies-post/wma-declaration-of-geneva/> accessed 21 May 2024.

562 World Medical Association, *Declaration of Geneva* (1964), para 3 ("I will practice my profession with conscience and dignity") (archived) <https://www,wma.net/policies-post/wma-decalration-of-geneva/> accessed 12 April 2025.

563 World Medical Association, *Declaration of Geneva* (1948) para 2.

564 World Medical Association, *Declaration of Geneva* (1964) para 3.

565 World Medical Association, *Declaration of Geneva* (1964) paras 2-3

This shift is further reinforced by the principlist model articulated by Beauchamp and Childress's principlism model, which identifies autonomy, beneficence, non-maleficence, and justice as the foundational principlism of biomedical ethics.[566] Rather than elevating non-maleficence above all other values, principlism requires balancing competing ethical considerations.[567] Within this framework, respect for patient autonomy may justify actions that foreseeably hasten death, provided the intention is to relieve suffering and appropriate safeguards are in place.[568]

Legal standards governing informed consent further entrench this approach in clinical practice.[569] Physicians are required not merely to preserve life, but to respect competent patients' informed choices regarding their own medical treatment. In this context, the ethical duty to care expands to encompass the promotion of well-being and relief from intolerable suffering, consistent with constitutional protections of dignity and autonomy.[570]

Scholarly commentary reflects the evolution of medical ethics[571] from the classical Hippocratic prohibition on administering lethal drugs,[572] to contemporary interpretations that emphasise patient autonomy and compassionate relief of suffering.[573] At the same time, scholars caution that strict eligibility criteria and procedural safeguards remain essential to prevent abuse and preserve public trust in medical professionals.[574]

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566 Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn, Oxford University Press 2019) 13-15.
567 Beauchamp and Childress, *Principles of Biomedical Ethics* 16-20.
568 Beauchamp and Childress, *Principles of Biomedical Ethics* 150-152.
569 Beauchamp and Childress, *Prinicples of Biomedical Ethics* 99-105.
570 Beauchamp and Childress, *Principles of Biomedical Ethics* 168-170.
571 William Robert Nielson, 'MAiD in Canada: Ethical Considerations in Medical Assistance in Dying' (2021) 4(2) Canadian Journal of Bioethics 93,93-98 <https://doi.org/10.7202/1084456ar> accessed 12 May 2025.
572 Nielson, 'MAiD in Canada: Ethical Considerations' 93-94.
573 Nielson 'MAiD in Canada: Ethical Considerations' 95- 96.
574 Nielson 'MAiD in Canada: Ethical Considerations' 96- 97.

iv. Conscientious objection and provider integrity

The most persistent ethical tension arising from Canada's MAiD framework concerns conscientious objection and the preservation of provider integrity. Scholars such as Carpenter and Vivas caution that mandatory participation in assisted dying, whether direct or indirect may conflict with deeply held moral or religious convictions.[575] They argue that compelling involvement risks undermining professional conscience and eroding trust within the medical community.[576] To mitigate this concern, less intrusive mechanisms have been proposed, including centralised care coordination systems that facilitate patient access without requiring objecting physicians to participate directly.[577] Such models seek to preserve both timely access to MAiD and the moral integrity of healthcare professionals.

Canadian regulatory frameworks reflect a similar attempt at balance. Conscientious objection policies permit physicians to abstain from providing MAiD, while effective referral requirements ensure that patients are not denied lawful medical services. This approach illustrates a deliberate effort to reconcile competing commitments, the physician's freedom of conscience and religion and the patient's constitutionally grounded rights to autonomy, dignity and security of the person.

As Brenna observes, opposition to euthanasia often stems from religious and moral conceptions of the human body as a divine trust,[578] traditions that historically shaped medical ethics and prohibited physician assisted dying.[579] Although she does not explicitly address the Hippocratic Oath, these traditions historically shaped medical ethics and prohibited physician-assisted dying. However, contemporary regulation increasingly situates these moral commitments within a broader constitutional order

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575 Travis Carpenter and Lucas Vivas, 'Ethical Arguments Against Coercing Provider Participation in MAiD (Medical Assistance in Dying) in Ontario, Canada' (2020) 21 BMC Medical Ethics 46,1-5 <https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-020-00486-2>accessed 12 May 2025.

576 Carpenter and Vivas, 'Ethical Arguments Against Coercing Provider Participation in MAiD' 2.

577 Carpenter and Viva, 'Ethical Arguments Against Coercing Provider Participation in MAiD' 3.

578 Connor T A Brenna, 'Regulating Death: A Brief History of Medical Assistance in Dying' (2021) Indian Journal of Palliative Care 448, 448-449.

579 Brenna, 'Regulating Death: A Brief History of Medical Assistance in Dying' 449.

that prioritises patient autonomy and relief of suffering.[580] The result is not the abandonment of the Hippocratic tradition, but its reinterpretation within a rights-based framework.[581]

Nonetheless, ethical disagreements persist. Some practitioners maintain that the foundational Hippocratic commitment to preserve life should remain absolute, resisting any accommodation of assisted dying.[582] This continuing debate underscores that the tension between medical ethics and constitutional imperatives has not been resolved but recalibrated through regulatory compromise.

4.2.4 Interpreting the limitation clause in the context of MAiD in Canada

The limitation Clause in the Canadian Charter of Rights and Freedoms, found in section 1 allows for certain rights and freedoms to be restricted where such limitations are "reasonable" and "demonstrably" justified in a free democratic society.[583] This provision functions as a constitutional balancing mechanism, ensuring that individual rights are protected while allowing the state to pursue legitimate public interests.[584] Rather than weakening rights, section 1 structures the manner in which they may be limited through principled justification.[585]

Canadian courts apply the *Oakes* test, established in *R v Oakes* 1986,[586] to determine whether a limitation satisfies section 1, the test requires that, (i) the limitation pursues a pressing and substantial objective, (ii) the measure be connected to that objective, (iii) the measure minimally impair the right in question, and (iv) there be proportionality

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580 Brenna, 'Regulating Death: A Brief History of Medical Assistance in Dying' 450.

581 Shawn Whatley, 'More than we imagined? Unresolved tensions and the current state of physician-assisted suicide and euthanasia in Canada (Macdonald-Laurier Institute Commentary, 20 April 2023) <https://macdonaldlaurier.ca/more-than-we-imagined-unresolved-tensions-and-the-current-state-of-physician-assisted-suicide-and-euthanasia-in-canada/> accessed 11 May 2025.

582 Ezekiel J Emanuel and Steven Joffe, 'Assisted Suicide and Euthanasia' in DW Kufe, RE Pollock, RR Weichselbaum et al (eds), *Holland-Frei Cancer Medicine* (6th edn, BC Decker 2003) [NCBI Bookshelf ID: NBK13381].

583 Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982 Schedule B to Canada Act 1982 (U.K.), c 11, s1.

584 *Carter v Canada* (AGI) paras 5-7; Saunders, 'Protecting Rights in Common Law Constitutional Systems'112-115.

585 Jocelyn Downie and Jennifer, A Chandler, Interpreting *Canada's Medical Assistance in Dying Legislation* (Institute for Research on Public Policy, 2021) 8-9. <https://irpp.org/research-studies/interpreting-canadas-maid-legislation> accessed 9 November 2025.

586 *R v Oakes* [1986] 1 S.C.R 103 (SCC) para 69.

between the salutary and deleterious effects of the measure.[587] Hogg observes that section 1 is interpreted with sufficient flexibility to permit contextual adjudication, allowing courts to adapt proportionality analysis to the specific rights and circumstances at issue.[588] This flexibility does not dilute constitutional scrutiny, rather, it ensures that limitations are carefully justified within a democratic framework.

In the context of MAiD, section 1 provides a structured mechanism for balancing individual autonomy against broader societal and ethical concerns, particularly where vulnerable groups are implicated.[589] Critics have argued that requests for assisted dying by person with mental illness or disabilities may in some instances, reflect conditions of poverty, social isolation, inadequate community support, or gaps in mental health care rather than autonomous and enduring suffering.[590] These concerns directly engage the minimal impairment and proportionality stages of the Oakes analysis, requiring the state to demonstrate that safeguards sufficiently protect vulnerable persons without unduly restricting constitutional rights.[591]

Consequently, Canada's MAiD framework incorporates layered safeguards, including rigorous eligibility assessments, independent medical evaluations, and procedural requirements designed to ensure voluntariness and informed consent.[592] These mechanisms aim to ensure that any limitation on the right to life, liberty and security of the person is narrowly tailored and proportionate. Taken together, these medical, legal, and ethical protections illustrate how section 1 operates as a rights structuring provision rather than a rights negating one.[593]

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587 Kent Roach, *Canadian Justice, indigenous injustice: The Gerald Stanley and Colton Bushy Case* (McGill-Queen's University Press, 2020) 88-90.

588 Peter W Hogg, *Constitutional Law of Canada* (5th edn. Thomson Reuters, 2017) 49-55.

589 Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), c 11, s 1; *R v Oakes* [1986] 1 SCR 103, paras 69–71.

590 Scott Y.H. Kim and Trudo Lemmens, 'Should assisted dying for psychiatric disorders be legalised in Canada?' (2016) 188 (14) Canadian Medical Association Journal E337, E359-E360 <https://www.cmaj.ca/content/188/14/E358> accessed 12 May 2025.

591 *Hunter v Southam Inc* [1984] 2 SCR 145, 158; Peter W Hogg, *Constitutional Law of Canada* (5th edn, Thomson Reuters 2017) ch 36.

592 Scott Douglas Jacobsen, 'Legal Assistance in Dying (MAiD) in Canada: Legal Framework, Strict Safeguards & Protecting Vulnerable Populations' (Humanist Perspectives Magazine, 19 September 2025) <https://humanistperspectives.org/article/legal-assistance-in-dying-maid-in-canada-legal-framework-strict-safeguards-protecting-vulnerable-populations/> accessed 1 October 2025; Downie and Chandler, *Interpreting Canada's Medical Assistance in Dying* 18.

593 Downie and Chandler, *Interpreting Canada's Medical Assistance in Dying* 20.

Canada's interpretation of the limitation clause demonstrates that assisted dying can be regulated in a manner that advances rather than diminishes fundamental rights, provided proportionality and safeguards are rigorously applied.

This comparative experience is particularly instructive for South Africa, where section 36 of the Constitution similarly requires that any limitation of rights be reasonable and justifiable in an open and democratic society.[594] The Canadian emphasis on proportionality, vulnerability analysis, and layered safeguards provides a framework against which South Africa's potential development of an assisted dying regime may be critically assessed in the chapters that follow.

4.2.5 The role of stakeholder involvement in shaping MAiD policy and legislation

The development of Canada's MAiD legal framework was shaped by extensive stakeholder engagement, recognising that inclusive consultation was essential to crafting legislation that is legally robust, ethically legitimate, practically workable and socially responsive. Key stakeholders included medical professionals, advocacy groups, legal scholars, parliamentary committees, and members of the public.[595]

i. Parliamentary committees

Parliament responded to *Carter v Canada (AG)* by enacting Bill C-14,[596] informed by the Special Joint Committee's report Medical Assistance in Dying: A Patient-Centred Approach, which balanced autonomy with safeguards after consultation with medical, legal, ethical, and advocacy experts.[597] Subsequent reviews by the Standing Committee on Justice and Human Rights and the Senate Committee on Legal and Constitutional Affairs ensured that amendments under Bill C-7 aligned with the Charter and protected vulnerable populations.[598] This iterative process illustrates how

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594 Constitution of the Republic of South Africa, 1996 s 36.

595 Special Joint Committee on Physician Assisted in Dying, *Medical Assistance in Dying: A Patient Centred Approach* (First Report, House of Commons and senate of Canada,2016) 1-5 <https://www.parl.ca/DocumentViewer/en/42-1/PDAM/report-1> accessed 4 August 2025.

596 Marlisa Tiedeman, *Assisted Dying in Canada After Carter v Canada* (Library of Parliament Publication No 2019-43-E, 29 November 2019) 2–3 <https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/201943E> accessed 12 June 2024.

597 Special Joint Committee on Physician Assisted Dying, *Medical Assistance in Dying: A Patient-Centred Approach* 5–12.

598 Standing Committee on Justice and Human Rights, *Medical Assistance in Dying: Report on the Provision of MAiD in Canada* (House of Commons, 44th Parliament, June 2021); Senate

parliamentary committees not only translated judicial rulings into legislation but also worked hand-in-hand with expert stakeholders to refine the legislative framework. The legislative response was therefore not a single event, but an evolving dialogue between judiciary, Parliament and civil society.

ii. Professional and advocacy bodies

Legislative efforts were complemented by professional and advocacy bodies whose clinical and patient centred perspectives shaped the practical contours of MAiD implementation. Physicians, nurses, and palliative care specialists, coordinated through the Canadian Medical Association (CMA) and Canadian Nurses Association (CNA), provided critical insights into clinical realities and ethical considerations.[599] The CMA submitted briefs to Parliament and updated its ethical guidelines to ensure that eligibility criteria, procedural safeguards, and protections for conscientious objectors were embedded in the MAiD framework.[600] The CNA developed a national nursing framework on MAiD, clarifying nursing roles, responsibilities, and procedures, including guidance on conscientious objection.[601] Their input was complemented by advocacy organisations such as Dying with Dignity Canada, which emphasised autonomy and compassionate end-of-life options, lobbying for broader eligibility and safeguards that centred patient rights.[602]

This professional and advocacy perspective was further reinforced by expert bodies such as the Council of Canadian Academies (CCA), which produced independent reports addressing mature minors, advance requests, and cases where mental illness constituted the sole underlying condition.[603] The council reviewed international

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Committee on Legal and Constitutional Affairs, *Study on Medical Assistance in Dying* (Senate of Canada, 2016) 6–9.

599 Health Canada, *Model Practice Standard for Medical Assistance in Dying* (Health Canada 2023), ss 3–5 <https://www.canada.ca/en/health-canada/services/publications/health-system-services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html> accessed 12 June 2025.

600 Canadian Medical Association, *Medical Assistance in Dying*.

601 Canadian Nurses Association, *National Nursing Framework on Medical Assistance in Dying in Canada* (CAN, 2017) <https://cnpea.ca/images/cna-national-nursing-framework-on-maid_jan2017.pdf > accessed 24 May 2025.

602 Dying with Dignity Canada, 'Your end-of-life rights must be respected- tell your candidates to support advance requests' (Dying With Dignity Canada, 2024) <https://www.dyingwithdignity.ca/advocacy/make-advance-requests-priority/ > accessed 9 August 2025.

603 Council of Canadian Academies (CCA), *The State of Knowledge on Medical Assistance in*

practices, ethical considerations, and empirical data, offering evidence-based recommendations that informed legislative review. [604] Similarly the Expert Panel on MAiD and Mental Illness later assessed the specific implications of extending eligibility to individuals with mental illness as the sole condition, guiding the development of Canada's Health Policy through detailed recommendations Health Canada's framework reports and expert panel findings.[605] Ongoing government monitoring, reflected in annual MAiD reports, documented implementation trends and emerging challenges, embedding accountability and transparency within the regulatory framework.[606] Together, these professional, advocacy, and expert bodies ensured that policy development was grounded in clinical realities, patient rights, and evidence-based safeguards. Yet, despite these layered processes, legal scholars continue to identify interpretive uncertainties and areas requiring further legislative clarification.

iii. Legal scholars

Legal scholars Jocelyn Downie and Kate Scallion highlighted persistent interpretive uncertainties in Bill C-14, particularly the "reasonably foreseeable natural death" (RFND) criterion, warning that its ambiguity risked inconsistent application and Charter violations.[607] They emphasised the need for clearer statutory language and safeguards such as independent assessments and waiting periods to uphold autonomy while protecting vulnerable individuals.[608] Their critique preceded the eventual repeal of the RFND requirement in Bill C-7 (2021), which expanded eligibility

Dying for Mature Minors, Advance Requests, and Where a Mental Disorder is the Sole Underlying Medical Condition (CCA, Ottawa, 2018) 1–5 <https://cca-reports/medical-assistance-in-dying/> accessed 11 October 2025.

604 CCA, *The State of Knowledge on Medical Assistance in* Dying 7–15.

605 Health Canada, *Final Report of the Expert Panel on MAiD and Mental Illness* (Health Canada, 13 May 2022) (mandate, expert composition and recommendations) <https://www.canada.ca/en/health-canada/services/maid-mental-illness/final-report.html> accessed 9 August 2025

606 CCA, *The State of Knowledge on Medical Assistance in Dying* (general overview of evidence and safeguards).

607 Jocelyn Downie and Kate Scallion, 'Foreseeably Unclear: The Meaning of "Reasonably Foreseeable" Criterion for Access to Medical Assistance in Dying in Canada' (2018) 41 Dalhousie Law Journal 23, 23-35 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3126871> accessed 11 August 2025.

608 Downie and Scallion, 'Foreseeably Unclear' 30-35.

to individuals whose death was not reasonably foreseeable, subject to additional safeguards.[609]

While scholars such as Downie and Scallion warned that RFND's ambiguity undermined rights, others applied caution in the opposite direction. Ramona Coelho and David Shannon argued that limiting MAiD to those near death was necessary to protect vulnerable populations from systemic neglect and coercion.[610] Similarly, Jonas-Sébastien Beaudry later argued that the RFND requirement carried expressivist harms, signalling that some lives were less valuable, and that its removal was essential for equality and rights compliance.[611]

Parliamentary research likewise underscored the legislative complexity of RFND, situating it within Canada's evolving MAiD framework.[612] Collectively, this scholarly debate demonstrates the importance of ongoing legal scrutiny to ensure statutory language remains precise, proportionate, and rights compliant. The evolution from Bill C-14 to Bill C-7 illustrates how academic critique can materially influence legislative reform.

iv. Indigenous and cultural perspectives

Indigenous leaders and organisations have cautioned that MAiD risks exacerbating systemic inequities, particularly where culturally safe palliative care and mental health services and community supports remain inadequate.[613] Advocacy groups stress the importance of distinctions-based engagement, traditional healing, and family involvement in end-of-life decision-making.[614] Communities representing persons with

609 Bill C-7, *An Act to Amend the Criminal Code* (Medical Assistance in Dying*)*, SC 2021, c 2.(assented to 17 March 2021).

610 Ramona Coelho and David Shannon, *Bridging the Gaps: Legislative and Practice Problems in Canada's MAiD Regime* (Macdonald-Laurier Institute, 2025) <https://macdonaldlaurier.ca/bridging-the-gaps-legislative-and-practice-problems-in-canadas-maid-regime-ramona-coelho-and-david-shannon/> accessed 12 September 2025.

611 Jonas-Sébastien Beaudry, 'The "Reasonably Foreseeable Natural Death" Requirement in Bill C-7, and Expressivist Harm' and Expressivist Harm' in J Kotalik and DW Shannon eds, *Medical Assistance in Dying (MAID) in Canada: Key Multidisciplinary Perspectives* (Springer 2023) 85.

612 Tiedeman, *Medical Assistance in Dying in Canada After Carter v. Canada*.

613 Health Canada, *Indigenous perspectives on end-of-life care, including medical assistance in dying: What we heard* (December 2025) <https://www.canada.ca/en/health-canada/programs/engagement-indigenous-perspectives-medical-assistance-dying/what-we-heard.html> accessed 2 February 2026.

614 Native Women's Association of Canada, Medical Assistance in Dying (NWAC, 2021) <https://nwac.ca/allies-partners/medical-assistance-in-dying/> accessed 11 August 2025; CCA, *Medical Assistance in Dying: Evidence and Recommendations*;

disabilities and other vulnerable groups have similarly emphasised that MAiD must be assessed within broader contexts of poverty, racism and limited access to healthcare.[615]

The Expert Panel on MAiD and Mental Illness highlighted structural vulnerabilities and recommended systemic reforms alongside any extension of eligibility.[616] These perspectives underscore that assisted dying policy cannot be divorced from broader social justice considerations.

v. Public consultation[617]

Public engagement played a crucial role in shaping Canada's MAiD framework. The federal government's 2016 online consultation received over 15,000 submissions from citizens, health-care professionals, and community leaders, reflecting both support for reform and concern regarding adequate safeguards.[618] A subsequent consultation in 2020 addressed issues such as mental illness as a sole underlying condition, advance requests, and mature minors, ensuring that amendments introduced under Bill C-7 reflected evolving societal attitudes.[619] Reports from advocacy organisations such as Dying With Dignity Canada captured patient perspectives,[620] while scholars such as Jennifer Chandler stressed that engagement was indispensable for fostering trust and ensuring evidence-informed policy development.[621]

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615 Special Joint Committee on Physician Assisted Dying, *Medical Assistance in Dying: A Patient-Centred Approach* paras 32-36.

616 Expert Panel on MAiD and Mental Illness*, Final Report of the Expert Panel on MAiD and Mental Illness* (2023) <https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness.html> accessed 11 August 2025.

617 Government of Canada, *What We Heard Report: A Public Consultation on MAiD Policy, Eligibility and Safeguards* (Government of Canada 2020) <https://www.justice.gc.ca/eng/cj-jp/ad-am/wwh-cqnae/re-rap.pdf> accessed 9 August 2025.

618 Government of Canada, *Consultations on Physician-Assisted Dying: Summary of Results and Key Findings* (Department of Justice, 2016) <https://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/p9.html> accessed 12 May 2024.

619 Government of Canada, *What We Heard: A Public Consultation on Medical Assistance in Dying.*

620 Dying With Dignity Canada, 'Rising Above: Annual Report 2023' (May 2024) <https://wwwdyingwithdignity.ca/wpcontent/uploads/2024/05/DWDC_AR2023_AnnualReport_final.pdf > accessed 19 February 2025.

621 Jocelyn Downie and Jennifer Chandler, *Interpreting Canada's Medical Assistance in Dying Legislation* (Institute for Research on Public Policy, March 2018) 12-15, para 34.

Public input thus provided legitimacy and ensured that MAiD policy reflected not only expert analysis but also societal values.

This participatory process offers important comparative lessons for South Africa, demonstrating how sustained consultation can strengthen both the legitimacy and resilience of end-of-life legislation.

vi. Closing reflection

Canada's experience demonstrates that inclusive, multi-stakeholder engagement is critical in balancing autonomy, dignity, and protection of vulnerable populations. Broad consultation enhances legislative legitimacy, ensures responsiveness to ethical and practical challenges, and fosters public trust.[622] This participatory approach involving health professionals, ethicists, religious bodies, disability advocates, Indigenous voices, and the general public, produced an ethically defensible and socially acceptable framework for end-of-life decision-making.[623] For South Africa, adopting a similarly inclusive approach is essential to develop an end-of-life framework that aligns with constitutional values, gains societal acceptance, and withstands rigorous ethical scrutiny.

4.2.6 Expanding MAiD to include mental illness as a sole underlying condition

The expansion of Canada's MAiD regime to include individuals whose sole underlying condition is a mental illness represents a significant prospective shift in the country's end of life legal framework.[624] This trajectory began with Bill C-14 (2016), which restricted eligibility to cases where natural death was "reasonably foreseeable".[625] Judicial scrutiny in *Truchon c Procureur général du Canada* (2019 QCCS 3792) found this restriction unconstitutional, prompting Parliament to enact Bill C-7 (2021), which

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622 Special Joint Committee on Physician Assisted Dying, Medical Assistance in Dying: A Patient Centred Approach (Parliament of Canada, 2016) 4-7 <https://www.parl.ca/Content/SEN/Committee/421/PAID/Reports/RP8587409/paidrp05-e.pdf >.

623 David Bilchitz 'Dignity, Fundamental Rights and Legal Change: Comparing South Africa and Canada' (2015) 11 (3) International Journal of Constitutional Law 745, 751.

624 Parliament of Canada, Bill C-14. *An Act to amend the Criminal Code and to make related amendments to other Acts* (*Medical Assistance in Dying*) (Royal Assent, 17 June 2016) <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent> accessed 11 August 2025.

625 Parliament of Canada, Bill C-7, *An Act to amend the Criminal Code* (*medical assistance in dying*) (Royal Assent, 17 March 2021).

removed the foreseeability requirement and contemplated eventual expansion to mental illness.[626] Implementation was then postponed by Bill C-39 (2023) to March 2024, and further delayed by Bill C-62 (2024) until March 2027, reflecting the need for additional safeguards, practitioner training, and infrastructure.[627] Thus this timeline demonstrates that the expansion remains prospective, with ongoing legislative adjustments balancing Charter rights, ethical concerns, and protection of vulnerable populations. Since its enactment, Canada's MAiD law has provoked robust discussions on access for individuals with disabilities, mature minors, and persons with mental health conditions.

The Expert Panel on MAiD and Mental Illness[628] concluded that no additional legislative safeguards were required for extending eligibility to persons whose sole underlying medical condition is a mental disorder, provided that existing MAiD eligibility criteria were correctly interpreted and applied.[629] Instead, the Panel recommended the development of national MAiD Practice Standards through collaboration among federal, provincial, and territorial regulators, to ensure consistent approaches to the assessment of cases involving issues such as incurability, irreversibility, decision-making capacity, suicidality, and structural vulnerability.[630] Among its nineteen recommendations, the Panel emphasised that incurability and irreversibility should be determined on a case-by-case basis, with reference to treatment attempts, outcomes, and illness severity.[631] It further recommended that assessors conduct comprehensive and, where necessary, multiple evaluations of a requester's capacity to give informed consent, in line with clinical and legal standards.[632]

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626 Parliament of Canada, Bill C-7, *An Act to amend the Criminal Code* (*medical assistance in dying*) 1-5. <https://www.parl.ca/DocumentViewer/en/43-2/bill/C-7/first-reading.> accessed 12 October 2025.

627 Parliament of Canada, Bill C-62, *Act to amend the Criminal Code* (*medical assistance in dying*), No 2, 1st Sess, 44th Parl, 2023(first reading 1 February 2024). <https://www.parl.ca/documentviewer/en/44-1/bill/C-62/royal-assent> accessed 11 August 2025.

628 Health Canada, Final Report: Expert Panel on MAiD and Mental Illness (2022) 52-58. <https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness.html> accessed 11 June 2025.

629 Health Canada, *Final Report of the Expert Panel on MAiD and Mental Illness* 12.

630 Health Canada, *Final Report of the Expert Panel on MAiD and Mental Illness* 12-13.

631 Health Canada, *Final Report of the Expert Panel on 1MAiD and Mental Illness* 13.

632 Health Canada, *Final Report of the Expert Panel on MAiD and Mental Illness* 14.

The Panel also advised that requesters demonstrate "serious consideration" of all reasonable means available to relieve suffering, such as housing and income assistance.[633] Collectively, these measures, the Panel concluded, could be implemented within the existing Criminal Code framework without further legislative amendment.[634]

Legal scholars have raised significant ethical and practical concerns about extending MAiD. Charland, Lemmens and Wada argue that such an expansion challenges the principle of non-maleficence, the validity of consent, and the reliability of psychiatric prognoses.[635] They caution that assessing capacity for MAiD in cases of mental illness is especially fraught, given fluctuating symptoms and the difficulty of determining whether suffering is truly irremediable.[636] Wiebe and Mullin further highlight that MAiD requests cannot be divorced from broader social determinants of health.[637] Autonomy is always exercised within structural contexts marked by systemic inequality, inadequate mental-health resources, poverty, and social isolation conditions that can influence the perception of suffering and choice.[638]

Lemmens, Kim, and Kurz further argue that these restrictions are not consistent with *Carter vs Canada* and are necessary to avoid the pitfalls observed in more permissive jurisdictions such as Belgium's, where under-reporting, normalisation of euthanasia, and inadequate safeguards have raised serious ethical and legal concerns.[639] They caution against expanding MAID to include mature minors, advance directives, or mental illness as a sole criterion, emphasizing that such changes could compromise

633 Health Canada, *Final Report of the Expert Panel on MAiD and Mental Illness 14*, 61-62.
634 Health Canada, *Final Report of the Expert Panel on MAiD and Mental* Illness 12-14.
635 Louis Charland, Trudo Lemmens and Kyoko Wada 'Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders' (2016) Journal of Ethics in Mental Health Open Vol 1, 1-14 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2784291> accessed 1 July 2025.
636 Charland, Lemmens and Wada, 'Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders' 1-14.
637 Kayla Wiebe and Amy Mullin, 'Choosing death in unjust conditions: hope, autonomy and harm reduction' (2024) 50(6) Journal of Medical Ethics 407, 407-412 <https://doi.org/10.1136/jme-2023-109284.> Accessed 12 October 2025.
638 Wiebe and Mullin 'Choosing death in unjust conditions' 412-412.
639 Trudo Lemmens, Heesoo Kim and Elizabeth Kurz 'Why Canada's Medical Assistance in Dying Legislation Should Be C(h)arter Compliant and What it May Help to Avoid' (2018) 11(1) McGill Journal of Law and Health/Revue de droit et sante de McGill <https://www.canlii.org/w/canlii/2017CanLIIDocs3586.pdf> S61, S70-S74 accessed 13 June 2024.

public trust and regulatory integrity.[640] Ultimately, the authors advocate for maintaining the current end-of-life limitations, improving oversight, and resisting premature liberalization, asserting that Canada's approach better aligns with its constitutional framework and public policy objectives.[641] Lemmens also questioned whether parliamentary committee had sufficiently evaluated safeguards before expanding MAiD eligibility to cases not involving reasonably foreseeable natural death.[642] He argued that instituting such reforms before systematically assessing outcomes risked unintended consequences akin to prematurely issuing a novel therapeutic intervention.[643]

Empirical studies provide insight into the challenges of extending MAiD to individuals with psychiatric conditions. Duong and Vogel (2023) report that over 31,000 Canadians have accessed MAiD since its legalisation, with a growing proportion presenting non-terminal conditions.[644] In 2021, the first year individuals whose natural death was not reasonably foreseeable became eligible, this group accounted for 2.2% of MAiD cases, nearly half involving neurological conditions.[645] These findings highlight the complexity of assessing psychiatric suffering, which varies in severity, responsiveness to treatment, and is shaped by social determinants such as housing insecurity and lack of support.[646] Scholars including Schuklenk and Konder caution that extending MAiD to mental illness as a sole criterion raises distinct ethical and legal

640 Lemmens, Kim and Kurz, 'Why Canada's Medical Assistance in Dying Legislation' S71-S73.

641 Lemmens, Kim and Kurz, 'Why Canada's Medical Assistance in Dying Legislation' S76-S84.

642 Trudo Lemmens, evidence to the Special Joint Committee on Medical Assistance in Dying, 44th Parliament, 1st Session, No 39 (21 November 2023) <https://www.parl.ca/DocumentViewer/en/43-2/AMAD/meeting-3/evidence>accessed 1 September 2025.

643 Special Joint Committee on Medical Assistance in Dying (House of Commons and Senate), *Evidence, 44th Parliament, 1st Session, No 39* (21 November 2023) (Testimony of Trudo Lemmens) <https://www.parl.ca/documentviewer/en/44-1/AMAD/meeting-39/evidence> 25 August 2025.

644 Diana Duong and Laura Vogel, 'What's the Status of Medical Assistance in Dying in Canada' (2023) 195(13) CMAJ E488–E489 <https://www.cmaj.ca/content/195/13/E488> accessed 3 July 2025.

645 Duong and Vogel, 'What's the Status of Medical Assistance in Dying in Canada' E488, E488–E489.

646 Sisco MP Van Veen, Andrea M Ruissen and Guy AM Widdershoven, 'Irremediable Psychiatric Suffering in the Context of Physician-Assisted Death: A Scoping Review of Arguments' (2020) 65(9) Canadian Journal of Psychiatry 593, 593–603.; Pauline Hagedoorn and others, 'Is Suicide Mortality Associated with Neighbourhood Social Fragmentation and Deprivation? A Dutch Register Based Case Control Study Using Individualised Neighbourhoods' (2020) 74(2) Journal of Epidemiology and Community Health 197, 197–202.

challenges, particularly around safeguards and consent.[647] Clinicians echo these concerns, noting the difficulty of distinguishing enduring, autonomous requests from transient suicidal ideation, and the inherent complexity of capacity assessments in severe mental illness.[648]

Disability advocacy groups, including Inclusion Canada, DAWN, and the Council of Canadians with Disabilities, welcomed the federal government's decision to delay expansion until 2027, viewing it as an opportunity to strengthen safeguards and pursue constitutional challenges to "Track 2" provisions.[649] This trajectory underscores the need for rigorous evaluation of vulnerability, consent, and systemic inequities before expanding MAiD to psychiatric conditions.

This tension is particularly evident in cases where the line between a settled wish to die and a treatable mental health crisis is blurred. The case of Alan Nichols, a 61-year-old man who was admitted to hospital under British Columbia's Mental Health Act due to suicidal ideation and later died by MAiD despite lacking a terminal illness, exemplifies these concerns.[650] His family reported that he had a history of depression and had expressed suicidal thoughts prior to admission, raising ethical and procedural questions about how capacity and voluntariness were assessed in his MAiD application.[651] Although Nichols had experienced hearing loss and previously received a cochlear implant, his family noted that he was not actively using the device and

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647 Jocelyn Downie and Udo Schuklenk, 'Social Determinants of Health and Slippery Slopes in Assisted Dying Debates: Lessons from Canada' (2021) 47(10) Journal of Medical Ethics 662, 662–669.; Ricarda M Konder and Timothy Christie, 'Medical Assistance in Dying (MAiD) in Canada: A Critical Analysis of the Exclusion of Vulnerable Populations' (2019) 15(2) Healthcare Policy 28, 28–38.

648 Caroline Favron-Godbout and Eric Racine, 'Medical Assistance in Dying for People Living with Mental Disorders: A Qualitative Thematic Review' (2023) 24 BMC Medical Ethics Article 86,86.; Patrick Craine, 'Questioning the Ethics of Assisted Dying for the Mentally Ill' (2023) 6(3–4) Canadian Journal of Bioethics 115, 115-127.; Grainne Neilson and others, 'Capacity Assessments and the Assessment of Voluntariness in the Context of MAiD Legislation: The Role and Responsibility of Psychiatrists' [2023] Canadian Psychiatric Association Position Paper <https://journals.sagepub.com/doi/pdf/10.1177/07067437231220458>accessed 11 November 2025.

649 Inclusion Canada, 'Disability Rights Coalition Challenges Discriminatory Sections of Canada's Assisted Dying Law in Court' (Inclusion Canada, 26 September 2024); Inclusion Canada, DAWN Canada and Council of Canadians with Disabilities, *Press Conference on Bill C-62: Call for Indefinite Delay of MAiD Expansion to Mental Illness* (National Press Gallery, Ottawa, 23 February 2024).

650 Ray Pennings, 'Why the federal rush to amend assisted dying legislation is risky' CBC *News* (Toronto, 30 January 2020) <https://www.cbc.ca/news/opinion/opinion-assisted-dying-legislation-maid-1.5437433> accessed 12 November 2025.

651 Pennings, 'Why the federal rush to amend assisted dying legislation is risky'.

contended that his condition was not life-threatening, arguing that he did not satisfy the requirement of having a "grievous and irremediable" medical condition.[652] The case drew international attention and sparked debate over Canada's euthanasia legislation. Critics and Nichol's family contended that his request for MAiD request was granted for a non-life-threatening condition without adequate safeguards, prompting renewed scrutiny of clinical discretion in MAiD eligibility assessments.[653]

These concerns resonate with broader disability advocacy critiques, as Maria Cheng reports, warning that Canada's euthanasia laws risk pressuring vulnerable individuals, including those with disabilities or inadequate social supports into choosing MAiD as a substitute for care.[654]

This convergence of individual cases, empirical evidence and systemic critique underscore the need for robust safeguards to prevent premature or inappropriate expansion of eligibility. Canada's cautious, incremental approach including delayed implementation, expert panel reviews and public consultations provides important lessons for South Africa.

4.3 Canada's palliative care system and the role of healthcare practitioners in end-of-life care

Palliative care is a cornerstone of Canada's end-of-life healthcare policy, providing holistic support aimed at alleviating suffering for patients with life limiting conditions.[655] This section explores the national framework for palliative care and examines how healthcare practitioners operate within both medical and legal boundaries when addressing patient needs, particularly in the context of legally available MAiD.

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652 Zachary Mettler, 'Tragic Case in Canada Highlights Problems with Permissive Euthanasia Laws' *Daily Citizen* (Colorado Springs, 23 August 2022) <https://dailycitizen.focusonthefamily.com/tragic-case-in-canada-highlights-problems-with-permissive-euthanasia-laws/ >accessed 14 November 2025.

653 Pennings, 'Why the federal rush to amend assisted dying legislation is risky.'

654 Maria Cheng, 'Darker side: Canada's euthanasia laws a threat to disabled, experts say' (*The Associated Press*, 11 August 2022) <https://www.globalnews.ca/news/9052672/canada-euthanasia-laws-disabled/> accessed 13 April 2025 and <https://nationalpost.com/news/experts-see-canadas-euthanasia-laws-as-threat-to-disabled> accessed 14 November 2025.

655 Government of Canada, *Palliative Care: Overview-What We're Doing* (2023) <https://www.canada.ca/en/health-canada/services/palliative-care.html> accessed May 2025.

Canada's experience illustrates the importance of integrating comprehensive palliative services with respect for patient autonomy within a regulated end-of-life framework.

4.3.1 Canada's palliative care framework

Canada's palliative care framework seeks to address the physical, emotional, and spiritual needs of patients, while also supporting their families.[656] The federal government's Framework on Palliative Care in Canada emphasises the importance of ensuring that all health-care providers possess core competencies in palliative care, with access to specialist support where necessary.[657] Over the past five years, targeted efforts to improve training, education, and resource availability have strengthened providers' capacity to deliver holistic care.[658] Importantly, MAiD is positioned as a complementary rather than substitutive measure, reinforcing the principle that robust palliative services remain essential.[659]

Since the introduction of the 2018 framework, measurable progress has been reported. By 2021–22, 58% of Canadians received palliative care, an increase from 52% in 2016–17.[660] The number of residential hospice sites also rose significantly, from 88 to 142 nationwide.[661] Professional development initiatives and the implementation of competency frameworks have enhanced health-care providers' ability to deliver high-quality end-of-life care, thereby establishing a stronger foundation for the integration of MAiD where appropriate.[662]

Federal funding plays a pivotal role through the Action Plan on Palliative Care, which supports ,training, research and service expansion.[663] The federal government

656 Health Canada, *Framework on Palliative Care in Canada* (Health Canada 2018) <https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/framework-palliative-care-canada.html> accessed 2 February 2025.

657 Health Canada, *Framework on Palliative Care in Canada.*

658 Health Canada, *Framework on Palliative care in Canada- Five years Later: A Report on the State of Palliative Care in Canada* (Health Canada 2023) <https://www.canada.ca/en/health-%09%09<canada/services/publications/health-system-services/framework-palliative-care-five-years-later.html> accessed 11 December 2024.

659 Health Canada, *Framework on Palliative Care in Canada-Five years Later 12*.

660 Health Canada, *Framework on Palliative Care in Canada- Five Years Later*.

661 Health Canada, *Framework on Palliative Care in Canada- Five Years Later* 10.

662 Health Canada, *Framework on Palliative Care in Canada- Five Years Later* 11-12.

663 Health Canada, *Action Plan on Palliative Care* (Government of Canada, 2019) 2, para 3 <https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/action-plan-palliative-care.html >accessed 11 October 2025.

committed significant long term funding toward home and family care ,[664] followed by additional allocations of $24 million in 2019 and $29.8 million between 2021 and 2027.[665] According to Health Canada's 2023 assessment, approximately $18.5 million has been invested in training initiatives and resource development to improve clinical and caregiver support, while provinces adapted services to local needs.[666] This policy-driven expansion of palliative care services aligns with professional guidance from the Canadian Medical Association (CMA), which advocates for MAiD to be integrated within a spectrum of end-of-life options.[667] This integrated approach seeks to ensure that patients have access to both palliative and assisted dying services, reflecting a commitment to autonomy and comprehensive care. However, challenges remain in achieving seamless integration, particularly in ensuring consistent standards, equitable access, and ethical clarity across health-care settings.[668]

Despite measurable progress, inequities persist. Only and estimated 15–30% of Canadians receive integrated palliative care, with disparities arising from geographic, socioeconomic, and systemic factors.[669] A 2023 report by the Canadian Institute for Health Information (CIHI) highlights that while residential hospices offer an alternative to hospital-based end-of-life care, their availability varies significantly across provinces and territories.[670] This disparity underscores the need for a more uniform approach to palliative care accessibility nationwide. The report further notes that patients experiencing homelessness face significant barriers, with 27% of such hospitalisations involving extended stays due to delays in accessing appropriate care facilities.[671]

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664 House of Commons, *Committee Report No 2 – AMAD (44-1), Palliative Care in Canada: Funding* (Parliament of Canada, 2023) 60, para 2. <https://www.parl.ca/documentviewer/en/44-1/AMAD/report-2/page-60> accessed 11 October 2025.

665 House of Commons, *Committee Report No 2* 60, para 3.

666 Health Canada, *Framework on Palliative Care in Canada Five Years* Later 34–35, paras 1–2.

667 Canadian Medical Association, *Medical Assistance in Dying (MAiD): Policy Document* (June 2020) 2, para 1 <https://toolkit.cma.ca/media/PolicyPDF/PD17-03.pdf> accessed 11 October 2025.

668 Health Canada, *Framework on Palliative Care in Canada Five Years Later*; Canadian Cancer Society, *Analyzing Hospice Palliative Care Across Canada: A Report on Federal, Provincial, Territorial and Community Actions* (2023) <https://cancer.ca/-/media/files/abous-us/media-releases/2023/palliative-care-report/adv23163palliative-care-report85x11en04.pdf> accessed 13 May 2025.

669 Canadian Institute for Health Information (CIHI), *Access to Palliative Care in Canada* (2018) 6.

670 Canadian Institute for Health Information, *Access to Palliative Care in Canada* 12.

671 Canadian Institute for Health Information, *Access to Palliative Care in Canada* 13.

Dr Kelli Stajduhar, a leading expert in palliative care, emphasises the scarcity of end-of-life options for individuals with unstable housing, stating, “There aren’t a lot of options at the end of life for people who have unstable housing, observing that it is not uncommon for vulnerable persons to die in non-clinical settings such as cars or public spaces”.[672] This situation reflects how inadequate palliative care infrastructure can lead vulnerable individuals to consider MAiD as their only viable option.

Emerging qualitative and policy evidence underscores that inadequate palliative access can alter genuine end of life decisions, a concern echoed by patient advocacy groups, who argue that MAiD should only be chosen when comprehensive care options have been exhausted.[673] This issue highlights the ethical and systematic challenges within Canada’s health care system, particularly regarding equitable access to end of life care services. Despite policy improvements, access to palliative care and MAiD remains significantly uneven across regions and populations. The next section explores structural barriers and inequalities affecting vulnerable groups across Canada.

4.3.2 Structural barriers and inequalities in access to MAiD and palliative care.

Access to both palliative care and MAiD remain uneven across Canada due to regional disparities, limited healthcare infrastructure, and systemic marginalisation. Rural residents face logistical challenges, including fewer trained professionals, delayed assessments, and inadequate home care funding.[674] Indigenous peoples, persons with disabilities, and low-income patients frequently encounter barriers shaped by

672 Kelli Stajduhar quoted in Access *to Palliative Care in Canada,* Canadian Institute for Health Information, (2023) 13.

673 Andrew Collins and Brendan Leier, ‘Can medical assistance in dying harm rural and remote palliative care in Canada’ (2017) 63(3) Canadian Family Physician 186, 187-190. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5349713> accessed 12 May 2025; Health Canada, *Fifth Annual Report on Medical Assistance in Dying in Canada*, 2023 (11 December 2024)<htttps://www.canada.ca/en/health-canada/services/publications/health-systems-services/annual-report-medical-assistance-dying-2023.html> accessed 9 August 2025 ;Gilla K Shapiro and others, ‘Perspectives of Canadian health leaders on the relationship between medical assistance in dying and palliative and end of life care services: a qualitative study’ (2024) 196 Canadian Medical Association Journal E222, E222-E234 <https://doi.org/10.1503/cmaj.231241> accessed 9 August 2025; Rinat Nissim and others, ‘ “Walk me through the final day”: a thematic analysis study on the family caregiver experience of the Medical Assistance in Dying procedure day’ (2024) 38 (6) Palliative Medicine 660.

674 Catherine J Schiller, ‘Medical Assistance in Dying in Canada: Focus on Rural Communities’ (2017) 13(9) The Journal for Nurse Practitioners 628, 630–631 .

historical distrust, cultural insensitivity, and economic exclusion.[675] The legal right to MAiD does not automatically translate into equitable access,[676] raising concerns under the Canadian Charter of Rights and Freedoms.[677]

Healthcare providers report moral and legal strain when institutional supports or resources are insufficient, illustrating systemic challenges in delivering end-of-life care in under-resourced regions.[678] The case of Normand Meunier, a 66-year-old quadriplegic man from Quebec, underscores the profound impact of structural deficiencies on end-of-life decision making.[679] After enduring a traumatic hospital experience, including prolonged time on a stretcher without appropriate support, Meunier opted for MAiD.[680] His death in 2024 prompted public outcry and renewed debate about the accessibility and quality of palliative and disability inclusive care in Canada[681] The case highlighted that even in jurisdictions with legalised assisted dying, inequities in care provision and inadequate support for vulnerable populations may compromise genuine choice and dignity in dying.

The Canadian experience demonstrates that legislation alone is insufficient. Ethical dialogue, practitioner support, and sustained investment in palliative care infrastructure are critical to ensuring that autonomy and dignity are respected without compromising protection for those at risk.

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675 Adrian Ghobrial, 'Marginalised Communities Concerned About Changes to Assisted Dying Laws' *City News* (22 January 2021) para 4 <https://toronto.citynews.ca/2021/01/22/marginalized-communities-concerned-about-changes-to-assisted-dying-laws/ >accessed 1 September 2025.

676 Jocelyn Downie and Abby Scallion, 'MAiD and Vulnerable Populations: Assessing the Gap Between Rights and Realities' in Jocelyn Downie, Stephanie Green and Udo Schuklenk (eds), *MAiD in Canada: Key Legal and Policy Debates* (University of Ottawa Press 2021) 192–195.

677 Jennifer Flood and Trudo Lemmens, 'Medical Assistance in Dying, Health Inequity and the Charter: Towards Substantive Equity in End-of-Life Care' (2019) 44 UBC Law Review 623, 630.

678 Barbara Pesut and others, 'The Rocks and Hard Places of MAiD: A Qualitative Study of Nursing Practice in the Context of Legislated Assisted Death' (2020) 19 BMC Nursing 12, para 3.

679 Vanessa Etienne 'Quadriplegic Man Chose Medical Aid in Dying After 'Horror' Hospital Stay' (*People*, 8 May 2025) available at <https://people.com/quadriplegic-man- chose-medical-aid-in-dying-after-horror-hospital-stay-11729097> accessed 5 June 2025.

680 Etienne, 'Quadriplegic Man Chose Medical Aid in Dying After 'Horror'.

681 Etienne, 'Quadriplegic Man Chose Medical Aid in Dying After 'Horror'.

4.3.3 Role of health-care practitioners in end-of-life care

Healthcare practitioners are central to delivering end-of-life care, encompassing both palliative and MAiD services. Their responsibilities include assessing patient eligibility, providing information on available options, and ensuring that care aligns with the patient's values and preferences.[682] Integrating palliative principles into general medical practice is critical for addressing the complex physical, psychological and social dimensions of suffering.

Practitioners often experience moral distress when navigating MAiD cases, particularly where patients' choices intersect with inadequate palliative care or social support.[683] While some physicians invoke the Hippocratic Oath to prioritise preserving life,[684] others argue that respecting patient autonomy and alleviating suffering aligns with contemporary medical ethics.[685] MAiD is legally regulated under the Criminal Code, with criteria and safeguards designed to protect both patients and practitioners.[686] Professional bodies, including the Canadian Medical Association (CMA),[687] and provincial colleges, provide guidance emphasising collaboration with palliative teams and informed patient decision-making.[688]

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682 Health Canada, *Model Practice Standard for Medical Assistance in Dying (MAiD)* (Government of Canada, March 2023) s 4.0 <https://www.canada.ca/en/healthcanada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html> accessed 11 September 2025.

683 Anita Ho and others, 'How Does Medical Assistance in Dying Affect End-of-Life Care Planning Discussions? Experiences of Canadian Multidisciplinary Palliative Care Providers' (2021) 15 Palliative Care and Social Practice 1, 6 <https://journals.sagepub.com/doi/pdf/10.1177/26323524211045996> accessed 11 November 2025.

684 Lois Snyder Sulmasy and Paul S Mueller, 'Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper' (2017) 167(8) Annals of Internal Medicine 576, 576-578.

685 Jocelyn Downie, *A Legal Overview of Medical Assistance in Dying (MAiD) in Canada* (Dalhousie University Schulich School of Law, 2021) <https://research.schulichlaw.dal.ca/en/publications/a-legal-overview-of-medical-assistance-in-dying-maid-in-canada> accessed 12 October 2025.

686 Criminal Code (RSC, 1985, c C-46) s 241.2(1).

687 Canadian Medical Association, *Code of Ethics and Professionalism* (December 2018) s 5.1 <https://www.cma.ca/cma-code-ethics-and-professionalism> accessed 11 September 2025.

688 Health Canada, *Model Practice Standard for Medical Assistance in Dying* s 9.0.

For many practitioners, the established framework allows them to reconcile MAiD with professional responsibilities and ethical obligations.[689]

The Canadian Medical Association's Code of Ethics and Professionalism underscores physicians' obligation to respect patient autonomy while ensuring professional integrity within ethically complex practices like MAiD.[690] Systemic supports, including training, consultation pathways, and institutional oversight are critical to ensuring that MAiD is practised in accordance with stringent legal and ethical standards that protect both patient rights and the integrity of the healthcare system.

This debate over conscientious objection intersects with the lived experiences of healthcare practitioners navigating MAiD in practice. Studies highlight the complex experiences of practitioners involved in MAiD. Pesut, Thorne, and Tishelman note that supportive frameworks, training, and clear guidelines are vital for nurses to deliver ethically sound care,[691] particularly in rural or resource-limited settings.[692]

Beuthin, Bruce, and Scaia report that nurses involved in MAiD face emotional challenges and role ambiguity,[693] yet many also express a sense of professional fulfilment in respecting patient autonomy and providing compassionate care.[694] Their study further identifies a lack of formal education and training on MAiD within nursing curricula, suggesting the need for enhanced educational programmes to prepare nurses for such responsibilities.[695] Nurses emphasise the importance of institutional support, including clear policies and access to counselling services, to help them navigate the complexities of providing care in the context of MAiD,[696] underscoring the need for sustained professional guidance.[697]

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689 *Carter v Canada (Attorney General)* [2015] 1 SCR 331, 2015 SCC 5 <https://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.html> accessed 11 November 2025.

690 Canadian Medical Association, *Code of Ethics and Professionalism* s 5.1.

691 Barbara Pesut, and others, 'Constructing Good Nursing Practice for Medical Assistance in Dying in Canada: An Interpretive Descriptive Study' (2020) 7 Global Qualitative Nursing Research 1, 6.

692 Pesut and others, 'Constructing Good Nursing Practice' 7.

693 Rosanne Beuthin, Anne Bruce and Margaret Scaia, 'Medical Assistance in Dying (MAiD): Canadian Nurses' Experiences' (2018) 53(4) Nursing Forum 511, 512

694 Beuthin, Bruce and Scaia, 'Medical Assistance in Dying (MAiD): Canadian Nurses' 514.

695 Beuthin, Bruce and Scaia, 'Medical Assistance in Dying (MAiD): Canadian Nurses' 515.

696 Beuthin, Bruce and Scaia, 'Medical Assistance in Dying (MAiD): Canadian Nurses' 516.

697 Beuthin, Bruce and Scaia, 'Medical Assistance in Dying (MAiD): Canadian Nurses' 517.

These insights reinforce the importance of balancing practitioner integrity with patient rights, especially in ethically contested terrain.[698]

Conscientious objection is respected within Canadian law, allowing practitioners who morally oppose MAiD to refrain from direct participation while ensuring patients receive access through effective referrals.[699] This balance supports professional integrity while upholding patient autonomy. Some scholars, including Schuklenk and Smalling, challenge this accommodation, arguing that legal services should not be withheld based on personal beliefs, particularly in publicly funded systems.[700] Others, such as Cowley, defend conscientious objection as integral to professional integrity.[701] Schuklenk, however, contends that permitting conscientious objection risks undermining equitable access and professional obligations.[702]

Practitioners such as Dr Green, Co-founder and President of the Canadian Association of MAiD Assessors and Providers (CAMAP),[703] advocate for the recognition of assisted dying as consistent with medical ethics and human dignity and view MAiD as respecting the right to die with dignity.[704] Green highlights that MAiD addresses loss of autonomy, dignity and meaningful engagement with life, rather than solely physical pain.[705] In her research Green demonstrates that MAiD can provide patient with psychological reassurance, enabling them to live more meaningfully in their final days.[706] Testimonies before the House of Commons in 2021[707] further illustrate that MAiD is performed ethically, within professional standards and legal

698 Udo Schuklenk and Ricardo Smalling, 'Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies' (2017) 43(4) Journal of Medical Ethics 234, 238: Udo Schuklenk, 'A Defence of Conscientious Objections in Medicine' (2015) 30(5) Bioethics 358, 364.

699 Health Canada, *Model Practice Standard for Medical Assistance in Dying (MAiD)* (March 2023) s 5.0.

700 Schuklenk and Smalling, 'Why Medical Professionals Have No Moral Claim to Conscientious Objection' 237-238.

701 Christopher Cowley, 'A Defense of Conscientious Objection in Medicine: A Reply to Schuklenk and Savulescu' (2016) 30(4) Bioethics 358, 359–363.

702 Schuklenk and Smalling, 'Why Medical Professionals Have No Moral Claim to Conscientious Objection' 238.

703 More information on Dr Stefanie Green and contribution to MAiD available at <https://www.solacebc.ca/ > accessed 12 January 2025.

704 Stefanie Green, *This is Assisted Dying: A Doctor's Story of Empowering Patients at the End of Life* (Scribner, 2022) ch 5.

705 Green, *This is Assisted Dying: A Doctor's Story of Empowering Patients* ch 7.

706 Green, *This is Assisted Dying: A Doctor's Story of Empowering Patients* ch 9.

707 House of Commons of Canada, *Committee Report No. 1 – AMAD (44-1)* (2021) 57 <https://www.parl.ca/DocumentViewer/en/44-1/amad/report-1/page-57> accessed 11 November 2025.

frameworks, Green asserting ‘we are, in fact, the community of professionals who do the work to the highest of medical standards and always within the law of the country, whatever that law may be’.[708]

Murphy’s 2018 critical review of the Canadian Medical Association’s (CMA) approach to assisted suicide in Canada examines the evolution of CMA policies and how they have both influenced and responded to legal developments regarding MAiD.[709] He emphasises that the CMA’s position shifted in response to changing legal and public perspectives from strong opposition to a more permissive stance that aligns with Canada’s evolving legal framework.[710] Initially, the CMA opposed euthanasia and assisted suicide, viewing them as incompatible with medical standards, a position evident in its policies prior to 2014.[711] However, as legal and societal attitudes changed particularly following the Supreme Court’s decision in *Carter v Canada* the CMA revised its stance to allow physicians to follow their conscience, whether that meant participating in MAiD or opting out.[712]

Murphy critiques this shift, highlighting concerns about the ethical and practical implications for physicians who may feel pressured to participate in MAiD despite personal or professional reservations.[713] He questions whether the CMA’s approach adequately protects physicians’ rights to conscientious objection and whether it reflects the complexities and ethical concerns within the medical community.[714] His review calls for a more nuanced approach by the CMA, suggesting that future policy developments should carefully balance the rights of patients seeking MAiD and the professional and ethical rights of physicians.[715] Murphy’s critique serves as an important reminder of the ongoing ethical debates surrounding MAiD in Canada and the role of medical organisations in shaping related policies.

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708 Canada, *House of Commons Standing Committee on Justice and Human Rights, Evidence, 2nd Sess, 43rd Parl* (5 November 2020).

709 Sean Murphy, *Canadian Medical Association and Euthanasia and Assisted Suicide in Canada: Critical Review of CMA Approach to Changes in Policy and Law* (Protection of Conscience Project, 2018) 3–5.

710 Murphy, *Canadian Medical Association and Euthanasia and Assisted Suicide in Canada* 3-4.

711 Murphy, *Canadian Medical Association and Euthanasia and Assisted Suicide in Canada* 3.

712 Murphy, *Canadian Medical Association and Euthanasia and Assisted Suicide in Canada 4.*

713 Murphy, *Canadian Medical Association and Euthanasia and Assisted Suicide in Canada* 5.

714 Murphy, *Canadian Medical Association and Euthanasia and Assisted Suicide in Canada* 5.

715 Murphy, *Canadian Medical Association and Euthanasia and Assisted Suicide in Canada* 6.

Canada's experience illustrates that while palliative care is a fundamental component of end-of-life care, it may not fully address the needs of all patients. The integration of MAiD into the healthcare system represents an acknowledgement of the limitations of palliative care in certain circumstances and a commitment to honouring patient autonomy. For countries like South Africa, examining Canada's approach offers valuable lessons in balancing comprehensive palliative care with legal frameworks that support end of life choices.

4.3.3 Attitudes of loved ones caring for the terminally ill patients at home

Family caregivers are crucial in end-of-life care, often experiencing emotional, physical, and financial burdens. Their involvement extends beyond practical support to encompass complex ethical decisions, emotional labour, and advocacy for patient dignity. These experiences shape their attitudes toward palliative care and, in some cases, MAiD, particularly when navigating limited resources, prognostic uncertainty, and the desire to alleviate suffering.

Studies, including McPherson's seminal work, highlight the multifaceted burdens faced by caregivers of terminally ill patients.[716] These include emotional distress, physical fatigue,[717] and financial strain,[718] which can significantly impact their capacity to provide sustained care. In parallel, patients frequently report feelings of anxiety, depression, and guilt associated with the perception of being a burden to their loved ones,[719] which in turn can shape both patient and caregiver perspectives on MAiD.[720] The cumulative effect of these challenges underscores the need for targeted interventions and systemic support to enable caregivers to provide compassionate care while safeguarding their own well-being.

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716 Christine J McPherson, Keith G Wilson and Mary Ann Murray, 'Feeling Like a Burden: Exploring the Perspectives of Patients at the End of Life' (2007) 64(2) Social Science and Medicine 417, 417–427.

717 McPherson, Wilson and Murray, 'Feeling Like a Burden: Exploring the Perspectives of Patients at the End of Life' 418–419.

718 McPherson, 'Feeling Like a Burden: Exploring the Perspectives of Patients at the End of Life' 419–420.

719 McPherson, 'Feeling Like a Burden: Exploring the Perspectives of Patients at the End of Life' 422–423.

720 McPherson, 'Feeling Like a Burden: Exploring the Perspectives of Patients at the End of Life' 419–425.

A study by Brazil and others compared rural and urban caregivers, revealing that rural caregivers often face limited access to health-care services, leading to increased stress and feelings of isolation.[721] This cross-sectional survey involved 100 informal caregivers (44 rural and 56 urban) actively providing end-of-life care to terminally ill patients in northeastern Ontario, Canada.[722] The study assessed caregivers' perceived health status, care-giving burden, social support, and the pattern of formal care services used.[723] Findings indicated that both rural and urban caregivers reported low levels of care-giving burden and high levels of social support.[724] However, significant differences were observed in the types of services utilised: rural caregivers were more likely to rely on respite services and to have relocated in order to assume care-giving responsibilities.[725] These results underscore the importance of geographic location when implementing palliative care programmes and services,[726] highlighting that while caregivers across settings report similar levels of perceived burden and social support, the types of services they use and the need for relocation can differ.[727]

A qualitative study based on interviews with 22 caregivers of patients who requested MAiD explores the experiences and perspectives of family members involved in end-of-life decision-making.[728] The study found that many caregivers supported assisted dying not only out of compassion for the patient's suffering but also due to the unsustainable demands placed on them when palliative care was insufficient.[729] Several participants highlighted that the lack of comprehensive palliative resources increased caregiver burden, influencing their support for MAiD.[730] Caregivers described their journey as a "race to the end," adopting roles such as "co-runner", "onlooker" and "tending to the finish line".[731] These metaphors reflect the emotional and logistical challenges faced during the MAiD process. The study emphasised the

721 Kevin Brazil and others, 'Comparing the Experiences of Rural and Urban Family Caregivers of the Terminally Ill' (2013) 13(1) Rural and Remote Health 2250, 2251.
722 Brazil and others, 'Comparing the Experiences of Rural and Urban Family Caregivers' 2251.
723 Brazil and others, 'Comparing the Experiences of Rural and Urban Family Caregivers' 2252.
724 Brazil and others, 'Comparing the Experiences of Rural and Urban Family Caregivers' 2253.
725 Brazil and others, 'Comparing the Experiences of Rural and Urban Family Caregivers' 2254.
726 Brazil and others, 'Comparing the Experiences of Rural and Urban Family Caregivers' 2255.
727 Brazil and others, 'Comparing the Experiences of Rural and Urban Family Caregivers' 2256-2258.
728 Tharshika Thangarasa and others, 'A Race to the End: Family Caregivers' Experience of Medical Assistance in Dying a Qualitative Study' (2021) 37(4) Journal of General Internal Medicine 809, 811–812.
729 Thangarasa and others 'A Race to the End' 811-812.
730 Thangarasa and others 'A Race to the End' 813-814.
731 Thangarasa and others 'A Race to the End' 810-811.

need for tailored support programmes to address caregivers' unique needs in the context of MAiD.[732]

When considering MAiD, insights from studies such as Beuthin and Bruce suggest that home caregivers, including those in rural areas, experience distinct emotional and ethical challenges.[733] Their study highlights that caregivers often undergo a unique form of grief and bereavement shaped by the planned and controlled nature of MAiD, which allows them to anticipate the timing of death and participate actively in end-of-life preparations.[734] This involvement including assisting with practical tasks and witnessing the assisted death can provide a sense of agency and closure, but may also bring emotional strain and moral complexity.[735]

Moreover, a report by Health Canada acknowledged that informal caregivers often lack awareness of available services, leading to unmet needs.[736] The report emphasised the importance of providing accessible information and resources to support caregivers effectively.[737] Families of terminally ill patients frequently experience a complex mix of grief and relief, some studies suggest that knowing a loved one dies on their own terms can reduce prolonged bereavement.[738] The Canadian Hospice Palliative Care Association (CHPCA) reports that while home-based care is often preferred, it places significant strain on informal caregivers, many of whom are elderly or employed family members.[739]

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732 Thangarasa and others 'A Race to the End' 809-815.

733 Rosanne Beuthin and Anne Bruce, 'Experiences of Grief and Bereavement After a Medically Assisted Death in Canada: Bringing Death to Life' (2021) 45(10) Death Studies 590, 591 .

734 Beuthin, and Bruce, Experiences of Grief and Bereavement '592-593.

735 Beuthin, and Bruce, Experiences of Grief and Bereavement '594-595.

736 Janet Dunbrack, *The Information Needs of Informal Caregivers Involved in Providing Support to a Critically Ill Loved One* (Health Canada, 2005) 3 <https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-info-caregiver-aidant/2005-info-caregiver-aidant-eng.pdf> accessed August 2025.

737 Dunbrack, *The Information Needs of Informal Caregivers.*

738 Harvey M Chochinov, 'Dignity and the Essence of Medicine: The A, B, C and D of Dignity Conserving Care' (2007) 335 British Journal of Psychiatry 184,184-187.

739 Canadian Hospice Palliative Care Association, *Valuing Caregiving and Caregivers: Family Caregivers in the Integrated Approach to Palliative Care* (CHPCA, 2013/2021 reprint) 2 <https://www.chpca.ca/wp-content/uploads/2024/04/TWF-VA1.pdf> accessed 12 March 2025.

MAiD may alleviate some of this burden by offering a timely, patient-centred option,[740] though attitudes vary according to religious, cultural, and personal convictions.[741]

Empirical research highlights that the availability of MAiD can improve the psychological preparedness of caregivers, allowing for more meaningful goodbyes and greater closure, which ultimately enhances bereavement outcomes.[742] These findings suggest that the attitudes of loved ones are not merely shaped by ideological or cultural beliefs but are also heavily influenced by the lived realities of care-giving, the perceived quality of palliative care, and the desire to uphold the dignity and autonomy of the dying individual.

Overall, Canada's framework demonstrates the importance of integrating caregivers' perspectives without subordinating patient autonomy, offering a balanced model relevant for South Africa's consideration of end-of-life legislation.

4.4 Conclusion

Canada's MAiD legislation reflects the interplay of constitutional rights, ethical reasoning, and stakeholder engagement. Anchored in sections 7 and 15 of the Charter, MAiD jurisprudence emerged from the tension between autonomy and the prohibitions in sections 14 and 241(b) of the Criminal Code, resolved in *Carter v Canada* (AG). This was broadened in *Truchon* (2019), which invalidated the "reasonably foreseeable death" criterion.

Subsequent reforms under Bills C-14, C-7, and C-62 established a rights-based framework prioritising dignity and relief from suffering, while ongoing debates about mental illness highlight unresolved ethical and clinical challenges. Persistent inequities in palliative care, practitioner training, and access for rural and Indigenous communities reveal gaps between rights in law and care in practice. Healthcare providers and families remain central to end-of-life care, underscoring the need for

740 Thangarasa and others, 'A Race to the End: Family Caregivers' Experience of Medical Assistance in Dying – A Qualitative Study' (2021) 37(4) Journal of General Internal Medicine 811–812.

741 Barbara Pesut and others, 'The Moral Web of Accessibility to Medical Assistance in Dying: Reflections from the Canadian Context' (2025) 32(1) Nursing Ethics 365 .

742 Sheila Holmes and others, 'Exploring the Experience of Supporting a Loved One Through a Medically Assisted Death in Canada' (2018) 64(9) Canadian Family Physician e387, e387–e393.

institutional support and compassionate policy design. Canada's experience shows how constitutional values can inform humane reform but also cautions that legal permissibility alone does not guarantee ethical implementation.

For South Africa, the key question is whether assisted dying can be constitutionally and culturally justified within its unique framework. Chapter Five examines this through the lens of dignity, autonomy, privacy, and section 36's limitations clause, alongside medico-legal instruments such as living wills. It also considers whether the South African Law Reform Commission's Discussion Paper 71 provides scope for reconsideration. Placed within South Africa's broader rights-based trajectory from reproductive rights to marriage equality and gender recognition the comparative enquiry asks whether a regulatory framework for assisted dying could be both normatively sound and legally feasible in South Africa today.

CHAPTER FIVE

5. South Africa's constitutional rights and the case for legalising euthanasia: with insights from Canada

5.1 Introduction

South Africa's constitutional democracy is founded on the values of dignity, freedom, and equality.[743] These values inevitably shape debates about end-of-life decision-making, particularly as questions of euthanasia and assisted dying become more pressing. This chapter examines how constitutional rights intersect with medical ethics and social realities and considers whether the current prohibition on euthanasia can be reconciled with the Constitution. Drawing comparative insights from Canada, the analysis will explore both the potential for reform and the safeguards required to protect vulnerable groups.

The analysis begins with the constitutional rights most directly implicated, namely, life, dignity, autonomy, and privacy and evaluates how they are limited by the current legal framework. It then applies the general limitation clause under section 36 to assess whether the prohibition of euthanasia is justifiable.[744] Relevant case law is examined alongside comparative insights from Canada, where medical assistance in dying (MAiD) has been constitutionally entrenched.[745]

The chapter also considers the South African Law Reform Commission's (SALRC) Discussion Paper 71,which explores whether limited forms of euthanasia could be legalised under strict conditions with professional oversight, presenting draft proposals for public debate rather than binding recommendations.[746] Although the National Health Act 61 of 2003 and the National Health Insurance Act 20 of 2023 do not explicitly regulate euthanasia, they embed principles of patient autonomy, informed

743 Constitution of the Republic of South Africa, 1996 s 1(a); s 7(1).
744 Constitution of the Republic of South Africa, 1996 s 36(1).
745 *Carter v Canada* (Attorney General) 2015 SCC 5, [2015] 1 SCR 331.
746 South African Law Reform Commission, *Euthanasia and the Artificial Preservation of Life* (Discussion Paper 71 Project 86, 1998) paras 2.1–2.5 (hereafter cited SALRC, *Euthanasia and the Artificial Preservation of Life*).

consent, and ethical health-care delivery, that are relevant to the constitutional analysis of assisted dying .[747]

Precedent-setting reforms such as the Choice on Termination of Pregnancy Act 92 of 1996, the Civil Union Act 17 of 2006, and judicial recognition of transgender rights under the Alteration of Sex Description and Sex Status Act 49 of 2003 demonstrate that dignity and autonomy have driven progressive legal change.[748] These developments underscore the need for this chapter to confront the constitutional legitimacy of South Africa's prohibition on euthanasia and to consider whether a regulated framework that respects individual rights could be developed.

5.1.1 The Constitution as a framework for end-of-life rights

The Constitution of the Republic of South Africa, 1996, reshaped the legal framework governing healthcare, ethics, and personal autonomy. It guarantees dignity (s10), freedom and security of the person (s12), privacy (s 14), and access to healthcare (s 27), all of which must be interpreted to promote an open and democratic society.[749]

In the context of end-of-life care, the Constitution demands that medical decisions reflect both clinical judgment and constitutional rights. The National Health Act 61 of 2003 affirms informed consent, allowing patients to refuse treatment even if it hastens death.[750] However, it does not extend to assisted dying, creating tension between patient autonomy and criminal law. This tension is evident in *S v Hartmann*[751], where a doctor was convicted for assisting his terminally ill father to die. The court acknowledged his compassionate motives but upheld the prohibition on active euthanasia.[752] In *Stransham-Ford v Minister of Justice*, the High Court held that denying physician-assisted death violated constitutional rights, though the Supreme Court of Appeal later set aside the ruling on procedural grounds.[753] Under section 36,

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747 National Health Act 61 of 2003 ss 6–7; National Health Insurance Act 20 of 2023.

748 Choice on Termination of Pregnancy Act 92 of 1996; Civil Union Act 17 of 2006; Alteration of Sex Description and Sex Status Act 49 of 2003.

749 Constitution of the Republic of South Africa, 1996 ss 10, 12, 14, 27.

750 National Health Act 61 of 2003 ss 6(1)(d), 7(1).

751 *S v Hartmann* 1975 (3) SA 532 (c) 534–535 (hereafter cited *Hartmann*).

752 *Hartmann* 536-537.

753 *Stransham-Ford v Minister of Justice and Correctional Services* 2015 (4) SA 50 (GP) (hereafter cited *Stransham-Ford* (GP); *Minister of Justice and Correctional Services v Estate Stransham-Ford* 2017 (3) SA 152 (SCA) paras 13, 44 (hereafter cited *Estate Stransham-ford)*.

any limitation of rights must be reasonable and justifiable.[754] A blanket prohibition on assisted dying must be assessed against the suffering it imposes and whether less restrictive means such as medical safeguards could achieve the same protective aims.[755]

Legal scholars argue that euthanasia reform is not radical but a continuation of South Africa's constitutional project. Woolman emphasises that the Constitution's commitment to dignity requires recognition of individual autonomy in deeply personal decisions, including those concerning bodily integrity and end-of-life choices.[756] Within this interpretive tradition, assisted dying can be understood as an extension of constitutional values already affirmed in cases addressing privacy, lifestyle, and freedom, thereby situating reform within the broader trajectory of South Africa's constitutional jurisprudence.[757]

As the Constitutional Court has emphasised in *S v Makwanyane*, the Constitution is a transformative charter that requires the law to evolve in ways that promote dignity and autonomy in an open and democratic society.[758] Within this framework, section 36's proportionality test provides the doctrinal lens through which assisted dying must be assessed, balancing individual suffering against the state's protective aims.[759]

Against this constitutional backdrop, the South African Law Reform Commission undertook its most comprehensive inquiry into euthanasia and the artificial preservation of life, producing Discussion Paper 71 (Project 86) as a foundational policy document that sought to reconcile constitutional values with the practical regulation of end-of-life decision-making.

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754 Constitution of the Republic of South Africa, 1996 s 36(1).

755 Andrew McGee, 'Me and My Body: The Relevance of the Distinction for the Difference Between Withdrawing Life Support and Euthanasia' (2011) 39(4) Journal of Law, Medicine and Ethics 671,671-677 <https://doi.org/10.1111/j.1748-720X.2011.00634.x> accessed 12 May 2025.

756 Stuart Woolman, 'Dignity' in Stuart Woolman, Michael Bishop & Jason Brickhill (eds), *Constitutional Law of South Africa* (2nd edn, Juta,RS 3, 2007) ch 36.

757 *Minister of Justice and Constitutional Development and Others v Prince* 2018 (6) SA 393 (CC) para 108 (hereafter cited *Prince*).

758 *S v Makwanyane and Another* 1995 (3) SA 391 (CC) para 104 (hereafter cited *Makwanyane*).

759 Lourens Botha Grové, 'Framework for the Implementation of Euthanasia in South Africa' (LLM dissertation, University of Pretoria 2007) 78–82 <https://hdl.handle.met/2263/26182> accessed 11 April 2025.

5.1.2 The South African Law Reform Commission (SALRC), Discussion Paper 71, Project 86, Euthanasia and the Artificial Preservation of Life: The Status of euthanasia policy reform

The South African Law Reform Commission's Discussion Paper 71 (1998), part of Project 86 on Euthanasia and the Artificial Preservation of Life, remains the most comprehensive policy document addressing assisted dying in South Africa.[760] It explored legal, ethical, and practical dimensions of euthanasia and proposed three policy options, maintaining the status quo, legalising limited forms of euthanasia under strict safeguards, or fully legalising physician-assisted dying.[761]

Although the SALRC did not endorse a specific option, it acknowledged that legalisation under a regulated framework could be constitutionally permissible, provided it included professional oversight, procedural safeguards, and ethical accountability.[762] The paper also included a draft bill, signalling legislative intent to engage with the issue.[763] Despite this groundwork, no legislative reform has followed. The absence of statutory clarity has left a legal vacuum, placing patients and health-care professionals in ethically precarious positions.[764] McQuoid-Mason argues that this inertia undermines constitutional rights and fails to provide legal certainty for end-of-life decision-making.[765] The SALRC's cautious yet open stance reflects the complexity of balancing individual rights with societal concerns. However, its findings remain relevant, particularly considering evolving constitutional jurisprudence and international developments.[766]

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760 SALRC, *Euthanasia and the Artificial Preservation of Life* para 1.1.

761 SALRC, *Euthanasia and the Artificial Preservation of Life* paras 2.1–2.5.

762 SALRC, *Euthanasia and the Artificial Preservation of Life* paras 3.3–3.5.

763 SALRC, *Euthanasia and the Artificial Preservation of Life* paras 3.3–3.5; Annexure A (Draft Bill).

764 Willem A Landman, *End of Life Decisions and, ethics and the Law*: *A Case for Statutory Legal Clarity and Reform in South Africa* (Globethics.net 2012)136.

765 David J McQuoid-Mason, 'Doctor Assisted Suicide: What Is the Present Legal Position in South Africa?' 527, 527.

766 Ben P White and Lindy Willmott (eds), *International Perspectives on End-of-Life Law Reform: Politics, Persuasion and Persistence (*Cambridge University Press 2021*)* 250.

In the absence of legislative reform following the SALRC's recommendations, South Africans have increasingly turned to living wills as a practical means of asserting autonomy in end-of-life decision-making. However, the uncertain legal status underscores the need for statutory clarity.

5.1.3 Living wills and advance directives as emerging instruments in end-of-life decisions

In South Africa's post-constitutional legal landscape, living wills often referred to as advance directives offer individuals a mechanism to assert autonomy over future medical care should they become incapacitated.[767] Although not formally recognised by statute, they find interpretive support in the National Health Act 61 of 2003, particularly section 7(1)(a),[768] which allows for consent by a mandated proxy, and section 7(1)(e),[769] which requires respect for prior refusals of treatment.[770] These provisions suggest a legal space for recognising living wills as expressions of patient autonomy.

Legal scholars such as Jordaan argue that, despite the absence of statutory recognition of advance directives, constitutional imperatives such as dignity, bodily integrity, and freedom of decision-making support the enforce-ability of advance directives.[771] The South African Law Reform Commission (SALRC), in Discussion Paper 71, and the Draft National Health Amendment Bill (2019), have explored formalising living wills within health-care law, emphasising procedural safeguards and ethical alignment with constitutional rights.[772] Though limited in scope, living wills nonetheless reflect a growing respect for patient self-determination. They offer a legal and ethical bridge between passive euthanasia and full legalisation of assisted dying.[773] As such, living wills represent a constitutionally grounded, ethically sensitive

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767 Louise Jordaan, 'The Legal Validity of an Advance Refusal of Medical Treatment in South African Law (Part 1)' (2011) 44(1) De Jure 32, 33–35 <https://saflii.org/za/journals/DEJURE/2011/3.html> accessed 14 June 2024.

768 National Health Act 61 of 2003 s 7(1)(a): allows consent by a mandated proxy.

769 National Health Act 61 of 2003 s 7(1)(e): requires respect for prior refusals of treatment.

770 National Health Act 61 of 2003 ss 7(1)(a), 7(1)(e).

771 Jordaan, 'The Legal Validity of an Advance Refusal of Medical Treatment' 39–43.

772 SALRC, *Euthanasia and the Artificial Preservation of Life* paras 2.1, 2.5; National Department of Health, Draft National Health Amendment Bill (2019).

773 Gertruida Le Roux Grove, 'Living Wills: What Is the Current Legal Status in South Africa?' (2020) 31(2) Stellenbosch Law Review 270, 270-289 <https://hdl.handle.net/2263/82731> accessed 12 May 2024.

mechanism for honouring patient autonomy, one that could inform the development of a broader legal framework for assisted dying in South Africa. Comparative jurisprudence reinforces this trajectory. In Canada, advance directives are integrated into the broader framework of medical assistance in dying (MAiD) under the Criminal Code, which permits physician-assisted death subject to strict safeguards.[774]

In sum, while South African law prohibits active euthanasia under common law and the Criminal Procedure Act 51 of 1977, living wills lie at the intersection of constitutional autonomy and medical ethics. They demonstrate how patient wishes may be respected without direct recourse to assisted dying and signal a broader shift toward rights-based end-of-life regulation.[775] While living wills illustrate how South Africans have sought to safeguard autonomy within the current legal vacuum, the broader constitutional question of euthanasia itself demands closer attention, particularly as comparative insight from Canada demonstrates how dignity, freedom of choice, and privacy can be reinforced through a carefully regulated framework.

5.2 Euthanasia: a re-enforcement of Constitutional rights to dignity, autonomy, freedom of choice, and the right to privacy: with insight from Canada

The Constitution of the Republic of South Africa, 1996, has fundamentally reshaped the legal framework governing all aspects of life, including healthcare, ethics and personal autonomy.[776] Since its adoption, the Constitution has transformed legal thinking in a wide range of disciplines. It places emphasis on dignity,[777] freedom and security of the person,[778] privacy[779] and access to health-care services.[780] These rights are interdependent and must be interpreted in a manner that promotes the values underlying an open and democratic society.[781]

774 Criminal Code, RSC 1985, c C-46, ss 241.1–241.4.
775 Criminal Procedure Act 51 of 1977 s 259; SALRC, *Euthanasia and the Artificial* paras 3.3–3.5.
776 Constitution of the Republic of South Africa, 1996.
777 Constitution of the Republic of South Africa, 1996 s10.
778 Constitution of the Republic of South Africa, 1996 s12.
779 Constitution of the Republic of South Africa, 1996 s14.
780 Constitution of the Republic of South Africa, 1996 s27.
781 Iain Currie and Johan De Waal J, *The Bill of Rights Handbook* (*6th edn,* Juta law, 2013).

A growing body of South African scholarship argues that a carefully regulated framework for euthanasia can be constitutionally justified through the rights to dignity, autonomy (freedom of choice) and privacy. Paleker contends that the progressive loss of dignity experienced by terminal patients may ground a constitutionally defensible claim to choose the manner and timing of one's death, provided robust safeguards are in place.[782] Brink similarly emphasises that dignity and autonomy must remain central to any rights sensitive framework for assisted dying in South Africa.[783] While Jordaan emphasises that human dignity must play a central role in shaping the future legal response to voluntary active euthanasia.[784]

From a doctrinal perspective, Grove and Skinner argue that a narrowly tailored legislative model limited to competent adults, subject to strict eligibility criteria, independent medical confirmation and transparent oversight could satisfy the section 36 proportionality test as the least restrictive means of protecting competing interests.[785] Although cautious, McQuoid-Mason affirms that the constitutional rights to bodily integrity and personal autonomy are central to end of life decision making,[786] while Bilchitz's argues that a robust constitutional theory of fundamental rights must treat each individual's life as having equal importance and ensure the conditions for living a life of value, thereby linking human dignity directly to the protection of self-directed, meaningful life choices.[787]

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782 Farzana Paleker, 'Euthanasia in South Africa: A Normative Analysis and Application of Dignity' (MSc Med (Bioethics & Health Law) thesis, University of the Witswatersrand, 4 November 2016) 27-30, 45-47 <https://hdl.handle.net/10539/21392> accessed 12 June 2024.

783 Raphael Grant Brink, 'The Case for Assisted Dying/Euthanasia in South Africa with Reference to the Canadian Jurisprudence Under a Human Rights Political Order' (Doctoral Thesis, University of Cape Town, 2022)73-89 <https://hdl.handle.net/11427/36767> accessed 12 September 2025.

784 Donrich W Jordaan, 'Human dignity and the future of the voluntary active euthanasia debate in South Africa' (2017) 107 SAMJ 383, 383-384 <https://doi.org/10.7196/SAMJ.2017.v107i5.12339 > accessed 12 May 2024.

785 Lourens B Grove, 'Framework for the Implementation of Euthanasia in South Africa (LLM dissertation, University of Pretoria, 2007) 154-167 <https://hdl.handle.net/2263/26182> accessed 12 May 2024;
Todd Skinner, 'Decriminalising Voluntary Active Euthanasia through the Recognition of Fundamental Human Rights: A Comparison of South Africa and Foreign Jurisdictions (LLM (Public Law) dissertation, University of Pretoria, 2021) 52-55 <https://hdl.handle.net/2263/84100 > accessed 12 May 2023.

786 David J McQuoid-Mason, 'Assisted suicide and assisted voluntary euthanasia: *Stransham-Ford* High Court case overruled by the Appeal Court, but the door is left open' (2017)107 (5) SAMJ 381, 381-382.

787 David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (Oxford University Press 2007) 30–45.

For South Africa, these insights are not prescriptive but supportive. They demonstrate that the arguments advanced by Paleker, Brink, Jordaan, Grove, Skinner, McQuoid-Mason, and Bilchitz establish how dignity and autonomy can constitutionally justify a carefully regulated framework for assisted dying. Comparative perspectives reinforce this reasoning. Brink writing from a South African constitutional standpoint, illustrates how dignity and autonomy must remain central to any rights sensitive framework for assisted dying, and argues that these values can support end-of-life choice if accompanied by stringent safeguards against abuse.[788] By contrast, Canadian scholars Downie and Chandler analyse how these same values were given legislative effect in *Carter v Canada (AG*), where dignity and autonomy informed the creation of a safeguard-based statutory regime.[789]

Ultimately, the combined force of dignity, autonomy, and privacy supports a principled case for the legalisation of voluntary euthanasia in a constitutionally compliant manner.[790] Yet this claim must be weighed against section 11's protection of life, a foundational right often invoked to resist assisted dying. The next section examines how the right to life interacts with dignity and autonomy in shaping constitutional limits on end-of-life decisions.

5.2.1 The right to life: interpretive differences between South Africa and Canada

The right to life, enshrined in section 11 of the South African Constitution and section 7 of the Canadian Charter of Rights and Freedoms, is often invoked as a barrier to legalising euthanasia.[791] However, the interpretive trajectory in each jurisdiction reveals fundamentally different constitutional logics.[792] In South Africa, the right to life has traditionally been treated as an absolute, life-preserving norm.[793] In Canada, it has

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788 Brink, 'The Case for Assisted Dying/Euthanasia in South Africa' 73–89

789 Jocelyn Downie and Jennifer, A Chandler, *Interpreting Canada's Medical Assistance in Dying Legislation (*Health Law Institute Report, 2018)13-16.

790 White and Willmott, *International Perspectives on End-of-Life Law Reform* 250.

791 *Rodriguez v British Columbia (Attorney General)* [1993] 3 SCR 519 (hereafter cited *Rodriguez*) paras 129-133; *Makwanyane* paras 144-146.

792 *Carter* 62-66, (para 63 specifically notes that *Rodriguez* is no longer determinative. The Supreme Court clarified that the legal and social context had changed since Rodriguez (1993), and therefore its precedent did not bind the Court in *Carter*).

793 *Estate Stransham-Ford* (SCA) para 197; *Makwanyane* para 104; Andrew Konstant, 'Euthanasia Case in South Africa: Does the Right to Life Include the Right to Die with Dignity?' (Oxford Human Rights Hub, 3 June 2015) <https://ohrh.law.ox.ac.uk/euthanasia-cases-in-south-africa-does-the-right-to-life-include-the-right-to-life-includie-the-right-to-die-with-dignity/> accessed 23 October 2025.

evolved into a relational right, one that must be balanced against liberty, security of the person, and dignity.[794]

South African courts have yet to directly confront the question of whether the right to life includes the right to die. In *Stransham-Ford*, the High Court acknowledged that forcing a terminally ill patient to endure unbearable suffering may itself violate the right to life when read in conjunction with dignity and bodily integrity.[795] Although the judgment was subsequently overturned on procedural grounds by the Supreme Court of Appeal, its substantive reasoning remains influential in shaping debates on end-of-life rights.

The Constitutional Court's jurisprudence in *S v Makwanyane* provides an important interpretive foundation for these debates. In striking down the death penalty, the Court held that the right to life must be understood in conjunction with dignity, rejecting the notion that life is merely "organic matter" and affirming instead that it is a life with dignity.[796] This substantive reading of rights suggests that end-of-life choices, including euthanasia, should be evaluated not only in terms of biological existence but also in relation to autonomy, dignity, and privacy.

Building on this reasoning, scholars such as Mlotshwa argue that section 11 of the Constitution must be interpreted contextually rather than in an absolutist manner.[797] She maintains that the right to life protects meaningful existence rather than mere biological survival and must be read harmoniously with dignity and bodily integrity.[798] Read alongside the Canadian Supreme Court's decision in *Carter v Canada*, which similarly recognised that the right to life cannot be interpreted as an obligation to endure suffering,[799] *Makwanyane* demonstrates how constitutional democracies can reconcile ethical complexity with the safeguarding of rights.

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794 *Carter* paras 62–66.
795 *Stransham-Ford* (GP) paras 26-30.
796 *Makwanyane* para 144.
797 Vanessa Nobukhosi Mlotshwa, An Analysis of Section 11 of the Constitution and *Stransham-Ford v Minister of Justice: Are people permitted to waive the right to life?* (LLM thesis, University of Cape Town 2023) 45-50 <https://hdl.handle.net/11427/39680> accessed 11 November 2025.
798 Mlotshwa, 'An Analysis of Section 11 of the Constitution '45–47.
799 *Carter* paras 62–66, 89.

Skinner contends that the South African legal system has conflated the right to life with a duty to live, ignoring the possibility that autonomy may include the right to end one's life in cases of grievous suffering.[800] This doctrinal rigidity, he argues, risks violating the very values the Constitution seeks to uphold.[801] Sneiderman and McQuoid-Mason argue that the line often drawn between "letting die" through withdrawal of treatment and "assisting death" through active measures is not ethically sustainable,[802] both involve deliberate choices that hasten death, yet the law treats them differently.[803] They caution that this inconsistency risks arbitrary outcomes, where patients may be permitted to endure prolonged decline but denied a more immediate and dignified end.[804] For them, legal clarity is essential to ensure that constitutional values of dignity and autonomy are applied consistently in end-of-life decision-making.[805]

By contrast, Canadian jurisprudence has undergone a profound transformation. In *Rodriguez v British Columbia*, the Supreme Court upheld the prohibition on assisted suicide, citing the sanctity of life and the need to protect vulnerable persons.[806] However, in *Carter v Canada*, the Court reversed course, holding that the blanket prohibition violated section 7 of the Charter by depriving individuals of life, liberty, and security in a manner that was overboard and disproportionate.[807] The Court reasoned that forcing individuals to choose between premature death (while still physically able) and prolonged suffering (when assistance is unavailable) paradoxically undermines the right to life.[808]

800 Skinner, 'Decriminalising Voluntary Active Euthanasia'.
801 Skinner, 'Decriminalising Voluntary Active Euthanasia' 52-55.
802 Barney Sneiderman and David McQuoid-Mason, 'Decision-Making at the End of Life in Canada and South Africa' (2000) 33(2) Comparative and International Law Journal of Southern Africa 193, 205 <https://collections.concourt.org.za/handle/20.500.12144/31883> accessed 12 July 2025.
803 Sneiderman and McQuoid-Mason, 'Decision-Making at the End of Life in Canada and South Africa' 205-209.
804 Sneiderman and McQuoid-Mason, 'Decision-Making at the End-of-Life in Canada and South Africa' 193-209.
805 Sneiderman and McQuoid-Mason, 'Decision-Making at the End-of-Life in Canada and South Africa' 193-209.
806 *Rodriguez* para 519.
807 *Carter* para 89.
808 *Carter* para 105.

Downie and Chandler observe that in *Carter*, the Supreme Court of Canada interpreted section 7 of Canadian Charter of Rights and Freedoms in a manner that is intrinsically linked to dignity and autonomy.[809]

The Court recognised that the Charter protects individuals from being forced to endure suffering that deprives life of its essential quality.[810] This interpretive shift reflects a broader constitutional logic, that rights must be balanced, not absolutised. The Canadian model recognises that autonomy and dignity are not subordinate to life, but integral to its meaningful exercise.

The implications for South Africa viewed through the lens of the Canadian experience are significant. While section 11 has not been judicially interpreted to include a right to die, the Constitution's purposive and transformative ethos suggests that such an interpretation is not doctrinally impossible. As Jordaan argues that dignity is not absolute and suffering from terminal illness undermines dignity, meaning the Constitution's respect for human worth should inform evolving ethical and medical norms about euthanasia.[811] The right to life, when read alongside sections 10, 12, and 14, may support a framework that allows for assisted dying in exceptional circumstances.

Moreover, the SALRC's Discussion Paper 71 implicitly acknowledges that the right to life must be balanced against other constitutional rights.[812] The Draft National Health Amendment Bill (2019) similarly explores mechanisms for recognising patient autonomy in end-of-life decisions, including advance directives and living wills.[813] These instruments reflect a growing legal and ethical consensus that the right to life cannot be interpreted in isolation.

In sum, the interpretive divergence between South Africa and Canada on the right to life reveals a constitutional crossroads. South Africa's jurisprudence is cautious but not closed. The Canadian experience shows that legal systems can evolve to

809 Downie and Chandler, *Interpreting Canada's Medical Assistance in Dying Legislation* 4–6.
810 Downie and Chandler, *Interpreting Canada's Medical Assistance in Dying Legislation* 13–14.
811 Jordaan, 'Human Dignity and the Future of the Voluntary Active Euthanasia' 383-385.
812 *SALRC*, *Euthanasia and the Artificial Preservation of Life* paras 2.1–2.5.
813 National Department of Health, Draft National Health Amendment Bill (2019).

accommodate ethical complexity without sacrificing constitutional integrity. For South Africa, the challenge is not whether the right to life can support assisted dying, but whether the legal system has the courage to interpret it in a way that affirms dignity, autonomy, and compassion. This inevitably directs the analysis towards the constitutional right to dignity, which has long been recognised as a foundational value in South African jurisprudence and serves as the lens through which end-of-life choices must ultimately be understood.

5.2.2 Right to dignity as a foundational value in euthanasia jurisprudence

Dignity has long been recognised as a foundational value in South African constitutional jurisprudence.[814] Section 10 of the Constitution affirms that "everyone has inherent dignity and the right to have their dignity respected and protected."[815] In *S v Makwanyane*, Justice O'Regan emphasised that human dignity recognises the inherent worth of every person, noting that dignity is possessed by all individuals by virtue of their humanity and cannot be taken away, even from those who have committed serious crimes.[816] Currie and De Waal similarly interpret dignity as an intrinsic constitutional value that underpins rights to autonomy and equality, reinforcing its centrality in constitutional adjudication.[817] In the context of euthanasia, dignity is not merely symbolic, it is a legal principle that demands recognition of individual suffering, autonomy, and the right to make meaningful choices about one's life and death.

Beyond *Stransham-Ford*, South African jurisprudence has recognised dignity as inseparable from autonomous choice in end-of-life contexts. In *Clarke* v *Hurst NO* and *Others*, the Court held that continuing artificial feeding against a patient's prior wishes violated his dignity, thereby affirming the principle of dying with dignity.[818]

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814 Constitution of the Republic of South Africa, 1996 s 10; *Makwanyane* paras 144–146; *Prince* 108; *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D)*;* Stu Woolman, "Dignity" ch 36; Henk Botha, 'Human Dignity in Comparative Perspective' (2009) 20 Law Review 171,171-172 <https://scholar.sun.ac.za/bitstreams/3e2fadd3-a9fc-417a-a67d-1a43833bf70e/download> accessed 1 August 2024.

815 Constitution of the Republic of South Africa, 1996 s 10.

816 *S v Makwanyane and Another* 1995 (3) SA 391 (CC) para 328 (O'Regan J).

817 Iain Currie and Johan De Waal, *The Bill of Rights Handbook* (7th edn, Juta 2022) 273–276.

818 *Clarke v Hurst NO* and *Others* 1992 (4) SA 630 (D) (hereafter cited *Clarke v Hurst*).

Scholars such as Kotzé and Roos similarly argue that dignity in South Africa's constitutional order requires respect for meaningful choice at the end of life, opening space for a principled framework for voluntary assisted dying under strict safeguards.[819]

Legal scholars such as Bilchitz offers a normative account of human dignity that goes beyond autonomy, he argues that laws should recognise the legal capacity of individuals who are dependent or largely passive, because their dignity is not contingent on full self-determination.[820] While his focus is on psychological disability, his model has implications for legal reform broadly, suggesting that dignity ought to guide reform even in contexts where the law currently imposes disproportionate burdens on vulnerable persons.

Steinmann argues that dignity, understood in its ontological, relational and state duty dimensions, ought to guide legal reform, including around assisted dying, because denying terminally ill persons the choice of assisted death may itself be a dignity infringement.[821] Woolman, meanwhile argues that human dignity functions not only as a justiciable right but as a fundamental constitutional value that informs the interpretation and limitation of other rights.[822] Forcing individuals to endure unbearable suffering undermines this right and may constitute cruel, inhuman, or degrading treatment under section 12(1)(e).[823]

Comparative jurisprudence reinforces this interpretation. Canadian Bioethicist Pullman cautions that, although dignity is frequently invoked in debates on assisted dying, its subjective formulations often tied to perceptions of loss of control, dependence, or bodily decline are too vague and inconsistent to serve as a reliable legal foundation, risking reduction to what he terms moral nonsense.[824] Wright argues

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819 Carla Kotzé and Johannes L Roos, 'End-of-life care in South Africa: Important legal developments' (2022) 28 S Afr J Psychiat a1748, PDF 1,3 <https://doi.org/10.4102/sajpsychiatry.v28i0.1748> accessed 15 September 2024.

820 David Bilchitz, 'Dignity, Fundamental Rights and Legal Capacity: Moving Beyond the Paradigm Set by the General Comment on Article 12 of the CRPD' (2016) 32(3) SAJHR 410, 410–437.

821 Rinie Steinmann, 'Law and Human Dignity at Odds Over Assisted Suicide' (2015) De Rebus 213, 213-215 <https://www.saflii.org/za/journals/DEREBUS/2015/213.html> accessed 17 July 2024.

822 Woolman, 'Dignity' ch 36, 36.3(d).

823 Constitution of the Republic of South Africa, 1996 s 12(1)(e).

824 Daryl Pullman, 'Death, dignity and moral nonsense' (2008) 34 Journal of Palliative Care 171, 171-178 <https://pubmed.ncbi.nlm.nih.gov/15511036/> accessed 12 March 2024.

that dignity in the context of medical assistance in dying, provides a constitutional foundation for autonomy and self-determination but its meaning is contested, depending on constitutional structure and social actors.[825]

The South African and Canadian debates reveal that dignity is often invoked without precision. To advance the discourse, it is useful to distinguish between moral dignity the inherent worth of persons that grounds fundamental rights and aesthetic dignity the subjective sense of composure or grace in dying.[826] While both notions matter in pluralistic societies, only moral dignity can serve as a principled foundation for law reform.[827] Statutory clarity must therefore ensure that end-of-life choices are protected not merely as matters of sentiment, but as expressions of the constitutional value of dignity.

Building on this foundation, the constitutional commitment to dignity necessarily extends to the right to freedom of choice, for it is through autonomous decision-making that individuals give practical effect to their dignity, particularly in the context of end-of-life decisions.

5.2.3 Autonomy and freedom of choice in the constitutional treatment of euthanasia

Section 12(2)(b) of the South African Constitution guarantees "security in and control over one's body," affirming the principle of bodily autonomy.[828] This right is central to medical ethics and constitutional jurisprudence, particularly in end-of-life contexts. Autonomy empowers individuals to make informed decisions about their healthcare, including the refusal of life-sustaining treatment.[829] In *Clarke v Hurst NO*, the court recognised the importance of patient autonomy in withdrawing treatment, even though it stopped short of endorsing active euthanasia.[830]

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825 Isaac Wright, 'Dignity in Death: A Comparative Account of the United States, Canada and the Netherlands' (2025) 62 Alberta Law Review 1001, 1003-1010 <https://doi.org/10.29173/alr2838> accessed 1 January 2026.

826 *S v Makwanyane* para 328 (O'Regan J), where dignity was recognised as the inherent worth of every person, even those convicted of serious crimes. See also Iain Currie and Johan De Waal, *The Bill of Rights Handbook* (7th edn, Juta 2022) 273–276.

827 Christopher McCrudden, 'Human Dignity and Judicial Interpretation of Human Rights' (2008) 19(4) European Journal of International Law 655, 656–660; Downie and Chandler, *Interpreting Canada's Medical Assistance in Dying Legislation* 4–6.

828 Constitution of the Republic of South Africa, 1996 s 12(2)(b).

829 National Health Act 61 of 2003 ss 6–7.

830 *Clarke v Hurst* 653C–E.

The case affirmed that medical decisions must respect the wishes of the patient, particularly where continued treatment offers no therapeutic benefit.[831]

Legal scholars argue that autonomy must extend beyond passive refusals to include active choices about the timing and manner of death. McQuoid-Mason contends that autonomy understood in both legal and biomedical ethics contexts, justifies a legal framework for physician assisted suicide and voluntary euthanasia. [832] He argues that patient self-determination at end of life should be respected and offers ethical legal guidelines for how practitioners can respond to such requests consistently with professional responsibility.[833] Bhamjee contends that autonomy, especially in the context of terminal illness, should be constitutionally protected as part of dignity, such as that patients should have the legal right to make end-of-life decisions, including requesting medical assistance in dying.[834]

Canadian scholarship and policy analysis consistently emphasise autonomy and freedom of choice as the constitutional foundation of medical assistance in dying (MAiD). The Special Joint Committee on Physician-Assisted Dying stressed that respect for autonomy was the guiding principle of Canada's legislative response, framing MAiD as a rights based reform that reconciles individual choice with societal protection.[835] Downie argues that autonomy is not merely a clinical principle but a deeply normative value in end of life law, justifying recognition of assisted death as a personal choice.[836] Chandler similarly supports autonomy in MAiD, while acknowledging the need for safeguards to prevent coercion, she warns that overly restrictive regimes risk undermining the self-determination rights of competent individuals.[837]

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831 *Clarke v Hurst* 653I–654B.

832 McQuoid-Mason, 'Doctor Assisted Suicide' 526–527.

833 McQuoid-Mason, '*Stransham-Ford'*. 34.

834 Suhayfa Bhamjee, 'Death and Dying in a Constitutional Democracy: An Analysis of the South African Criminal Law and a Call for Law Reform' (PHD Thesis, University of KwaZulu-Natal 2022) 88 <https://hdl.handle.net/10413/23037> accessed 29 October 2025.

835 Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying: A Canadian Approach* (Report of the Committee, 2016) 15–18.

836 Jocelyn Downie, *Dying Justice: A Case for the Decriminalization of Assisted Dying in Canada* (University of Toronto Press 2004) 93-94.

837 Sarah J Lazin and Jennifer Chandler,' Two Views of Vulnerability in the Evolution of Canada's Medical Assistance in Dying Law (2023) 32 Cambridge Quarterly of Health-care Ethics 105, 108-109.

Tiedemann, writing for the Library of Parliament, reinforces this view by noting that autonomy in end-of-life decisions reflects Canada's broader constitutional commitment to liberal democratic values, where dignity and self-determination are inseparable from freedom of choice.[838] Additionally, Downie and Chandler argue that individual autonomy in end of life decision making must be respected, but that meaningful safeguards are essential to prevent abuse, they caution that denying choice altogether risks undermining core constitutional principles of liberty and security.[839] Together, these scholarly and institutional perspectives demonstrate that autonomy is not treated as a peripheral consideration in Canada's constitutional framework, but as a cornerstone of rights-based regulation.

This comparative insight underscores the relevance for South Africa's constitutional values of dignity, privacy, and freedom of choice, which could be reinforced through carefully regulated frameworks. In South Africa, the constitutional commitment to autonomy demands a reconsideration of laws that criminalise assisted dying.[840] A rights-based framework must recognise that the freedom to choose death in the face of unbearable suffering is not a negation of life, but an affirmation of dignity and self-determination. This reasoning inevitably extends to the constitutional right to privacy, which protects the sphere of personal decision-making against unwarranted state intrusion. It is within this private domain that individuals make profound choices about their bodies and medical treatment, and it is here that the debate on assisted dying must be situated if constitutional values are to be given full effect.

5.2.4 The right to privacy and personal decision-making at the end of life

Section 14 of the South African Constitution guarantees that "everyone has the right to privacy," which includes the right to make deeply personal decisions free from state interference.[841] In the context of end-of-life care, this right encompasses decisions about medical treatment, bodily integrity, and the timing and manner of death.[842]

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838 Marlisa Tiedemann, Medical Assistance in Dying in Canada After *Carter v Canada* (Library of Parliament Research Publication No 2019-43-E, revised 2024) 12–14.

839 Downie and Chandler, *Interpreting Canada's Medical Assistance in Dying* 31.

840 Willem A Landman, *End of Life Decisions and the Law: A Case for Statutory Legal Clarity and Reform in South Africa* (Globethics.net Focus Series, 2012) 136.

841 Constitution of the Republic of South Africa, 1996 s 14.

842 McQuoid-Mason, 'Doctor Assisted Suicide' 527.

Privacy is not limited to informational or spatial boundaries it extends to autonomy in intimate life choices.[843] In *Minister of Justice and Constitutional Development v Prince*, the Constitutional Court affirmed that privacy includes the right to make personal lifestyle decisions, even where those decisions challenge prevailing legal norms.[844] Although *Prince* did not address assisted dying directly, it's broad interpretation of privacy supports the view that decisions about end-of-life choice may fall within the protected sphere of personal autonomy.[845] However, any such claim remains subject to the general limitations clause in section 36 of the Constitution, and cannot be read as establishing an unqualified right to assisted dying.[846]

Legal scholars Jordaan and Steinmann argue that the right to privacy must be interpreted in conjunction with dignity and bodily integrity, especially in cases involving terminal illness.[847] Denying individuals the ability to make end-of-life decisions may constitute an unjustifiable intrusion into their private lives and violate their constitutional rights.

While Canadian law does not explicitly frame MAiD as a right to privacy, the protection of bodily integrity, freedom of self-determination and the inviolability or deeply personal medical choices functions analogously, ensuring that individuals retain control over decisions that intimately affect their physical and existential well-being. Canadian ethicist Kim critiques the MAiD regime as operating on an 'autonomy-only' model, he argues that the law treats death as a matter of personal choice rather than purely medical necessity, highlighting that the decision to die is deeply private.[848] Similarly, McGuinty describes a 'radical autonomy' in Canadian constitutional law, a view that sees self-determination as a private, subjective freedom rather than something rooted in shared moral frameworks.[849]

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843 Currie and De Waal, *The Bill of Rights Handbook* 254–256.

844 *Prince* para 112.

845 Currie and De Waal, *The Bill of Rights Handbook para* 112.

846 Constitution of the Republic of South Africa, 1996, s 36.

847 Jordaan, 'The Legal Validity of an Advance Refusal of Medical Treatment' 39–43; Steinmann, 'Law and Human Dignity' 213.

848 Scott T H Kim, 'Assisted Dying in Canada: Ideology Masquerading as Medicine?' (2025) 8(4) Canadian Journal of Bioethics/ Revue canadienne de bioethique 21, 21-29 & 21-22 <https://doi.org/10.7202/1121332ar> accessed 13 June 2025.

849 Dylan McGuinty, 'Radical Autonomy in Supreme Court of Canada Jurisprudence' in Jaro Kotalik and David W Shannon(eds), *Medical Assistance in Dying (MAiD) in Canada: Key Multidisciplinary Perspective*s (Springer, 2023) ch 1, 13-14.

Taken together, these scholarly perspectives suggest that Canada's MAiD regime conceptualises assisted dying through the lens of privacy like interests, privileging confidentiality and respect for personal decision. However, because both scholars are critical, this interpretation should be seen as contested rather than definitive.

For South Africa, this comparative insight suggests that privacy should be recognised not only as a shield against state intrusion but also as an enabling right that empowers individuals to make deeply personal end-of-life decisions within a regulated framework. Yet these rights are not absolute, the Constitution itself requires that they be balanced against competing interests through the general limitations clause in section 36.

5.2.5 Section 36: limitation of rights in the context of assisted dying

Any proposed statutory framework for physician assisted suicide or euthanasia in South Africa must be analysed through the Section 36 limitations framework. The South African Constitution provides that rights may be limited only if the limitation is "reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom".[850] This proportionality test requires the state to justify any infringement of constitutional rights, including those implicated in assisted dying.[851] The Constitutional Court's articulation of section 36 highlights factors such as the nature of the right, the importance and purpose of the limitation, the relationship between the limitation and its purpose, and whether safeguards could achieve the same objectives without imposing disproportionate burdens, an analysis that maps directly onto end-of-life contexts where dignity, autonomy, privacy, and vulnerability are in tension.[852]

It is important to highlight that Section 36 operates bidirectionally.[853] Legalisation of assisted dying may enhance autonomy, but it also implicates the state's protective responsibilities under section 11 (right to life), section 12(1)(c) (freedom from

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850 Constitution of the Republic of South Africa, 1996 s 36(1).

851 *Makwanyane* paras 100–104; *Prince* paras 108–110.

852 Constitution of the Republic of South Africa, 1996 s 36(1).

853 *Carmicheal v Minister of Safety and Security* 2001(4) SA 938 (CC); *Makwanyane* paras 117-118 *(*discusses the state's duty to protect life*); S v Manamela 2000 (3) SA 1 (CC) paras 32-36 (clarifies how section 36 operates as a structured proportionality inquiry.*

violence), and the conscience rights of healthcare practitioners, acknowledging these tensions demonstrates that proportionality requires balancing competing constitutional interests, not simply expanding autonomy. [854]

In *Stransham-Ford*, the High Court applied section 36 to conclude that denying physician-assisted death unjustifiably infringed the applicant's rights to dignity and autonomy.[855] Although the judgment was later set aside on procedural grounds, and carries no precedential value, its reasoning remains influential, within public debate and constitutional scholarship at a discursive level rather than authoritative.[856]

The South African Law Reform Commission Discussion Paper 71 Project 86 recognises this constitutional constraint and specifically frames its law reform options, including proposed provisions and safeguards as matters to be assessed through a constitutional balancing exercise.[857] Section 36 jurisprudence also recognises positive constitutional obligations.[858] Where a blanket prohibition disproportionately harms terminally ill individuals, persons with degenerative conditions, or those without access to adequate palliative care, the state may be constitutionally obliged to regulate assisted dying in a manner consistent with dignity, equality, and freedom.

Doctrinal scholarship evaluates whether consent based or statutory safeguard regimes can be justified under the Section 36 limitation analysis. Krause argues that consent as a justificatory ground must be read in constitutional terms, linking dignity, privacy and autonomy, and assessed against the limitations test.[859] Grove applies a proportionality approach and concludes that legalisation may be constitutionally permissible only if rigorous safeguards can demonstrably reduce the risk of abuse.[860]

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854 Constitution of the Republic of South Africa, 1996 s 15 *(fr*eedom of religion, belief and opinion); *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC) para 35 (recognising freedom of belief and conscience in constitutional balancing).

855 *Stransham-Ford (*GP) para 26.

856 *Estate Stransham-Ford* (SCA) paras 13, 44.

857 *SARLC*, *Euthanasia and the Artificial Preservation of Life* ch 3, 28-48.

858 Constitution of the Republic of South Africa, 1996 s 36.

859 Samantha Krause, 'Going gently into that goodnight: The constitutionality of consent in cases of euthanasia' (2012) Obiter 33(1) 47, 59-61. <https://obiter.mandela.ac.za/article/download/12181/17191/72859> accessed 12 September 2025.

860 Grove, 'Framework for the Implementation of Euthanasia in South Africa' 154-167.

Brink's study gives a clear doctrinal primer on the South African proportionality test and employs a comparative lens by examining developments in Canadian jurisprudence, most notably the reasoning in *Carter v Canada (AG)*.[861] He suggest that Canada's section 1 analysis, balancing dignity, autonomy and vulnerability, may provide useful comparative insights for South Africa's section 36 framework, illustrating how proportionality reasoning can inform debates on whether a blanket prohibition on assisted dying could be constitutionally justifiable.

Additionally, Grové contends that the Constitution could be interpreted as permitting, and potentially requiring, the legalisation of voluntary euthanasia in South Africa, provided sufficient, robust safeguards (e.g. capacity assessments, independent medical opinions, and procedural oversight) are implemented,[862] which aligns with a less restrictive means approach under section 36. Canada's constitutional framework offers a useful model, for understanding how limitation clauses can be employed to reconcile individual rights with the state's protective obligations. Section 1 of the Canadian Charter of Rights and Freedoms provides that rights are guaranteed "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."[863] This clause has been interpreted through the *Oakes test*, which requires that any limitation pursue a pressing and substantial objective, be rationally connected to that objective, impair rights minimally, and balance benefits against deleterious effects.[864]

In the context of medical assistance in dying (MAiD), Parliament's legislative response following judicial scrutiny sought to ensure compliance with section 1 by embedding safeguards such as independent medical assessments, written requests, and mandatory reporting.[865] Scholarly commentary has underscored that these safeguards reflect the proportionality demanded by section 1, autonomy and privacy are preserved while vulnerable persons are protected.[866]

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861 Brink, 'The Case for Assisted dying/euthanasia in South Africa' 78-89.

862 Grové, 'Framework for the Implementation of Euthanasia in South Africa' 78–82.

863 Canadian Charter of Rights and Freedoms, s 1.

864 *R v Oakes* [1986] 1 SCR 103, 136–139.

865 Department of Justice Canada, *Legislative Background* M*edical Assistance in Dying* (Bill C-14 as assented on 17 June 2016) 12–15. <https://publications.gc.ca/site/eng/9.820692/publication.html> accessed 12 March 2024.

866 Special Joint Committee on Physician Assisted Dying, *Medical Assistance in Dying: A Canadian Approach* (Report of the Committee, 2016) 20–23.

Marlisa Tiedemann notes that Canada's approach illustrates how limitation analysis can transform rights into workable policy, ensuring that restrictions are narrowly tailored and constitutionally justified.[867]

In South Africa, the proportionality framework under section 36 suggests that the state is constitutionally obliged to reassess its position on euthanasia and end-of-life choices. Implementing a regulated framework that respects dignity, autonomy, and privacy while protecting the vulnerable could better satisfy constitutional requirements, though this remains a matter of ongoing scholarly and judicial debate.[868]

5.3 South African case law towards a constitutional basis for euthanasia

A constitutional analysis of euthanasia in South Africa must be grounded not only in abstract rights but in the interpretive trajectory of the courts. Jurisprudence plays a pivotal role in shaping the boundaries of bodily autonomy, dignity, and medical decision-making. This section examines key South African cases that, while not directly legalising euthanasia, have incrementally built a constitutional foundation for its recognition. These cases *Stransham-Ford*, *Clarke v Hurst NO*, *S v Hartmann*, *Soobramoney*, *Prince*, and the *Harck and Walters* application demonstrate how courts have grappled with the ethical and legal complexities of end-of-life decisions. Each judgment reflects a growing judicial willingness to prioritise personal autonomy and human dignity, even in morally contested domains.

867 Marlisa Tiedemann, *Assisted in Dying in Canada After Carter v Canada (*Library of Parliament, Publication No 2019-43-E, 2019, revised 19 March 2024) 14–16 <https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/201943E> accessed 12 June 2025.

868 SALRC, *Euthanasia and the Artificial Preservation of Life* paras 2.1–2.5.

5.3.1 Stransham-Ford v Minister of Justice and Correctional Services 2015 (4) SA 50 (GP)[869]

The High Court held that denying physician-assisted death violated rights to dignity (s 10), bodily integrity (s 12(2)(b)), and privacy (s 14). Judge Fabricius emphasised that the state's interest in preserving life must be balanced against the individual's right to avoid unbearable suffering. Although the Supreme Court of Appeal later set aside the order on procedural grounds, as a result, the case did not establish any legal precedent for the legalisation of assisted dying in South Africa.[870] The current legal position remains that active voluntary euthanasia and physician-assisted suicide are unlawful.[871]

Stransham-Ford shows how constitutional rights can be read together to support assisted dying under safeguards. It suggests that a future framework could legitimately balance state interests with individual autonomy.

5.3.2 S v Hartmann 1975 (3) SA 532 (c)

In *S v Hartmann*, the accused a medical doctor was convicted of culpable homicide after administering a lethal injection to his terminally ill father.[872] The court acknowledged the compassionate motives behind the act but reaffirmed that active euthanasia remains unlawful under South African criminal law.[873] Despite the absence of malicious intent, the court held that the act constituted unlawful killing, reinforcing the legal distinction between passive and active euthanasia.[874]

Although decided before the advent of South Africa's constitutional democracy, *Hartmann* remains influential. It underscores the need for statutory reform to reconcile compassionate medical practice with constitutional rights.[875]

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869 McQuoid-Mason, 'Doctor Assisted Suicide' 527.
870 *Stransham-Ford (GP)*; Estate *Stransham-Ford* 2016 ZA SCA 197.
871 South African common law position on unlawful killing; cf. *Stransham-Ford v Minister of Justice and Correctional Services 2015* (4) SA 50 (GP).
872 *Hartmann* 534A–C.
873 *Hartmann* 535D–F.
874 *Hartmann* 536B–C.
875 Landman, *End of Life Decisions and the Law* 136.

Legal scholars argue that the case exemplifies the ethical tension between medical duty and criminal liability, and that a rights-based framework could offer clearer guidance.[876]

5.3.3 Clarke v Hurst NO and Others 1992 (4) SA 630 (D)

In *Clarke v Hurst NO*, the court was asked to determine whether life-sustaining treatment could be withdrawn from a patient in a persistent vegetative state, in accordance with his living will.[877] The applicant's wife sought legal authorisation to discontinue artificial feeding, arguing that continued treatment violated her husband's dignity and autonomy.[878] The court held that the sanctity of life must be balanced against the quality of life and the patient's previously expressed wishes.[879] Thirion J recognised that dignity is a constitutional value and that preserving biological life at all costs may not serve the best interests of the patient.[880] Although the case did not involve active euthanasia, it affirmed the principle that medical decisions must respect patient autonomy and dignity.[881]

Legal scholars view *Clarke* as a foundational case in South African end-of-life jurisprudence.[882] The case demonstrates judicial willingness to interpret common law in consideration of constitutional values, particularly where continued treatment offers no therapeutic benefit and contradicts the patient's will.

5.3.4 Soobramoney v Minister of Health (KwaZulu-Natal) 1998 (1) SA 765 (CC)

In *Soobramoney*, the Constitutional Court considered whether a terminally ill patient had a right to access dialysis treatment under section 27 of the Constitution, which guarantees access to health-care services.[883]

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876 Hennie Oosthuizen, 'Doctors Can Kill: Active Euthanasia in South Africa' (2003) 22(3) Medicine and Law 551,551-560.

877 *Clarke v Hurst* 632B–C.

878 *Clarke v Hurst* 633F–634B.

879 *Clarke v Hurst* 638D–639C.

880 *Clarke v Hurst* 640A–C.

881 *Clarke v Hurst* 643E–644A.

882 McQuoid-Mason, 'Doctor-assisted suicide' 527; Kotzé and Roos, 'End-of-life care in South Africa' a1748, PDF 1-3.

883 *Soobramoney v Minister of Health (KwaZulu-Natal*) 1998 (1) SA 765 (CC) para 17 (hereafter cited *Soobramoney*).

The applicant, suffering from irreversible kidney failure, argued that the hospital's refusal to provide treatment violated his constitutional rights.

The Court held that the right to healthcare is subject to resource constraints and that the hospital's rationing policy was reasonable and consistent with section 27(2).[884] The judgment emphasised that constitutional rights are not absolute and must be balanced against practical limitations.[885] Although *Soobramoney* did not involve euthanasia directly, it is significant for end-of-life jurisprudence. It illustrates how courts interpret constitutional rights in the context of medical necessity, resource allocation, and ethical decision-making.[886] The case also highlights the tension between individual rights and systemic constraints a recurring theme in assisted dying debates. Legal scholars argue that *Soobramoney* underscores the need for clear statutory guidance on end-of-life care, particularly where medical futility intersects with constitutional values such as dignity and autonomy.[887]

5.3.5 Minister of Justice and Constitutional Development v Prince 2018 (6) SA 393 (CC): reinforcing the right to privacy and autonomy

South African jurisprudence has increasingly recognised the constitutional dimensions of personal autonomy in lifestyle and bodily decisions. In *Minister of Justice and Constitutional Development and Others v Prince*, the Constitutional Court affirmed the right of adults to use and cultivate cannabis in private, grounding its reasoning in the constitutional rights to privacy and autonomy.[888] This progressive interpretation illustrates the Court's willingness to protect intimate personal choices, even where such choices challenge entrenched moral and legal norms.

884 *Soobramoney* paras 20–25.
885 Constitution of the Republic of South Africa, 1996 s 27(2).
886 Tebogo Maputla, 'End-of-Life Decision-Making in South Africa: A Constitutional Perspective' (2018) 135 SALJ 256, 260–262.
887 Landman, *End of Life Decisions and the Law* 136.
888 *Prince* para 108.

In *Prince*, the Constitutional Court held that the criminalisation of the private use of cannabis unjustifiably infringed the right to privacy under section 14 of the Constitution.[889] The Court reasoned that personal decisions made in private spaces particularly those relating to bodily autonomy deserve constitutional protection.[890]

Although the case did not concern end-of-life decisions, its reasoning is directly relevant to euthanasia jurisprudence. The Court affirmed that the state may not intrude upon deeply personal choices unless such interference is justified under section 36.[891] This principle supports the argument that decisions about assisted dying, when made voluntarily and competently, fall within the protected sphere of personal autonomy and privacy.[892] Legal commentators have explicitly drawn parallels between *Prince* and euthanasia, noting that both involve intimate decisions about decisions on privacy, autonomy and debates about one's body and lifestyle. [893]

5.3.6 The Court Application Brought by Harck and Walters

The High Court application brought by Harck and Walters reflects contemporary pushes for legal reform in South Africa, seeking judicial recognition of physician-assisted suicide and euthanasia under constitutional protections.[894] In their application, Harck, who suffers from motor neuron disease, and Walter, a palliative care practitioner diagnosed with multiple myeloma, requested the court to order government to enact legislation permitting terminally ill persons, under strict safeguards, to end their lives.[895] The case foregrounds questions of autonomy, dignity, and relief from suffering. From a constitutional standpoint, this application illustrates both the demand side (the suffering of terminally ill people seeking dignity and choice) and the state side (the constraints posed by legal, ethical, public health, and resource limitations).[896]

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889 *Prince* para 108.
890 *Prince* paras 112–113.
891 Constitution of the Republic of South Africa, 1996 s 36(1).
892 Constitution of the Republic of South Africa s 14.
893 *Justice and Constitutional Development v Prince*' (2020) 10 Constitutional Court Review 401; Kotzé and Roos, 'End-of-life care in South Africa' a1748.
894 Medical Brief, 'First evidence heard in Gauteng High Court "right to die" case' *Medical Brief* (Johannesburg, 2021) <https://www.medicalbrief.co.za/first-evidence-heard-in-gauteng-high-court-right-to-die-case/> accessed August 2025.
895 Medical Brief, 'First evidence heard in Gauteng High Court "right to die" case'.
896 *Soobramoney.*

The application was opposed by the Health Professions Council of South Africa (HPCSA).[897] This opposition reflects a broader tension already noted in Chapter three regarding South Africa's health system. The HPCSA argued that existing legal frameworks permit the lawful withdrawal of futile treatment, but that active assisted dying would conflict with medical ethics.[898] They further cautioned that legalising assisted suicide could lead to abuse, a position reported in the coverage of Diethelm Harck's case.[899] These concerns are particularly significant in the South African context, where the health-care sector remains deeply constrained by inequalities in access, under-funding, and limited palliative care infrastructure as discussed earlier in chapter three.[900]

The Centre for Applied Legal Studies (CALS), a human rights organisation based at the Wits School of Law, was admitted as *amicus curiae* in the *Harck and Walters* application,[901] filing a notice of motion and providing comparative evidence from jurisdictions where assisted dying is legally regulated, such as the Netherlands, Canada, and the state of Oregon in the United States.[902] This intervention ensured that the South African court had before it not only the applicants' constitutional arguments based on dignity and autonomy, but also practical insights into how foreign legal systems have operationalised assisted dying within ethical and regulatory frameworks.[903]

Dr Walter and Mr Harck both argued that the current prohibition on euthanasia violated their constitutional rights, particularly the right to dignity and the right to freedom from inhuman and degrading treatment.[904]

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897 Tania Broughton, 'A dying man makes the case for legalising euthanasia' (GroundUp, 1 March 2021) <https://groundup.org.za/article/case-made-legalising-euthanasia/> accessed August 2025.

898 Health Professions Council of South Africa, *Guidelines for the Withholding and Withdrawing of Treatmen*t (Booklet 7, revised March 2023).

899 Broughton, 'A dying man makes the case for legalising euthanasia'.

900 See Chapter Three of this dissertation.

901 Centre for Applied Legal Studies (CALS), <https://www.wits.ac.za/cals/ > accessed 10 August 2025.

902 Centre for Applied Legal Studies (CALS), 'CALS joins landmark case on assisted dying' (Wits University, 10 June 2019).

903 Centre for Applied Legal Studies, 'Hearing of Witness Testimony on Assisted Dying Set to Begin' (Wits University, 24 November 2021) <https://www.wits.ac.za/news/sources/cals-news/2021/hearing-of-witness-testimony-on-assisted-dying-set-to-begin.html> accessed August 2025.

904 *Walter and Others v Minister of Health and Others* case number 31396/2017 (Gauteng High

As of 2026, the Harck and Walter application remains pending before the Gauteng High Court. Evidence has been heard by way of a *commission of de bene esse* before retired Judge CJ Claassen, but no final judgment has yet been delivered.[905] The prohibition on euthanasia and physician-assisted suicide therefore continues to reflect the current legal position in South Africa.

South African case law has laid important foundations for a constitutional discourse on euthanasia, particularly through decisions such as *Clarke v Hurst* and *Stransham-Ford v Minister of Justice*, which foregrounded dignity, autonomy, and the limits of criminal liability in end-of-life contexts. Yet, despite these developments, the jurisprudence remains fragmented, has not been consolidated by legislation, and therefore continues to leave significant gaps in the legal regulation of end-of-life choices.

To enrich this analysis, it is instructive to turn to comparative case law from Canada, where courts have engaged directly with constitutional rights in the context of medical assistance in dying (MAiD). Some of these Canadian cases were discussed previously in the section on Canada's constitutional framework and will be recapped here for comparative analysis. Canadian jurisprudence provides a coherent framework for balancing autonomy, dignity, and privacy with the state's protective obligations, offering valuable lessons for South Africa's evolving constitutional debate.

The case of Ian von Memerty, a South African television personality who succeeded in ending his life in February 2026 after publicly documenting his decision on Facebook, adds a further dimension to the constitutional debate. Von Memerty distinguished his act of 'self-deliverance' from euthanasia and assisted dying, emphasising that it was not rooted in terminal illness but in his desire to die on his own terms.[906]

Court).

905 Zelda Venter, 'Legal challenge for assisted suicide, euthanasia for terminally ill patients under spotlight' *Pretoria News* (IOL, 1 February 2022) <https://www.iol.co.za/pretoria-news/legalising-assisted-suicide-euthanasia-for-terminally-ill-patients-under-spotlight> accessed August 2025; CALS, 'Hearing of Witness Testimony on Assisted Dying Set to Begin' (Wits University, 24 November 2021) <https://www.wits.ac.za/news/sources/cals-news/2021/hearing-of-witness-testimony-on-assisted-dying-set-to-begin.html> accessed August 2025; Broughton, 'A dying man makes his case for legalising euthanasia'.

906 News24, 'TV personality Ian von Memerty dies at 61 in "act of self-deliverance"'

This illustrates the danger of a slippery slope: once autonomy alone becomes the justification, end-of-life choices risk extending beyond medical necessity to personal preference. Read alongside the Harck and Walters application, von Memerty's case demonstrates the complexity of balancing dignity, autonomy, and vulnerability in South Africa's evolving discourse.

5.4 Canadian case law in the development of physician assisted dying (MAiD)

Canadian case law has played a pivotal role in shaping the constitutional foundations of medical assistance in dying. Beginning with *Rodriguez v British Columbia (Attorney General)*, the Supreme Court initially upheld the criminal prohibition on assisted dying under section 241(b) of the Criminal Code, emphasising the state's interest in protecting vulnerable persons.[907] However, this restrictive approach was later overturned in *Carter v Canada (Attorney General)*, where the Court recognised that an absolute ban violated the Charter rights to life, liberty, and security of the person, and that autonomy and dignity required a carefully regulated framework.[908]

More recently, *Truchon v Canada (Attorney General)* extended the scope of MAiD by striking down eligibility criteria that limited access to those whose death was "reasonably foreseeable," not just imminent death, thereby reinforcing the principle that personal decision-making at the end of life is constitutionally protected.[909] Collectively, these cases illustrate how Canadian courts have interpreted constitutional rights to embed autonomy, privacy, and dignity within a regulated end-of-life regime, providing a persuasive comparative model for South Africa.

News24 (1 March 2026) <https://www.news24.com/life/arts-and-entertainment/celebrities/tv-personality-ian-von-memerty-dies-at-61-in-act-of-self-deliverance-20260301-0967> accessed 31 March 2026; Kathryn Kimberley, 'Arts celebrity Ian von Memerty ends his life at hotel In Johannesburg' *TimesLIVE* (1 march 2026) <https://timeslive.co.za/news/2026-03-01-arts-celebrity-ian-von-memerty-ends-his-life-at-hotel-in-johannesburg/> accessed 2 March 2026; Debashine Thangevelo 'Ian von Memerty dies at 61:tributes pour in for South African theatre and TV legend' *IOL*(1 March 2026) <https://iol.co.za/entertainment/celebrity-news/2026-03-01-ian-von-memerty-dies-at-61-tributes-pour-in-for-south-african-theatre-and-tv-legend/> accessed 2 March 2026; Thami Kwazi, 'shock and sorrow as beloved TV host Ian von Memerty's tragic death details emerge' *The Citizen* (2 March 2026) <https://www.citizen.co.za/lifestyle/entertainment/celebrity-news/shock-and-sorrow-as-beloved-tv-host-ian-von-memertys-tragic-death-details-emerge/> accessed 2 March 2026.

907 *Rodriguez* paras 126-134.

908 *Carter* 331.

909 *Truchon v Canada (Attorney General)* 2019 QCCS 3792 (hereafter cited Truchon).

5.4.1 Rodriguez v British Columbia (AG) [1993] 3 SCR 519: The Precursor to Carter

In *Rodriguez v British Columbia* (AG), the Supreme Court of Canada upheld the criminal prohibition on assisted suicide under section 241(b) of the Criminal Code.[910] The appellant, Sue Rodriguez, suffered from amyotrophic lateral sclerosis (ALS) and sought the legal right to end her life with medical assistance.[911] The majority held that while the prohibition infringed her rights under section 7 of the Canadian Charter (life, liberty, and security of the person), the infringement was justified under section 1.[912] The Court reasoned that protecting vulnerable persons and preserving life were sufficient justifications for the blanket ban.[913]

However, the dissenting opinions particularly that of Justice Cory emphasised the importance of autonomy and dignity in end-of-life decision-making.[914] These dissenting views laid the groundwork for the Court's later reversal in *Carter v Canada*, where the prohibition was found unconstitutional.[915] *Rodriguez* remains a landmark case in Canadian constitutional law. It illustrates the evolution of judicial thinking on assisted dying and highlights the tension between state interests in protecting life and individual rights.[916] Viewed from a South African perspective, the case offers a cautionary tale about the limits of judicial deference and highlighting the need to ensure that legal doctrine remains grounded in lived experience and constitutional values.

5.4.2 Carter v Canada (Attorney General) 2015 SCC 5, [2015] 1 SCR 331: A constitutional turning point

In *Carter v Canada*, the Supreme Court unanimously held that the blanket prohibition on physician-assisted dying violated section 7 of the Canadian Charter, which protects life, liberty, and security of the person.[917] The Court found that the law compelled individuals to endure intolerable suffering or to end their lives prematurely, thereby

910 *Rodriguez* paras 126-134.
911 *Rodriguez* paras 522–524.
912 *Rodriguez* paras 553–556.
913 *Rodriguez* paras 577–579.
914 *Rodriguez* paras 618–620 (Cory J, dissenting).
915 *Carter* para 89.
916 *Rodriguez* paras 133-140, 146-149.
917 *Carter* para 63.

infringing their rights in a manner that was not justified under section 1.[918] The decision marked a constitutional turning point. It recognised that autonomy and dignity are central to the right to make fundamental life choices, including the decision to die in circumstances of grievous and irremediable suffering.[919] The Court emphasised that a carefully designed regulatory framework could protect vulnerable persons while respecting individual rights.[920] *Carter* built on the dissenting reasoning in Rodriguez, affirming that the state's interest in preserving life must be balanced against the individual's right to self-determination.[921] The ruling led to the enactment of Canada's MAiD legislation in 2016, which legalised assisted dying under strict eligibility and procedural safeguards.[922]

For South Africa, *Carter* offers a persuasive comparative model. It demonstrates how constitutional rights particularly dignity, autonomy, and security of the person can be relied upon to justify legal reform in end-of-life care.[923]

5.4.3 Truchon and Gladu v Attorney General of Canada 2019 QCCS 37992: extending the scope of MAiD

The decision in *Truchon and Gladu v Attorney General of Canada* represents a critical evolution in the Canadian jurisprudence on assisted dying.[924] Jean Truchon and Nicole Gladu, both living with serious but non terminal degenerative conditions, challenged the constitutionality of section 241.2(2)(d) of the Criminal Code, which restricted access to medical assistance in dying (MAiD) to individuals whose natural death was "reasonably foreseeable".[925] They argued that the provision violated sections 7 and 15 of the Canadian Charter of Rights and Freedoms, which protects the rights to life, liberty and security of the person and the right to equality.[926]

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918 *Carter* paras 89–91.
919 *Carter* para 127.
920 *Carter* para 105.
921 *Rodriguez* paras, 618–620 (Cory J, dissenting).
922 Government of Canada, 'Medical Assistance in Dying' (2023).
923 Landman, *End of Life Decisions and the Law* 136.
924 *Truchon c Procureur general du Canada* 2019 QCCS 3792 (hereafter cited *Truchon*).
925 *Truchon* paras 20-45, 678.
926 Canadian Charter of Rights and Freedoms, ss 7,15; *Truchon* paras 6-10.

The Quebec Superior Court ruled in their favour, finding that the "reasonably foreseeable" death requirement imposed an unjustified limitations on fundamental rights, particularly for individuals suffering intolerably but not an at an immediate risks of death.[927] Justice Baudouin held that the restrictions infringed the applicants' dignity, autonomy and bodily integrity, noting that it forced them to endure unnecessary suffering and undermined their personal agency in medical decision making.[928] The ruling extended the interpretation of *Carter*, affirming that constitutional rights must accommodate the full spectrum of enduring grievous suffering, not just imminent death.[929] The federal government eventually responded with amendments to the MAiD regime, further liberalising eligibility criteria through Bill C-7 in 2021.[930]

The *Truchon* decision is particularly instructive for South Africa, as it illustrates the constitutional expansion of assisted dying rights in response to evolving medical realities and individual needs. It also reflects a shift away from death -based thresholds to suffering based criteria, rooted in autonomy and dignity. As South Africa contemplates whether and how to develop an assisted dying framework, *Truchon* demonstrates the legal and ethical necessity of avoiding arbitrary exclusions that disproportionately burden those with chronic, disabling but non-terminal conditions.

The legal cases examined reveal a persistent tension between the protection of life and the constitutional imperatives of dignity, autonomy, and freedom. South African jurisprudence has thus far demonstrated cautious judicial engagement with the right to die, whereas Canadian courts have adopted a more progressive constitutional interpretation, affirming the legality of assisted dying within a human rights framework. Collectively, these cases underscore the need for South Africa to move beyond ad hoc judicial reasoning and towards a coherent medico-legal framework capable of balancing individual rights with adequate procedural safeguards.

Yet judicial interpretation alone cannot establish a comprehensive regulatory regime. As comparative jurisprudence illustrates, courts often mirror broader societal ambivalence and institutional limitations.

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927 *Truchon* paras 60-75.
928 *Truchon* paras 70-75.
929 *Truchon* paras 70-80
930 Canada, House of Commons, Bill C-7*, An Act to amend the Criminal Code* (medical assistance in dying) 2nd Sess, 43rd Parl, 2021.

Accordingly, attention must also turn to legislative instruments and statutory bodies that guide medical practice and policy development. The case law discussed highlights the judiciary's cautious but evolving engagement with the complex legal, ethical, and constitutional dimensions of euthanasia. While these rulings have not yet produced legislative reform, they demonstrate judicial recognition of the tension between criminal liability and the constitutional rights to dignity, autonomy, and bodily integrity at the end of life.

The Canadian jurisprudence, from *Rodriguez* through *Carter* and *Truchon*, illustrates how courts have grappled with the tension between protecting vulnerable persons and affirming autonomy and dignity at the end of life. While Canada has moved towards a constitutionally entrenched framework for medical assistance in dying, South Africa has yet to resolve this debate. These comparative lessons highlight both the risks and possibilities of reform, but the ultimate question remains how South Africa's own constitutional values dignity, autonomy, privacy, and the protection of life should be balanced. It is to this domestic debate, between proponents and opponents of legalisation, that the next section now turns.

5.5 Towards a constitutionally grounded framework for euthanasia and assisted dying in South Africa: proponents and opponents in debate

The preceding analysis reveals a growing constitutional basis for the legalisation of assisted dying in South Africa. Rights to dignity (s 10), autonomy and bodily integrity (s 12(2)(b)), and privacy (s 14) form the normative core of this foundation.[931] These rights are not abstract ideals they are actionable entitlements that demand legal recognition, particularly in the context of terminal illness and unbearable suffering.

Case law such as *Stransham-Ford*, *Clarke,* and *Prince* demonstrates judicial willingness to interpret common law in light of constitutional values.[932] Although the courts have stopped short of legalising euthanasia, their reasoning affirms that personal decisions about death fall within the protected sphere of constitutional rights.[933]

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931 Constitution of the Republic of South Africa, 1996 ss 10, 12(2)(b) 14.
932 *Stransham-Ford* (GP), *Clarke v Hurst; Prince*.
933 McQuoid-Mason, 'Doctor Assisted Suicide' 527.

The South African Law Reform Commission's Discussion Paper 71 provides a legislative blueprint that remains relevant.[934] Its proposed regulatory framework grounded in medical oversight, ethical review, and procedural safeguards can be adapted to meet constitutional standards.[935]

The scholarly debate on euthanasia in South Africa reveals a profound tension between constitutional imperatives and moral pluralism. Proponents emphasise that rights to dignity, autonomy, and privacy demand legal recognition of assisted dying, particularly in cases of terminal illness and unbearable suffering.[936] They argue that a regulated framework, grounded in safeguards and medical oversight, would provide clarity and uphold constitutional values.

Opponents, however, caution that legalisation of euthanasia may undermine respect for life and expose vulnerable patients to coercion. South Africa is rooted in a complex interplay of religious doctrine, cultural norms, medical ethics, and legal conservatism.[937] Religious scholars such as Denson and Van der Walt argue that euthanasia may be perceived as incompatible with dominant faith traditions, including Christianity, Islam, and African customary beliefs,[938] and warn that reform must be sensitive to these convictions, to avoid moral backlash.[939]

In the Harck and Walters application, counsel for the HPCSA similarly warned that legalising assisted dying could expose patients to exploitation, with the court hearing that "patients would be vulnerable to unscrupulous doctors and relatives".[940]

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934 SALRC, *Euthanasia and the Artificial Preservation of Life* paras 2.1–2.5.

935 Landman, *End of Life Decisions and the Law* 136.

936 Jordaan, 'Human Dignity and the Future of the Voluntary Active Euthanasia' 386;
Fundisiwe C Ntsebesha, 'The Legalisation of Physician-Assisted Suicide: A South African Constitutional Perspective' (LLM thesis, University of Johannesburg 2023) 52 <https://hdl.handle.net/10210/512638> accessed 11 November 2025;
McQuoid-Mason, 'Doctor Assisted Suicide' 526;
Landman, End of Life Decisions and the Law 136;
White and Willmott, *International Perspectives on End-of-Life Law* 250.

937 Razaana Denson and Glynis Van der Walt, 'Euthanasia in South Africa: Critical Analysis of Contemporary Legislative Issues in Relation to Religious Values' (2025) 8(2) Ulul Albab: Jurnal Studi dan Penelitian Hukum Islam 231, 231 <https://doi.org/10.30659/jua.v8i2.42182> accessed 10 January 2026.

938 Denson and Van der Walt, 'Euthanasia in South Africa' 236-238.

939 Denson and Van der Walt, 'Euthanasia in South Africa' 236-239.

940 Tania Broughton, 'Right to die: patients would be vulnerable to unscrupulous doctors and relatives, judge hears' *GroundUp* (CapeTown,4 March 2021) <https://groundup.org.za/article/legalising-euthanasia-would-leave-patients-without-protection-unscrupulous-doctors-and-family-members-commission-hears/> accessed 12 May 2025.

Steinmann cautions that decriminalisation might erode the constitutional value of human dignity and risk vulnerability to coercion.[941]

Medical professionals also express concern about the psychological burden of participating in assisted dying. Oosthuizen highlights the ethical dilemma faced by doctors who are trained to preserve life, not end it,[942] and argues that without clear legal protections and ethical guidelines, practitioners may be exposed to criminal liability or moral distress.[943]

Comparative experience, particularly in Canada, demonstrates that robust safeguards can mitigate risks while respecting individual rights.[944] In *Carter v Canada*, the Supreme Court outlined a regulatory framework that includes eligibility criteria, independent medical assessments, and oversight mechanisms, which have been effective in preventing abuse.[945]

While South Africa must chart its own path, these comparative lessons suggest that constitutional values of dignity and autonomy can be reconciled with protections for the vulnerable. In this sense, the constitutional debates on assisted dying form part of a wider trajectory in which South Africa has recognised autonomy and dignity in contested areas such as reproductive choice, same-sex marriage, and transgender identity. These precedents provide a useful lens for understanding how end-of-life decisions may also be constitutionally protected.

941 Steinmann, 'Law and Human Dignity' 213.
942 Oosthuizen, 'Doctors Can Kill Active Euthanasia in South Africa' 554-560.
943 Oosthuizen, 'Doctors Can Kill Active Euthanasia in South Africa' 557-558.
944 White and Willmott, *International Perspectives on End-of-Life Law* 250.
945 *Carter* para 105.

5.6 Precedent reforms advancing bodily autonomy and dignity: abortion, same- sex marriage, and transgender recognition

While South African and comparative case law have begun to sketch the constitutional contours of euthanasia, the broader trajectory of legal reform in South Africa demonstrates that other controversial rights-based issues such as termination of pregnancy, same-sex marriage, and transgender recognition were similarly contested yet ultimately upheld through constitutional values, offering persuasive precedent for a legal framework on end-of-life choice. South Africa's constitutional democracy has, over time, embraced legal reforms that were once considered morally controversial particularly in matters concerning bodily autonomy, identity, and dignity. These reforms demonstrate the legal system's capacity to accommodate moral pluralism while prioritising constitutionally enshrined rights. They offer persuasive precedent for the development of a legal framework for euthanasia.

5.6.1 The Choice on Termination of Pregnancy Act 92 of 1996

The Choice on Termination of Pregnancy Act was enacted despite strong opposition from religious and cultural groups.[946] When challenged in court, the Act was upheld as constitutionally valid because it promoted women's rights to dignity, bodily integrity, and reproductive autonomy, values which are protected under sections 10, 12(2), and 27 of the Constitution.[947] In *Christian Lawyers Association v Minister of Health*, the court affirmed that reproductive decisions fall within the ambit of personal autonomy and access to health-care.[948] This legislative milestone set a transformative precedent for how the state balances moral objections against constitutionally protected freedoms.

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946 *Christian Lawyers' Association v Minister of Health* 1998 (4) SA 1113 (T).
advocacy groups including the United Christian Action Group and Christians for Truth challenged the constitutionality of the Act; see also
South African Law Reform Commission, *Report on the Commission's Investigation into Abortion and Related Matters* (Project 85, 1996) noting widespread opposition from religious and cultural organisations.

947 Choice on Termination of Pregnancy Act 92 of 1996.

948 *Christian Lawyers Association v Minister of Health* 1998 (4) SA 1113 (T).

5.6.2 The Civil Union Act 17 of 2006 and Same-Sex Marriage

The legal recognition of same-sex marriage through the Civil Union Act followed the Constitutional Court's landmark ruling in *Minister of Home Affairs v Fourie*.[949] The Court held that denying same-sex couples the right to marry violated their rights to equality and dignity.[950] Crucially, the Court stated that "constitutional rights are not contingent on public approval or moral consensus but must be interpreted generously to protect the dignity and autonomy of all persons".[951] This interpretive principle is directly relevant to the euthanasia debate, where moral objections must be balanced against individual rights.

5.6.3 Recognition of transgender rights

In *KOS and Another v Minister of Home Affairs*, the Western Cape High Court held that the Department of Home Affairs had no lawful basis to delay the alteration of gender markers for individuals married under the Marriage Act 25 of 1961.[952] The Court affirmed that the Alteration of Sex Description and Sex Status Act 49 of 2003 provides a clear statutory mechanism for recognising gender identity, and that marital status cannot be used to frustrate this right.[953] The judgment affirmed the applicants' rights to equality, dignity, and identity under sections 9, 10, and 12 of the Constitution.[954] The judgment reflects a broader judicial willingness to accommodate evolving understandings of person-hood and autonomy principles that resonate with the right to die with dignity.

South African scholars have drawn parallels between these reforms and the potential legalisation of euthanasia. Jordaan argues that the *Stransham-Ford* case, though overturned on procedural grounds, opened a constitutional avenue for recognising voluntary active euthanasia as a rights-based issue.[955]

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949 *Minister of Home Affairs and Another v Fourie and Another* (Doctors for Life International as Amicus Curiae); *Lesbian and Gay Equality Project and Others v Minister of Home Affairs* [2006] (3) BCLR 355 (CC); [2006] (1) SA 524 (CC) (hereafter cited *Fourie*).

950 *Fourie* 60–63.

951 *Fourie* 60–63.

952 *KOS and Another v Minister of Home Affairs and Others* 2023 (2) SA 273 (WCC) 89–92.

953 Alteration of Sex Description and Sex Status Act 49 of 2003 s 2.

954 Constitution of the Republic of South Africa, 1996 ss 9, 10, 12.

955 Jordaan, 'Human Dignity and the Future of the Voluntary Active Euthanasia' 386.

Ntsebesha's LLM thesis contends that physician-assisted suicide can be reconciled with constitutional values if regulated through a carefully regulated legal framework.[956] Conversely, Denson and Van der Walt caution that religious and cultural values remain deeply embedded in South African society, and any reform must be sensitive to these beliefs.[957] They argue that while constitutional rights are paramount, legal reform must be accompanied by public education and institutional readiness to avoid backlash and ensure ethical coherence.[958]

These scholarly perspectives confirm that the trajectory of rights-based reform in South Africa provides a persuasive foundation for recognising end-of-life autonomy.[959] These precedents suggest that a legal framework for euthanasia could similarly be developed within South Africa's constitutional order, particularly if where such a framework includes appropriate safeguards, medical oversight, and protections for conscientious objection.

5.7 Conclusion

This chapter has demonstrated that South Africa's constitutional framework provides fertile ground for the recognition of euthanasia as a legitimate end-of-life choice. By analysing rights to dignity, autonomy, privacy, and freedom of choice, alongside the interpretive tensions surrounding the right to life, it has become clear that the Constitution can accommodate ethically complex questions of assisted dying. The jurisprudence of the Constitutional Court, together with cases such as *Stransham-Ford*, *Clarke v Hurst,* and *Soobramoney*, reveals a gradual but discernible trajectory towards recognising personal decision-making at the end of life as constitutionally significant.

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956 Ntsebesha, 'The Legalisation of Physician-Assisted Suicide: A South African Constitutional Perspective '45.

957 Denson and Van der Walt, 'Euthanasia in South Africa' 231-249.

958 Denson and Van der Walt, 'Euthanasia in South Africa' 246-248.

959 *Christian Lawyers Association v Minister of Health* 1998 (4) SA 1113 (T); Charles Ngwena, 'Constitutional Values and the Choice on Termination of Pregnancy Act: An African Perspective' (1998) 14 SAJHR 1,1-3; *Minister of Home Affairs v Fourie* 2006 (1) SA 524 (CC); Pierre de Vos, 'Same-Sex Marriage, Civil Unions and Domestic Partnerships in South Africa: Critical Reflections on an Ongoing Saga' (2004) 20 SAJHR 432, 432–450; *KOS* v *Minister of Home Affairs* 2020 (2) SA 390.

Comparative insights from Canada's MAiD jurisprudence, particularly *Carter* and *Truchon and Gladu* underscore how a mature constitutional democracy can balance autonomy with safeguards for the vulnerable. These cases illustrate that legal reform in contested moral domains is not only possible but necessary to ensure that constitutional rights remain responsive to evolving social realities. South Africa's own history of constitutional accommodation in areas such as abortion, same-sex marriage, and transgender recognition further supports the argument that euthanasia can be integrated into a rights-based framework without undermining constitutional integrity.

The chapter has also highlighted the importance of scholarly reflection and moral pluralism in shaping reform. While objections and concerns must be addressed through robust safeguards, the comparative analysis suggests that constitutional democracies are strengthened, not weakened, when they confront ethical complexity directly.

Having established the constitutional foundations and comparative lessons, the dissertation now turns to Chapter Six, which offers broader reflections, recommendations, and lessons. This next chapter will synthesise the findings of the study, propose pathways for reform, and consider how South Africa may develop a constitutionally grounded framework for assisted dying that is both principled and pragmatic.

CHAPTER SIX

6. Conclusion: reflections, lessons and recommendations

6.1 Introduction

The legal, ethical, and constitutional terrain surrounding euthanasia in South Africa is complex and layered. This dissertation has traced the historical, legal, and comparative dimensions of the right to die, focusing on constitutional principles such as dignity, autonomy, privacy, and equality. It examined South Africa's legal framework, healthcare realities, and palliative care policy, alongside insights drawn from Canada's Medical Assistance in Dying (MAiD) regime. Building on this foundation, the concluding chapter distils the study's findings into reflections, lessons, and recommendations, assessing the viability of euthanasia reform through a constitutional and ethically coherent lens.

6.2 Objectives, reflections and summary of findings

This section turns to a systematic evaluation of whether the study has achieved its six objectives. The reflections are structured around the aims set out in Chapter One, showing how each chapter contributed to answering the primary research question and clarifying South Africa's readiness for euthanasia reform.

This study was guided by the primary research question: To what extent is South Africa legally, socially and institutionally ready to implement legislation on euthanasia, considering lessons from Canada's Medical Assistance in Dying (MAiD) framework?

The following reflections demonstrate how each objective has been addressed, drawing directly on the evidence developed in the preceding chapters.

i. Objective 1: To analyse the constitutional provisions in South Africa that underpin debates on euthanasia and assisted dying, with particular emphasis on the rights to dignity, life, autonomy and privacy, with a view to gauging whether these rights support or limit the possibility of legalizing euthanasia.

Reflection and summary of findings: Chapter Five demonstrated that constitutional rights to dignity (s10)[960], life (s11)[961], bodily integrity (s12)[962], and privacy (s14) provide a foundation for euthanasia reform. This was tested in *Stransham-Ford v Minister of Justice and Correctional Services,*[963] where the High Court recognised that these rights could justify assisted dying, though the order was later set aside on procedural grounds. The case remains the most direct South African authority, reflecting both the potential and limits of constitutional adjudication.

Other jurisprudences reinforce this tension, *Soobramoney v Minister of Health* (1997)[964] illustrates how courts balance individual rights against systemic resource constraints, suggesting that even where rights such as life and dignity are implicated, courts may be reluctant to extend them in light of broader institutional and policy considerations. In contrast, *Treatment Action Campaign v Minister of Health* (2002)[965] shows judicial willingness to enforce access to healthcare where dignity is at stake, suggesting a more interventionist approach, which signals the potential for a more expansive rights-based interpretation. Taken together, the *Soobramoney* and *Treatment Action Campaign* decisions reflect distinct judicial approaches, underscoring that South African jurisprudence simultaneously supports and limits the evolution of euthanasia law.

These findings, grounded in the definitional distinctions and historical background established in chapter two, clarify the scope of euthanasia and assisted dying within South Africa's constitutional framework and situate these debates in global and domestic evolutions. Judicial caution in end-of-life contexts reflects legitimate concerns about institutional readiness, but it may unduly limit autonomy particularly where dignity supports recognition of end-of-life choices. The limitation clause in section 36 tempers the prospect of

960 Constitution of the Republic of South Africa, 1996, s 10 (dignity).
961 Constitution of the Republic of South Africa, 1996, s 11 (life).
962 Constitution of the Republic of South Africa, 1996, s 12 (bodily integrity).
963 *Stransham-Ford v Minister of Justice and Correctional Services and Others* [2015] ZAGPPHC 230 (Gauteng Division, Pretoria); *Minister of Justice and Correctional Services v Estate Stransham-Ford* (531/2015) [2016] ZASCA 197.
964 *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 (1) SA 765 (CC).
965 *Minister of Health v Treatment Action Campaign* (TAC) 2002 (5) SA 721 (CC).

immediate legalisation, underscoring both the potential and the constraints of constitutional rights in this domain. [966]

ii. Objective 2: Explore Canada's MAiD framework and assess its relevance as a comparator

Chapter Four analysed Canada's MAiD framework, anchored in *Carter* v *Canada* (2015)[967], which recognised assisted dying as constitutionally protected under the rights to life, liberty, and security of the person. Canada's reform was staged through judicial progression (*Rodriguez*, *Carter*, *Truchon*, *Taylor*)[968] and legislative roll-outs (Bill C-14 in 2016, Bill C-7 in 2021). Each Bill was debated extensively, implemented within a few years of the preceding court decision, and accompanied by safeguards such as judicial oversight, reporting obligations, and independent review. This incremental structuring demonstrates how autonomy can be balanced with protection of the vulnerable.

By contrast, Chapter Three highlighted South Africa's systemic fragility infrastructural shortages, human resource constraints, and uneven palliative care provision while Chapter Five underscored fragmented jurisprudence (*Clarke v Hurst*, *Stransham-Ford*, *Harck* and *Walters*)[969] and unresolved constitutional questions. The South African Law Reform Commission's Discussion Paper 71 (Project 86), published in 1998, has remained untouched for over two decades, despite constitutional developments and comparative lessons. Oversight failures, most starkly illustrated by the Life Esidimeni tragedy, further reveal how vulnerable groups can be exposed to abuse when safeguards collapse. Cultural conservatism and plural religious traditions complicate reform even further.

This comparison demonstrates that while Canada's MAiD framework provides a coherent model of staged judicial and legislative reform, South Africa's fragmented jurisprudence, stalled law reform, and systemic fragilities mean that

966 Constitution of the Republic of South Africa, 1996, s36 (limitations clause).
967 *Carter v Canada* (*Attorney General*) 2015 SCC 5, [2015] 1 SCR 331.
968 *Rodriguez* v *British Columbia (Attorney General*) [1993] 3 SCR 519; *Truchon v Procureur général du Canada* 2019 QCCS 3792; *Attorney General of Canada v Taylor* 2021 FCA 148.
969 *Clarke v Hurst NO* and *Others* 1992 (4) SA 630 (D).

its readiness remains limited. As analysed in Chapter Four and contrasted with findings in Chapters Three and Five, the objective has therefore been achieved by clarifying both the potential and the constraints of using Canada as a comparator.

iii. Objective 3: To analyse Canada's experience with the proposed expansion of MAID to include mental illness as a sole condition, identifying best practices and challenges, and to consider their implications for South Africa's legal and ethical readiness. To assess whether South Africa's health system, including its palliative care services and ethical oversight mechanisms, is adequately prepared to support legal regulation of assisted dying.

Reflection and summary of findings: Chapter Four examined Canada's debates on expanding MAiD to mental illness, revealing how ethically and practically sensitive such integration is. Concerns about vulnerability, diagnostic uncertainty, and adequacy of safeguards remain unresolved, and Canada has repeatedly postponed eligibility first from 2023 to 2024, and now to 2027 reflecting the difficulty of balancing autonomy with protection. Chapter Three showed that South Africa's health system, marked by infrastructural shortages, human resource constraints, and oversight failures exemplified by the Life Esidimeni tragedy, is not institutionally prepared to support any form of assisted dying legislation, let alone for the vulnerable.

Canada's deliberations highlight the importance of inclusive consultation and gradual reform, while South Africa's systemic fragility underscores that premature legislation of any kind would risk inequity and abuse.

iv. Objective 4: To examine the risks and challenges including inequality, cultural and religious resistance and the potential for misuse of euthanasia provisions in a resource strained health sector that could undermine the feasibility of legalising euthanasia in South Africa.

Reflection and summary of findings: Chapters Three and Five identified concrete risks that undermine the feasibility of legalising euthanasia in South Africa. Entrenched inequality in healthcare access means that poorer communities, already underserved by palliative care, could be pressured into

euthanasia as a substitute for treatment. Cultural and religious resistance, grounded in Ubuntu and diverse faith traditions, raises constitutional questions under s15,[970] requiring sensitivity to pluralism. Oversight failures such as the Life Esidimeni tragedy demonstrate the danger of misuse in a resource-strained sector, where vulnerable groups may be exposed to abuse. The Health Ombud's 2017 report described the Esidimeni transfers as 'irrational and inhumane,' underscoring how systemic neglect can strip patients of dignity, life, and equality. This case illustrates that without robust safeguards, legalising euthanasia in South Africa risks compounding existing vulnerabilities rather than alleviating suffering.

These risks are reinforced by the definitional and historical context traced in Chapter Two, which showed how global and domestic debates have long been shaped by inequality, cultural resistance, and ethical concerns about misuse. Taken together, the findings clarify that without statutory clarity and institutional safeguards, the feasibility of legalising euthanasia in South Africa is limited. The objective has therefore been achieved by identifying the concrete risks that constrain reform.

v. Objective 5: To examine the extent to which enhanced palliative care and home-based support can serve as genuine alternatives to euthanasia in South Africa by addressing unmet end-of-life needs, and to develop policy and legal measures that guarantee dignity and prevent inequity, abuse, and neglect in this regard.

Reflection and summary of findings: Chapter Three established that palliative care and home-based support can reduce demand for euthanasia, but current provision is inadequate. The National Policy Framework and Strategy on Palliative Care (2017–2022),[971] notwithstanding the expiry of its 2017–2022 implementation period remains under-implemented, leaving rural and disadvantaged communities without equitable access to palliative care.

970 Constitution of the Republic of South Africa, 1996, s15 (freedom of religion, belief and opinion).

971 Department of Health, *National Policy Framework and Strategy on Palliative Care 2017–2022*.

Jurisprudence such as *Soobramoney* shows how courts defer to resource constraints, yet s10 dignity and s27[972] healthcare rights point towards the need to strengthen end-of-life care as a constitutional safeguard. Without robust palliative care, euthanasia risks becoming a substitute for systemic reform rather than a genuine expansion of patient choice.

Comparative insights from Chapter Four further demonstrate that Canada only introduced assisted dying after substantial investment in palliative care, ensuring that choice was grounded in dignity rather than deprivation. This reflection clarifies that South Africa's current palliative care framework is insufficient to serve as a genuine alternative to euthanasia, and the objective has therefore been achieved by showing how constitutional rights to dignity and healthcare remain constrained by inadequate provision.

vi. Objective 6: Recommend contextually appropriate measures for South Africa.

Reflection and summary of findings: Chapter Six, the current chapter, consolidates findings above into recommendations, strengthening palliative care, commissioning a multidisciplinary inquiry, establishing oversight, updating the National Health Act,[973] embedding ethics in medical training, and anticipating AI in healthcare. These measures are contextually appropriate, but limitations remain, systemic inequality, cultural resistance, and judicial caution temper immediate reform. The recommendations therefore provide a cautious roadmap, affirming that South Africa must build institutional capacity before pursuing legalisation.

In sum, the reflections across the chapters reveal that South Africa's constitutional rights, existing health frameworks, and limited case law provide a foundation for debate on euthanasia, but significant gaps remain in statutory guidance, oversight, and implementation. Building on the reflections and summary of findings, this section distils the study's insights into a set of structured lessons. These lessons are not conclusions in themselves, but thematic syntheses drawn from across the chapters.

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972 Constitution of the Republic of South Africa, 1996, s10 and s27.

973 National Health Act 61 of 2003.

6.3 Lessons for South Africa: insights from Canada

The reflections above demonstrate that the study has achieved its objectives, but they also reveal broader lessons for South Africa's ongoing debate on euthanasia and assisted dying.

i. Lesson 1: Constitutional rights and institutional capacity

Comparative analysis demonstrates that constitutional rights, while foundational, cannot operate in isolation from institutional capacity and judicial precedent. In South Africa, rights to dignity (s10), life (s11), bodily integrity (s12), and privacy (s14) theoretically support reform. This was tested in S*transham-Ford v Minister of Justice and Correctional Services*, where the High Court recognised that these rights could justify assisted dying, though the order was later set aside on procedural grounds. Earlier cases such as *Clarke v Hurst NO* grappled with the withdrawal of treatment and the meaning of dignity in end-of-life contexts, while *Soobramoney v Minister of Health* and *Treatment Action Campaign v Minister of Health* illustrate how courts balance individual rights against systemic resource constraints and enforce access to healthcare where dignity is at stake. Together, these decisions reflect both the potential and limits of constitutional adjudication in this domain.

Comparative lessons from Canada show that reform was staggered through landmark cases: *Rodriguez v British Columbia* initially upheld prohibitions, *Carter v Canada* overturned them by enforcing Charter rights to life, liberty, and security, and subsequent cases such as *Truchon* and *Taylor* expanded eligibility and clarified safeguards. Each case was debated extensively, reinforcing the Charter and shaping legislative responses. Ethically, reform without safeguards risks exploitation of vulnerable groups; socially, it could deepen inequality by offering assisted dying where palliative care is absent. The lesson, therefore, is that constitutional rights must be matched with institutional capacity and judicial engagement, ensuring that reform proceeds incrementally through case law and robust oversight before legislation can be responsibly enacted.

ii. Lesson 2: The centrality of palliative care

The research highlights that palliative care is a constitutional, ethical, and social prerequisite for any discussion of euthanasia. Legally, section 27[974] of the Constitution affirms the right of everyone to have access to healthcare services, which implies that end-of-life care must be progressively realised in a manner that is equitable and inclusive, rather than reserved for the privileged. The National Health Act provides the statutory framework for equitable healthcare delivery, while the National Health Insurance (NHI) seeks to achieve universal coverage. Yet, palliative care remains under-integrated into these systems. The 2017–2022 National Policy Framework and Strategy on Palliative Care despite the lapse of its 2017–2022 implementation period provides some guidance, but it has been under-implemented and does not address assisted dying. Ethically, palliative care ensures that choices about assisted dying are made in contexts where suffering is alleviated, not exacerbated by systemic neglect.

Socially, the absence of comprehensive palliative care risks deepening inequality. Comparative lessons from Canada show that MAiD was introduced alongside investment in palliative care, ensuring that assisted dying was not a substitute for care. The lesson, therefore, is that South Africa must integrate palliative care into the National Health Act and NHI structures, ensuring that it is accessible, implemented, and strengthened before contemplating reform.

iii. Lesson 3: Safeguards, oversight, and mental health as preconditions for reform

The study highlights that legal reform on euthanasia cannot succeed without robust safeguards, oversight mechanisms, and careful attention to mental health. Legally, South Africa's constitutional rights to dignity (s10) and bodily integrity (s12) provide a foundation for reform, but the absence of clear statutory frameworks and regulatory institutions means that no reform currently exists, and premature legislation would risk undermining those rights in practice. Although the South African Law Reform Commission addressed euthanasia in Discussion Paper 71, Project 86, no legislative

974 Constitution of the Republic of South Africa, 1996, s 27 (healthcare).

reform has followed, leaving the country without statutory safeguards or clear guidance.

Ethically, weak oversight exposes vulnerable populations to exploitation, particularly where medical professionals lack training or accountability structures. Socially, the Life Esidimeni tragedy demonstrates how systemic failures in healthcare oversight can lead to catastrophic consequences, underscoring the danger of introducing assisted dying without strong protections. Comparative lessons from Canada show that debates around extending MAiD to individuals with a sole underlying mental illness remain unresolved. The eligibility date has been postponed to 2027 reflecting the critical need to protect vulnerable groups and the complexity of balancing autonomy with protection. The lesson, therefore, is that before South Africa contemplates any reform, it must first establish credible oversight systems, professional training, transparent accountability, and develop mental health policy and safeguards, so that future legislation strengthens rather than erodes constitutional rights and ethical protections.

iv. Lesson 5: Building a comprehensive ecosystem for end-of-life reform

The study demonstrates that any consideration of euthanasia in South Africa must be situated within a broader ecosystem that integrates healthcare infrastructure, professional regulation, family experiences, advocacy groups, and religious communities. Legally, reform requires statutory clarity and professional accountability through bodies such as the HPCSA and the Department of Health. Constitutionally, protections for freedom of religion (s15), association (s18), and expression (s16) demand inclusive consultation so that reform reflects plural values. Ethically and socially, the lived experiences of families and caregivers, alongside investment in equitable healthcare and professional training, must be acknowledged to ensure that assisted dying emerges within a system capable of protecting the vulnerable.

Comparative insights from Canada show that reform was informed by broad consultation with medical associations, colleges of physicians, provincial health authorities, advocacy groups, and parliamentary debate, alongside phased implementation. This underscores the importance of engaging with diverse stakeholders and situating reform within a comprehensive framework. The lessons

therefore highlight that constitutional rights must be matched with institutional capacity, that palliative care is central to dignity, and that vulnerable groups must be protected through accountability. The Canadian reforms also show that inclusive stakeholder engagement and ongoing advocacy are indispensable to building a trustworthy and sustainable framework.

6.4 Recommendations for South Africa

Building on the reflections and lessons drawn from this study, it is clear that any move toward legalising euthanasia or assisted dying in South Africa must be cautious, contextually responsive, and ethically sound. The comparative analysis, particularly of Canada's MAiD framework, demonstrates that constitutional rights alone are insufficient without institutional readiness.

The study makes the following recommendations:

6.4.1 Strengthen and expand palliative care services

The foundational recommendation is to urgently invest in and expand equitable access to high-quality palliative care, especially in rural and historically disadvantaged communities. The World Health Organization (WHO) defines palliative care as an approach that improves the quality of life of patients and their families facing life threatening illness through prevention and relief of suffering, early identification and impeccable assessment and treatment of pain and other physical, psychological, and spiritual problems.[975] Inadequate access to such care undermines patient dignity and disproportionately burdens poor and marginalised populations.

South Africa's National Policy Framework and Strategy on Palliative Care (2017-2022) remains under implemented. Integrating palliative services into primary health care and training healthcare workers, including traditional healers in culturally appropriate palliative techniques is essential. This would allow terminally ill patients greater autonomy and comfort in their final days without resorting to unlawful or unsafe measures. Without equitable palliative care, debates on euthanasia risk becoming a

975 World Health Organization, *Palliative Care* (WHO, 5 August 2020) <https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/palliativecare#:~:text=Palliative%20care%20aims%20to%20prevent,answering%20people%20needs%20and%20expectations> accessed 12 March 2024.

substitute for systemic healthcare reform rather than a genuine expansion of patient choice.

6.4.2 Review and update the National Policy Framework on Palliative Care

Given that the implementation period of the *National Policy Framework and Strategy on Palliative Care 2017–2022* has ended, it is recommended that the framework be reviewed and updated to maintain alignment with current healthcare needs and constitutional obligations. The revised framework should explicitly integrate with the *National Health Insurance Act 2023*, ensuring coherence between palliative care provision and broader health system reforms. This would strengthen the sustainability of palliative care services, embed equity considerations, and provide a clear legislative and policy foundation for addressing end-of-life care within South Africa's evolving healthcare landscape.

6.4.3 Commission a new multidisciplinary inquiry on euthanasia and assisted dying

The South African Law Reform Commission's Discussion Paper 71 (Project 86) is over two decades old and predates key constitutional jurisprudence and international developments such as *Carter v Canada* (2015). A contemporary, inclusive inquiry is therefore essential. It should involve medical professionals, trans-disciplinary scholars including constitutional scholars, ethicists, traditional leaders, religious groups, disability advocates, and community representatives, revisiting the legal, ethical, and practical viability of euthanasia in light of South Africa's lived realities, including limited healthcare infrastructure, unequal access to justice, and risks of corruption.

The inquiry must be situated within the framework of the National Health Insurance (NHI), ensuring that end-of-life care is integrated into broader health reforms rather than treated as an isolated policy. Including traditional healers is vital, as they remain primary caregivers in many rural communities and provide culturally embedded forms of care and spiritual support. Canada's use of parliamentary committees and expert panels offers a comparative model, but South Africa's inquiry must reassure the public that reform is grounded in compassion, systemic readiness, and equitable access. A new inquiry would ensure that reform is grounded in contemporary realities rather than outdated or fragmented analysis.

6.4.4 Establish an independent ethics and oversight body

Should South Africa ever move toward the decriminalisation or limited legalisation of euthanasia or physician assisted dying, it would be imperative to first establish an independent body to regulate, monitor and adjudicate end of life decisions. This body must be autonomous, well-resourced, and accountable to both Parliament and the public. Its functions could include:

i. Reviewing individual requests for assisted dying: responding to concerns about unequal access to justice and the risk that vulnerable groups may be pressured into euthanasia without proper safeguards.

ii. Auditing compliance with legal and ethical safeguards: tackling oversight failures such as Life Esidimeni, where inadequate monitoring led to abuse and loss of life.

iii. Providing annual reports to the Department of Health: ensuring transparency and accountability in a healthcare system often undermined by corruption and administrative inefficiency.

iv. Facilitating the training of medical practitioners on ethical standards and legal parameters: addressing gaps in professional preparedness highlighted in Chapter Three, where limited training and uneven healthcare capacity risk inconsistent application of rights to dignity (s10) and bodily integrity (s12).

Such framework could draw on the model used by the Canadian Council of Academies, which conducted rigorous, transparent research to advise Parliament following the *Carter* judgment. Oversight must precede legalisation, ensuring that safeguards are enforceable rather than theoretical.

6.4.5 Update the National Health Act to reflect evolving end-of-life rights

Although the National Health Act 61 of 2003 enshrines patient autonomy and informed consent, it does not explicitly address terminal illness decision-making, advance directives, or end-of-life plans. This gap was highlighted in Chapter Three and Four, where the distinction between active and passive euthanasia was central to the analysis. South African law currently permits forms of passive euthanasia such as the

withdrawal of treatment or the use of palliative sedation under the principles of informed consent and patient autonomy, but active euthanasia remains unlawful. The absence of statutory clarity leaves patients and practitioners reliant on fragmented case law and ethical guidelines, creating uncertainty and inconsistency:

i. Legal recognition of advance directives or living wills: addressing the uncertainty identified in Chapter Three, where patients' wishes are often disregarded due to lack of statutory authority.

ii. Clear distinction between palliative sedation and euthanasia: reflecting the findings in Chapter Four that passive euthanasia is legally tolerated, but active euthanasia is prohibited, and that statutory clarity is needed to prevent misuse or confusion.

iii. Future legislative and policy reforms should be framed in rights-based language that explicitly incorporates dignity, choice, and bodily integrity, in alignment with constitutional jurisprudence (s 10 dignity, s 12 bodily integrity, s 27 healthcare) and South Africa's international obligations under Article 12 of the *International Covenant on Economic, Social and Cultural Rights*. Although this dissertation has not undertaken a discourse analysis of statutory language, the recommendation is made in normative terms to emphasise the importance of aligning future reforms with constitutional values and international commitments.

Updating the National Health Act would codify the distinction between active and passive euthanasia, provide certainty for patients and practitioners, and align end-of-life rights within constitutional and international commitments.

6.4.6 Prioritise ethics, education, and spiritual sensitivity in medical training

Any reform must be accompanied by targeted education and training for healthcare professionals. Medical schools, continuing professional development programmes, and the Health Professions Council of South Africa (HPCSA) should embed ethics modules on autonomy, dignity, and vulnerability; provide legal clarity on constitutional rights (s10 dignity, s12 bodily integrity, s27 healthcare) and the distinction between passive and active euthanasia; strengthen clinical skills in palliative care and end-of-life decision-making; and cultivate cultural and spiritual sensitivity by engaging

Ubuntu, religious diversity, and Afrocentric philosophies. Recognising the role of traditional healers and faith leaders is essential to ensuring that reform is not only legally coherent but also socially legitimate and ethically grounded.

Finally, reform must anticipate emerging challenges, including the role of artificial intelligence in end-of-life care. AI technologies may shape patient monitoring, decision-making, and oversight, but they also raise ethical and accountability concerns. Embedding ethics, cultural sensitivity, and adaptability into medical training will ensure that any future reform is socially legitimate, constitutionally coherent, and responsive to emerging challenges.

6.5 Conclusion

This chapter has drawn the dissertation to a close by linking the findings back to the aims and objectives set out in Chapter One. The reflections confirmed that while South Africa's constitutional rights provide a foundation for euthanasia reform, institutional and healthcare constraints limit immediate readiness. The lessons underscored the need for palliative care as a cornerstone, safeguards for vulnerable groups, and gradual reform that balances autonomy with compassion and justice. Building on these insights, the recommendations set out a cautious roadmap: strengthening palliative care, commissioning a multidisciplinary inquiry, establishing an independent oversight body, updating the National Health Act, embedding ethics and cultural sensitivity in medical training, and anticipating the role of artificial intelligence in healthcare.

Taken together, these reflections, lessons, and recommendations demonstrate that South Africa is not yet legally, socially, or institutionally prepared to implement euthanasia legislation. What is possible, however, is a comprehensive reform of palliative care as the starting point. Over time, through evaluation and systemic strengthening, this foundation may allow for broader consideration of end-of-life choices. By learning from Canada's MAiD framework and prioritising dignity, autonomy, and compassion, the study affirms that a rights-based, ethically sound approach to end-of-life care can emerge if pursued with caution, equity, and readiness.

6.5.1 Author's reflection

I entered this study believing that compassion for the dying might convince me that assisted dying could be justified. When that failed, I leaned on constitutional rights, hoping they might sway me. Yet, in reviewing the risks inequality, oversight failures, and the vulnerability of the mentally ill, I was convicted to retain my belief that God's design has no blemishes. As painful and unbearable as patients' circumstances may be, I could not reconcile with the idea of ending life through euthanasia.

Witnessing family members endure terminal illness affirmed this conviction. Their dignity was preserved not through euthanasia, but through moments of family and community care, despite limited training and resources. These experiences revealed that the preservation of dignity is an innate part of humanity; faith became their language of resilience, and compassion sustained them even in suffering.

Thus, my journey through law, ethics, and lived experience has deepened rather than altered my conviction. True dignity lies in preserving life through compassion, palliative care, and the humility of recognising that only God can take it away.

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