

The right to conscientious objection against administering euthanasia in the context of the right to freedom of religion

by

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Chapter 1

Introduction*

Questions related to euthanasia¹ and its moral validity goes far back into the annals of history. Francis Beckwith and Norman Geisler observe that the ancient world was rather divided about euthanasia. For example, in the Greek upper classes suicide and euthanasia were widely accepted, whilst the Pythagoreans condemned the practice of suicide and the Stoics did not support suicide for *any reason* but only when there was a terminal illness (or other extreme circumstances). Plato was generally negative towards the practice of suicide, although he was sympathetic to those whose “cruel and inevitable calamity had driven them to the act”, whilst Aristotle argued that it was cowardice to flee life on the grounds of “cruel and inevitable calamity”.² Ezekiel Emanuel contends that euthanasia was a common practice amongst the ancient Greeks. It appears that the Hippocratic Oath presented a turn in thought with regard to the ethics of euthanasia, as the statement in the Oath itself, “...neither give a deadly drug to anybody if asked for it, nor make any suggestion to this effect,”³ presented a minority view amongst the ancient Greek physicians.⁴ These brief extractions from ancient history are indicative of the contentiousness that has existed many centuries ago, and which has continued to date.

There is extensive scholarship on the issue of euthanasia itself as well as the ethical implications pertaining to euthanasia.⁵ There are also a plethora of scholarly works on

* This study reflects the legal position both in South Africa and abroad as to 3 May 2018, this date denoting the completion of this study. Also note that a reference to ‘he’, ‘him’ or ‘his’ also includes a reference to ‘she’, ‘her’ and ‘hers’ unless clearly implied otherwise.

¹ As to what is meant regarding euthanasia in general as well as the different forms thereof will be elaborated upon below.

² F. J. Beckwith & N. Geisler, *Matters of Life and Death. Calm Answers to Tough Questions about Abortion and Euthanasia*, (Grand Rapids: Baker Book House, 1991), 157-158.

³ The Hippocratic Oath as translated by L. Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation*, (Baltimore: The Johns Hopkins Press, 1943).

⁴ E. Emanuel, “Whose right to die?” *The Atlantic*, March 1997. <https://www.theatlantic.com/magazine/archive/1997/03/whose-right-to-die/304641/> (Accessed on 24 March 2016).

⁵ (also including South African scholarship): A. Egan, “Should the state support the ‘right to die’?”, *South African Journal of Bioethics and Law*, Vol. 1, 2(2008), 47-52; D. 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”, *South African Journal of Bioethics and Law*, Vol. 8, 2(2015), 34-40; M. Slabbert & C. van der Westhuizen, “Death with dignity in lieu of euthanasia”, *SA Public Law*, Vol. 22, 2(2007), 366-384; E. de Villiers, “Euthanasia and assisted suicide: A Christian ethical perspective”, *Acta Theologica Supplementum* 3, Vol. 22, 2(2002), 35-65; A. Dhali, “Physician-assisted dying and palliative care: Understanding the two”, *South*

conscientious objection in general, especially participation in abortion, military conscription and cloning.⁶ However, there exists an evident void pertaining to substantive constitutional jurisprudence and scholarship regarding the rights of medical practitioners to conscientiously object to administering euthanasia based on especially the right to freedom of religion (and by implication, the protection and freedom of the conscience).⁷ Consequently, this study serves as a contribution to the protection of religious rights and freedoms against the background of conscientious objection by medical practitioners regarding the administering of euthanasia. Although this study focuses especially on the South African legal and constitutional context, it also brings to the fore insights that are of worth to other democratic and plural societies.

Mark Wicclair observes that conscientious objection by health care professionals does not seem to have been a familiar occurrence and that “literature searches have not uncovered studies that attribute a significant place to it in the history of medicine or that apply the notion of ‘conscientious objector’ to pre-twentieth-century practitioners.”⁸ According to Alta Charo, medical professionals are increasingly resorting to the right to autonomy so as to refuse to partake, whether directly or indirectly (for example in the sense of referrals or counselling), in medical services that they find objectionable.⁹ John Stonestreet refers to the current position in Canada regarding the administering of euthanasia, where many medical doctors have been

African Journal of Bioethics and Law, Vol. 8, 2(2015), 2-3; R. Malherbe & R. Venter, “Die reg op lewe, die waarde van menslike lewe en die eutanasië-vraagstuk” (The right to life, the value of human life and the question related to euthanasia), *Tydskrif vir die Suid-Afrikaanse Reg* Vol. 2011, 3(2011), 466-495; J. A. Jackson, “The Ethics and Legality of Euthanasia and Physician Assisted Suicide”, *University of Tennessee Honors Thesis Projects*, 5-2003; P. McCormack, “Quality of life and the right to die: An ethical dilemma”, *Journal of Advanced Nursing*, Vol. 28, 1(1998), 63-69; J. Keown, *Euthanasia, Ethics and Public Policy; An Argument against Legislation*, (Cambridge: Cambridge University Press, 2004); A. Sloane, *Vulnerability and care: Christian reflections on the philosophy of medicine*, (London: Bloomsbury T&T Clark, 2016); A. Fisher, *Catholic bioethics for a new millennium*, (Cambridge: Cambridge University Press, 2012); B. Spring & E. Larson, *Euthanasia: Spiritual, Medical & Legal issues in terminal health care*, (Portland: Multnomah, 1988); R. Russel, *Freedom to die: Moral and legal aspects of euthanasia*, (New York: Dell, 1976); D. Novak, *The Sanctity of Human Life*, (Washington D.C.: Georgetown University Press, 2007); C. Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, (Burlington: Ashgate Publishing Company, 2008).

⁶ R. Grillo (ed.), *Legal Practice and Cultural Diversity*, (Farnham: Ashgate, 2009); A. Cohen & C. Wellman, (eds.), *Contemporary debates in applied ethics*, (Malden: Blackwell Publishers, 2005); R. Chadwick, “*The bioethics reader: Editors’ choice*”, (Malden: Blackwell Publishers, 2007); S. de Freitas, “Freedom of conscience, medical practitioners and abortion in South Africa”, *International Journal for Religious Freedom (IJRF)*, Vol. 4, 1(2011), 75-85.

⁷ For example the following substantive sources dealing with the right to freedom of religion and conscientious objection do not delve into the matter related to this study: R. Ahdar & I. Leigh, *Religious Freedom in the Liberal State*, (Oxford: Oxford University Press, 2013) and M. R. Wicclair, *Conscientious Objection in Health Care. An Ethical Analysis*, (New York: Cambridge University Press, 2011).

⁸ Wicclair, *Conscientious Objection in Health Care. An Ethical Analysis*, 14, 15. Wicclair adds, “It was not until the 1970s that a substantial literature began to develop on the subject of health care professionals’ conscience-based refusals to provide legal and professionally accepted services”.

⁹ R. A. Charo, “The celestial fire of conscience – Refusing to deliver medical care”, *The New England Journal of Medicine*, Vol. 352, 24(2005), 2471.

removed from voluntary referral lists because they did not want to be part of such practices.¹⁰ In South Africa, the matter related to the legalisation of euthanasia has gained in momentum and has consequently been exposed to renewed attention due to the South African High Court's recent involvement in the matter, which led to a proliferation of media reports on the topic. This in turn, implicates an awareness of the right of medical practitioners to conscientiously object to the administering of euthanasia.

On 30 April 2015, the South African High Court (as per Fabricius J) consented to Robin Stransham-Ford's application to the court, allowing a medical practitioner to euthanise him. However, before the medical practitioner could do so, Stransham-Ford passed away due to 'natural causes'. Although Stransham-Ford passed away before the order of the judge could be complied with, the debate was set in motion regarding euthanasia in South Africa, and accompanying this, the need for clarity regarding the legal position in this regard. Fabricius J held that the ruling serves as a basis for the further development of the law in this regard, as this amounted to an appropriate cause of action.¹¹ A number of cases¹² were heard prior to South Africa's constitutional democracy pertaining to euthanasia, where the courts, although

¹⁰ J. Stonestreet, "Second thoughts on assisted suicide: Canadian doctors balk", *Breakpoint*, 15 March 2017. www.breakpoint.org/2017/03/second-thoughts-on-assisted-suicide/ (Accessed on 30 March 2017).

¹¹ J. Versluis, "Genadedood: Regter gee rede vir bevel 'Wetsontwerp moet nou ernstig oorweeg word'", *Volksblad*, 5 May 2015; *Stransham-Ford v Minister of Justice and Correctional Services and Others* (27401/15) [2015] ZAGPPHC 230; 2015 (4) SA 50 (GP). In the *Stransham-Ford* case, the Judge relied particularly on section 8(3) of the *Constitution of the Republic of South Africa*, which reads: "When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court (a) in order to give effect to a right in the Bill of Rights, must apply or, if necessary, develop the common law to the extent that legislation does not give effect to that right; and (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36(1)." This latter section pertains to the criteria to be applied so as to qualify the reasonable and justifiable limitation of a right (or rights). Fabricius J expressly stated, "the topic is in my view important enough, having regard to the relevant principles contained in the Bill of Rights, that serious consideration be given to introducing a Bill based on the South African Law Commission's Report, which suggested a number of options, but supported the development of the common law in this context. It is certainly a topic that deserves broad discussion, but in the context of the Bill of Rights especially," Fabricius J, par. 1. The said judge was of the opinion that, regardless whether the patient benefitted from his ruling, since the patient passed away without the judge's knowledge, the ruling highlights an important vacuum in the law. However, the case did proceed further to the Supreme Court of Appeal in *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* (531/2015) [2016] ZASCA 197 (2016). Upon appeal, the Supreme Court of Appeal was of the view that the Pretoria High Court erred in making the decision it did, and upheld the appeal by the Minister of Justice and Constitutional Development, par. 101. The reasons provided for by the Court are set out in par. 5 and are briefly that Stransham-Ford had passed away at the time the order was made, and therefore the original cause of action had ceased to exist. More importantly, the Court determined that no "full and proper examination of the present state of our law in this difficult area" had been conducted in relation to the manner in which the Bill of Rights in South Africa is interpreted and the common law developed. Lastly, according to the Court, insufficient opportunity was afforded to interested parties to raise concerns and objections. Accordingly, the court was of the view that the court *a quo* acted inappropriately when it "engaged in a reconsideration of the common law in relation to the crimes of murder and culpable homicide."

¹² *S v De Bellocq* 1975 (3) SA 538 (T); *S v Marengo* 1991 (2) SACR 43 (W).

the act of active euthanasia is illegal, applied a fair degree of compassion towards those who administered euthanasia (in an active sense)¹³ in some form or another. Having said this, the courts in South Africa are unified in the view that the killing of someone (in an active sense), even where this has been done to alleviate the pain and suffering of the person killed, constitutes murder.¹⁴

What is the position and historical background of the legalisation of euthanasia in South Africa? There is no legislation concerning legal regulation of euthanasia in South Africa.¹⁵ The South African Law Commission presented a detailed report to the Minister of Health regarding euthanasia in South Africa in November 1998.¹⁶ This report contained a thorough investigation of what euthanasia is, including its effects, and provided guidelines for doctors as well as proposed legislation to be reviewed by said the Minister and Parliament. This report was a necessary step towards the fulfilment of South Africa's constitutional imperative of protecting the rights of all its citizens. In 1998, the government instructed the South African Law Commission to draft a report called the *Law Commission Report on Euthanasia and the Artificial Preservation of Life*, Project 86. This report entailed a comprehensive investigation into euthanasia and assisted suicide, and was addressed to the then-Minister of Justice, Dr AM Omar as determined by the South African Law Commission Act,¹⁷ for possible approval.¹⁸ It sets out *inter alia* comparative views of euthanasia across the globe; discussions pertaining to various moral, philosophical and ethical dilemmas; as well as a proposed draft bill for

¹³ Active euthanasia occurs when a patient's life is ended by the necessary fatal, deliberate steps taken by another person, such as the administration of a toxin. Passive euthanasia occurs when a patient dies due to the cessation of treatment or the complete failure thereof, by medical personnel. For example, a patient passes away due to a respirator being switched off or the disconnection of a feeding tube providing nutrients and water. This will be dealt with in more detail in Chapter Two.

¹⁴ Such was confirmed by Fabricius J in *Stransham-Ford v Minister of Justice and Correctional Services and Others*, par. 10: "The current legal position is that assisted suicide or active voluntary euthanasia is unlawful."

¹⁵ *Stransham-Ford v Minister of Justice and Correctional Services and Others*. Here it is worthwhile noting that Fabricius J merely 'exempted' the medical practitioner from criminal liability, and allowed Stransham-Ford's request. Had any other medical practitioner performed the same procedure on another person, such act would be murder. It is important to note that in the South African context 'passive' euthanasia is legal as confirmed in the said judgment namely: "I use the expressions [physician-assisted suicide] and [physician-assisted euthanasia] in this judgement specifically... They are to be distinguished from the refusal or withdrawal of treatment or life support or other conduct that is lawful in South Africa, but which in certain jurisdictions is regarded as passive euthanasia and may be illegal," *Minister of Justice and Correctional Services and Others v Estate Late Stransham-Ford and Others*, par. 2.

¹⁶ Law Commission Report on Euthanasia and the Artificial Preservation of Life, Project 86.

¹⁷ *South African Law Commission Act 19 of 1973* (Now the *South African Law Reform Commission Act 19 of 1973*, as amended by the *Judicial Matters Amendment Act 55 of 2002*), section 7(1): "The Commission shall prepare a full report in regard to any matter investigated by it and shall submit such report together with draft legislation, if any, prepared by it, to the Minister for consideration."

¹⁸ *Stransham-Ford v Minister of Justice and Correctional Services and Others*, par. 1.

regulating euthanasia in South Africa. At the time the Report was handed in, South Africa was still a very young constitutional democracy and various other pressing social mechanisms were prioritised. The Minister of Health was particularly embattled with the rising HIV pandemic, and thus these issues were deemed of greater importance.¹⁹ However, as alluded to in *Stransham-Ford*, the time, it seems, is ripe for government, the legislature and the judiciary to deal with this matter,²⁰ and for the progression of more robust and informative scholarship in this regard.

Several States have legalised the practice of active euthanasia for some time now, for example, Belgium, Colombia, Luxembourg and the Netherlands. Other States prohibit active euthanasia, yet make provision for passive euthanasia. Ireland, for example, considers active euthanasia illegal, but it is legal to withdraw life support upon the request of the patient. South Africa (as referred to earlier) also permits passive euthanasia.

Beyond the matter related to the legalisation of euthanasia, and acting as the focus of this study, is the issue regarding conscientious objection against the administering of euthanasia. Of interest is that Dutch law contains no conscientious objection clause, thus it appears that doctors have no other option than to comply with the law.²¹ On the other hand, the *Belgian Euthanasia Act* provides for conscientious objectors,²² but requires objectors to refer patients to non-objecting medical doctors. In Britain, the *Assisted Dying for the Terminally Ill Bill*²³ makes provision for the inclusion of conscientious objection by physicians,²⁴ but like the Belgians,

¹⁹ *Stransham-Ford v Minister of Justice and Correctional Services and Others*, par. 1.

²⁰ *Stransham-Ford v Minister of Justice and Correctional Services and Others*, par. 1.

²¹ The Netherlands Ministry of Foreign Affairs published a booklet on euthanasia titled, *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act in practice*. This booklet contains a set of questions and answers pertaining to euthanasia in the Netherlands. At question five, the answer is posed whether Dutch doctors are required to perform euthanasia at all times. The corresponding answer holds that doctors can indeed refuse to terminate life, and are thus guaranteed their freedom of conscience. Accordingly, there is an existent principle that patients do not have an absolute right to euthanasia whilst doctors do not have an absolute duty to administer euthanasia. However, according to a summary of the Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG): Code of Conduct for Physicians, II.16, a physician may make the patient aware of his personal beliefs, if these beliefs will not impede the physician's duty to provide the patient with the care to which he is entitled. Also, in a KNMG position paper namely, 'The role of the physician in the voluntary termination of life' it is held at 4.1 that, although doctors are not obligated to assist, they do have a professional duty to refer the patient to a non-objecting physician.

²² *Belgian Act on Euthanasia of 28 May, 2002 (Wet Betreffende de Euthanasie)*, Chapter VI, section 14.

²³ *Assisted Dying for the Terminally Ill Bill* HL Bill 17.

²⁴ *Assisted Dying for the Terminally Ill Bill*, section 7(1): "No person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any diagnosis, treatment or other action authorised by this Act to which he has a conscientious objection."

such physicians are not exempted from refusing to refer patients to other physicians.²⁵ Subsequently, in the *Assisted Dying Bill*,²⁶ which was drafted after the *Assisted Dying for the Terminally Ill Bill*, it appears that the wording was altered simply to offer the physician protection against participating in anything authorised in the Act to which he has a conscientious objection.²⁷ However, the British Parliament overwhelmingly rejected the *Assisted Dying Bill*,²⁸ thus placing the United Kingdom within the ranks of nations rejecting euthanasia and assisted dying. Despite the Bill being rejected, it still emphasises an important requirement namely that conscientious objectors would have been allowed the freedom to object to *any* aspect of the euthanasia procedure.

Ordinarily, conscientious objection clauses make fervent claims to protect objecting doctors, but they are required to refer the patient to another doctor whom they know will not have the same reservations. Some conscientious objectors are of the view that there is no difference between administering a toxin to a patient and referring the patient, as the practitioner will still consider himself complicit in the eventual killing of the patient. This is similar to matters related to pharmacists who conscientiously object against referrals pertaining to indirect abortion practices. Robert Vischer refers to Karen Brauer's (president of *Pharmacists for Life*) view that forcing a pharmacist who conscientiously objects to dispensing abortifacients to refer customers to another pharmacy constitutes the enforcement of such a pharmacist to say, "I don't kill people myself but let me tell you about the guy down the street who does."²⁹

Where recent events, as referred to above, in South Africa have brought to the fore questions and proposals related to the legalisation of euthanasia (and which indirectly implies matters related to conscientious objection by medical practitioners), recent developments in Canada

²⁵ *Assisted Dying for the Terminally Ill Bill*, section 7(2): "If an attending physician whose patient makes a request to be assisted to die in accordance with this Act or to receive pain relief under section 15 has a conscientious objection as provided in subsection (1), he shall take appropriate steps to ensure that the patient is referred without delay to an attending physician who does not have such a conscientious objection."

Section 7(3): "If a consulting physician to whom a patient has been referred in accordance with section 2(2)(g) has a conscientious objection as provided in subsection (1), he shall take appropriate steps to ensure that the patient is referred without delay to a consulting physician who does not have such a conscientious objection."

²⁶ *Assisted Dying Bill* HL Bill 24.

²⁷ *Assisted Dying Bill*, section 5: "A person shall not be under any duty (whether by contract or arising from any statutory or other legal requirement) to participate in anything authorised by this Act to which that person has a conscientious objection."

²⁸ R. Mason, "Assisted dying bill overwhelmingly rejected by MPs", *The Guardian*, 12 September 2017, www.theguardian.com/society/2015/sep/11/mps-begin-debate-assisted-dying-bill (Accessed on 30 September 2015).

²⁹ R. Vischer, *Conscience and the Common Good. Reclaiming the Space Between Person and State*, (Cambridge: Cambridge University Press, 2010), 162.

have acted as a catalyst towards the matter of conscientious objection against the administering of euthanasia. The Canadian judiciary was confronted recently with applications pleading for the granting of patients wishing to die, the ability to do so. In 1983, the Canadian Law Reform Commission proposed that euthanasia should be decriminalised. However, nothing of legal significance came from the proposal. Then, in 1993, another attempt was made to decriminalise euthanasia through the case of *Rodriguez v British Columbia (Attorney General)*³⁰ in which it was claimed that criminalising euthanasia in terms of sections 14³¹ and 241³² of the Canadian *Criminal Code*³³ infringes the patient's rights as held in the Canadian *Charter of Rights and Freedoms*.³⁴ However, the Court did not alter the Canadian position. Following *Rodriguez*, certain events³⁵ provided further discussion and debate regarding euthanasia, the most prominent being the drafting and promulgation of 'physician-assisted dying' legislation by the Canadian province of Quebec in 2014.

Consequently, Quebec became the first Canadian province to allow assisted dying. Finally, in the case of *Carter v Canada (Attorney General)*,³⁶ the court gave clarity regarding the Canadian position. The case was brought before the Supreme Court of Canada, which unanimously struck down the criminalising sections of the *Criminal Code* pertaining to doctor-assisted dying.³⁷ The ruling was suspended for twelve months, allowing parliament to promulgate necessary legislation (should it wish to do so) regulating assisted dying.³⁸ It appears that attention was to

³⁰ *Rodriguez v British Columbia (Attorney General)* [1993] 3 S.C.R. 519, par. 1. Sue Rodriguez suffered from amyotrophic lateral sclerosis. At the time of the case, she still had reasonable prospects of living a normal life, but her application was to allow a physician to, when such time comes that she can no longer enjoy life as she ordinarily would on account of the illness, set up a technological means enabling her to end her life upon such time of her choosing.

³¹ "No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given."

³² "Everyone who (a) counsels a person to commit suicide, or (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years."

³³ Canadian *Criminal Code* R.S.C. 1985, c. C-46.

³⁴ The *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c. 11, particularly section 7: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

³⁵ *R. v. Latimer* [2001] 1 S.C.R. 3, 2001 SCC 1, par. 1. Robert Latimer was a farmer accused of killing his severely disabled daughter, out of compassion, by causing her to inhale motor vehicle fumes. Further, Bills were drafted, discussed and voted upon in 2005 (Bill C-407) and 2009 (Bill C-384) but both failed to achieve desired results.

³⁶ *Carter v Canada (Attorney General)* SCC 5, [2015] 1 S.C.R. 331.

³⁷ *Carter v Canada (Attorney General)*, par. 4: "The appeal should be allowed. Section 241 (b) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life, and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition."

³⁸ *Carter v Canada (Attorney General)*, par. 11.

be given to the needs of both the patient *and the medical practitioner*, as the Court held that “Nothing in this declaration would compel physicians to provide assistance in dying. The *Charter* rights of *patients and physicians* will need to be reconciled in any legislative and regulatory response to this judgment.”³⁹ On 17 June 2016, Bill C-14 received royal assent and thus altered the *Criminal Code* by replacing section 14⁴⁰ and amending the criminalising provisions in section 241 of the *Criminal Code*. The effect of this Bill is far-reaching as (physician) assisted dying is now legal and available upon request. A nurse or medical doctor is exempted from criminal culpability for providing medical assistance in dying.⁴¹ The amendment further provides that no person can be held liable for culpable homicide if he assists a medical practitioner or a nurse in the process of providing medical assistance in dying.⁴² Section 2(4) creates a unique position in that it negates the provisions of section 14 (referred to above) of the *Criminal Code* with regard to active euthanasia.

Many doctors in Canada are fearful that legalising euthanasia will make them complicit to murder. The very act of killing a patient one has taken an oath to protect can be viewed as opposing the ethics and morals of the medical community⁴³ as well as the religious beliefs and values of certain doctors. Part of this challenge facing medical practitioners is the emphasis placed on the prioritisation of the patient in the context of a consumerist society. As Wesley J. Smith states,

Today, ‘patient rights’ are paramount; the competent customer is always right and, hence, held to be entitled to virtually any legal procedure from ‘service providers’ for which payment can be made – be it abortion, assisted suicide, or, someday perhaps,

³⁹ *Carter v Canada (Attorney General)*, par. 11 (Author’s emphasis).

⁴⁰“14. No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.” (see R.S., c. C-34, s.14) was replaced by “14. No person is entitled to consent to have death inflicted on them, and such consent does not affect the criminal responsibility of any person who inflicts death on the person who gave consent.” (see R.S., 1985, c. C-46, s. 14; 2016, c.3, s.1.). Bill C-14 clarifies these two seemingly identical statements through 2(4), which holds: “Section 14 does not apply with respect to a person who consents to have death inflicted on them by means of medical assistance in dying provided in accordance with section 241.2”.

⁴¹ Bill C-14, C 3, section 2.

⁴² Bill C-14, C 3, section 2.

⁴³ World Medical Association Statement on Physician-Assisted Suicide, adopted by the 44th World Medical Assembly, as revised by the 170th World Medical Association Council Session at Divonne-les-Bains, France in May 2005 stated: “Physician-Assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life the physician acts unethically.” *WMA Resolution on Euthanasia*. <https://www.wma.net/policies-post/wma-resolution-on-euthanasia/> (Accessed on 7 August 2016).

embryonic stem cell therapies and products made from cloned and aborted human foetuses.⁴⁴

A similar tendency in present day medical practice is observed by Rex Ahdar and Ian Leigh, “Modern medicine has shifted from a paternalistic approach, where the doctor knew best what was required for his or her patient’s health and determined the course of treatment, to a patient-centred approach based on the notion of consent. Medical treatment is based on the informed consent of the patient.”⁴⁵

If legislation is indeed enacted and no regard is given to the conscientious (whether religious or non-religious) convictions of medical practitioners then, according to Wesley Smith, “Those who feel called to a career in health care will face an agonizing dilemma: either participate in acts of killing or stay out of medicine. Those who stay true to their consciences will be forced into the painful sacrifice of embracing martyrdom for their faith.”⁴⁶ This dilemma not only pertains to the conscientious objection by religious doctors, but also to non-religious doctors who may conscientiously object due to another foundational belief. While the debate has been raging in Canada, South Africa is on the brink of a similar challenge that may come into conflict with the religious (or non-religious) convictions of medical practitioners. It is heartening to see that there is, as referred to earlier, pro-euthanasia legislation in some countries that also make provision for the rights of medical practitioners. It is hoped that the South African legislature will, if it also legalises active forms of euthanasia (as well as physician-assisted suicide⁴⁷), include a clause that provides for conscientious objection against the administering of euthanasia based on convictions of belief. In fact, it is the aim of this study to, from a jurisprudential point of view, provide an argument in support of the accommodation of the protection of the conscientious objection by a medical practitioner to the administering of euthanasia.

How important is the ‘religious motive’ pertaining to the conscientious objection against administering euthanasia? Fortunately, the South African judiciary, especially the Constitutional Court, has evinced a positive approach regarding the importance and protection

⁴⁴ W. J. Smith, “The coming of medical martyrdom”, 20 February 2015, www.firstthings.com/web-exclusives/2015/02/the-coming-of-medical-martyrdom (Accessed on 25 July 2017).

⁴⁵ Ahdar & Leigh, *Religious Freedom in the Liberal State*, 299.

⁴⁶ Smith, “The coming of medical martyrdom”.

⁴⁷ Physician-assisted suicide and its connection to euthanasia will be dealt with in more detail in Chapter Two.

of religious rights (also pertaining to thought, opinion, conscience and belief) against the background of the South African Constitution's Bill of Rights.⁴⁸ This is salutary regarding the furtherance of the protection of such a fundamental right, also bearing in mind that South African jurisprudence is still in its infancy in this regard. This provides even more reason for the qualification of the importance of this study in that the topic furthers jurisprudence on the parameters of the right to freedom of religion in South Africa, specifically regarding conscientious objection against the administering of euthanasia by medical practitioners. What adds to the importance of the topic related to conscientious objection against the administering of euthanasia is the sanctity and consequent protection of life that forms the backbone of many Constitutions and human rights instruments around the world. By its very nature, this right is inherent to total protection by virtue not only of South African jurisprudence, but as stated earlier, by international instruments (and foreign law) as well.⁴⁹ South African jurisprudence understands the importance of cherishing life and respecting its sanctity, and this was emphasised in the South African Constitutional Court judgment of *S v Makwanyane*.⁵⁰ As will become evident in the Chapters that follow, it is opined that life should be understood as being comprised of life in the sense of both the mind as well as the biological make-up; or stated otherwise, comprised of both intellectual as well as physical attributes.

⁴⁸ *Constitution of the Republic of South Africa*, section 15(1): "Everyone has the right to freedom of conscience, religion, thought, belief and opinion." There have been numerous challenges presented before the South African Constitutional Court pertaining to religious matters. In this regard, see *S v Lawrence* 1997(4) SA 1176 (CC); *Prince v President, Cape Law Society* 2002 (2) SA 794 (CC); *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC) and *MEC for Education: KwaZulu-Natal and Others v Pillay* 2008 (1) SA 474 (CC) 493-494. These judgments had important and insightful things to say regarding the importance of religion and the right to freedom of religion, see for example, *Prince v President, Cape Law Society* at par. 38; *Christian Education South Africa v Minister of Education* par. 19; and *S v Lawrence* par. 92. Also see *Minister of Home Affairs and Another v Fourie and Another* 2006 (3) BCLR 355 par. 89. South Africa is also party to a number of international instruments regarding the protection of religious freedom, namely: *International Covenant on Civil and Political Rights*, Art. 18; *African Charter on Human and Peoples' Rights*, Art. 8; *UN Declaration on the Elimination of all Forms of Intolerance and Discrimination based on Religion or Belief*, Arts. 1.1, 1.2, 2.1, 2.2, 4.1, 4.2 and 7; *Convention for Protection of Human Rights and Fundamental Freedoms*, Art. 9; *Universal Declaration of Human Rights*, Art. 18. From a South African context, further protection is evident through section 31 of the *Constitution of the Republic of South Africa*, which provides for specific protection to cultural, religious and linguistic groups.

⁴⁹ *Constitution of the Republic of South Africa*, section 11; *Universal Declaration of Human Rights*, section 3; *African Charter on Human and Peoples' Rights*, section 4; *American Convention on Human Rights*, section 4; *American Declaration on the Rights and Duties of Man*, section 1; *Arab Charter of Human Rights*, sections 5-8; *European Convention for the Protection of Human Rights and Fundamental Freedoms*, section 2; *International Covenant on Civil and Political Rights*, section 6; *European Convention for the Protection of Human Rights and Fundamental Freedoms concerning the abolition of the death penalty in all circumstances*, Protocol No. 13.

⁵⁰ *S v Makwanyane and Another* 1995 (2) SACR 1 (CC), par. 144. See also par. 217, Langa J: "The right to life is the most fundamental of all rights, the supreme human right."

This is important to note as, in the debates concerning the legalisation of euthanasia, those who support the administering of euthanasia place in many instances more emphasis on the mind as the determining factor in deciding whether a life may be terminated. This in turn relates to an elevation of the choices and experiences that a human being is entitled to, rather than the physical or biological life make-up of a person. For purposes of this study, the substantive importance (or in religious terms, the sanctity) of the right to life serves to enhance the credibility of the protection of the medical practitioner to conscientiously object to the administering of euthanasia, the latter slotting in with the primary focus of this study. In this regard, we are dealing primarily with the protection of the medical practitioner's conscientious aversion towards the administering of the termination of life where this 'termination of life' takes the form of both active and passive forms of euthanasia (as well as physician-assisted suicide). This does not mean that all types of euthanasia are necessarily opposed, but only those applicable to this study.⁵¹ The importance (or sanctity) of life is further bolstered by the religious commitment that a medical practitioner may have to abstain from any form of euthanasia. To many, religion plays an important role in ascribing dignity its rightful place in an individual.⁵² In this regard, it is not only the medical practitioner's aversion to causing the death of something *per se*, but also his aversion towards causing the death of someone in the eyes of God.

Bearing the above in mind, this study is comprised of an argument for the protection of a religious believer's right (which by implication also may overlap with the convictions of non-religious believers) to conscientiously object against the administering of euthanasia, especially within the South African context. This does not imply the irrelevance of this study for democratic jurisdictions beyond South Africa. This study also indirectly relates to the right of a medical practitioner not to even partake in *referrals* related to the administering of euthanasia as well as regarding the protection of the rights of pharmacists to conscientiously object towards the possible dispensing of medication that may be used in cases of euthanasia or 'physician-assisted suicide'. William Allen and David Brushwood point to the fact that when a prescription is presented to a pharmacist that prescribes medication for the termination of a

⁵¹ As elaborated upon in Chapter Two.

⁵² *Minister of Home Affairs and Another v Fourie and Another*, par. 89, Sachs J: "Religious belief has the capacity to awake concepts of self-worth and human dignity..."

patient's life, a moral dilemma may come to the fore. In this regard, the pharmacist should be viewed as a participant of whose beliefs should be taken cognisance of.⁵³

Conscientious objection against the administering of euthanasia by a medical practitioner constitutes an *inherent* aversion to participate in an act that overlaps with deep religious convictions pertaining to the taking of human life; convictions that may also be rationally justified. In this regard, one is not dealing with a mere dislike, dissatisfaction or preference, but rather with an aversion that touches on the most inner layers of being human, meaning of the self and the worth of life. Similar to conscientious objection cases by medical practitioners who do not want to participate in abortions, the protection of the medical practitioner who objects to administering euthanasia is viewed, and understandably so, as constitutive of fundamental importance. This inherent aversion is deeply layered due to its inextricable connection to the importance (sanctity) of life and to moral sensitivities as well as complexities related to such a freedom. This in turn constitutes a pre-argumentative aversion that requires protection *ab initio*. In other words, the intentional termination of an innocent life is a wrong in the same sense that it is for example wrong to terminate the life of a new born baby. In this regard, no sources require consultation to first determine whether such an action is moral. However, this does not exclude rational, philosophical, theological or jurisprudential argumentation to confirm such an aversion towards the intentional termination of innocent life. Cognisance also needs to be taken that foundational beliefs are at the core of such determinations as to what is morally the proper avenue to follow. This implies the importance of the protection of such beliefs that are inextricably connected to the protection of various human rights such as human dignity and the right to freedom of religion. In this regard, it is apt to refer to the view taken by Rex Ahdar and Ian Leigh namely that:⁵⁴

Medicine deals with pain, suffering, and death, subjects that touch the very heart of religion as well. It should not surprise anyone that medical treatment controversies often reflect differing world views of the protagonists ... to insist there is a neutral, objective basis upon

⁵³ W. L. Allen & D. B. Brushwood, "Pharmaceutically Assisted Death and the Pharmacist's Right of Conscience", *Journal of Pharmacy & Law*, Vol. 5, 1(1996), 1.

⁵⁴ Ahdar & Leigh, *Religious Freedom in the Liberal State*, 319.

which to judge these conflicts is to maintain ‘the fiction of neutrality’⁵⁵ as some medical ethicists call it. There is no ‘View from Nowhere’.⁵⁶

This comment by Ahdar and Leigh is most relevant to the matter related to conscientious objection to the administering of euthanasia by medical practitioners as it deals with pain, suffering and death in a most fundamental manner and therefore, naturally touches at the heart of many religions and their accompanying moral views (and moral points of view that are not necessarily linked to a religion). In this regard, neutrality of belief remains elusive. This in turn makes space for the importance of the acceptance of those forms of conscience that oppose participation in euthanasia. Bearing this in mind, the challenge established by the topic of this study is to discover and apply the relevant jurisprudential (and related) arguments in support of the protection of such a claimed freedom. In this regard, an argument is presented in support of the accommodation of the exemption of medical practitioners from administering euthanasia in instances where such practitioners express a conscientious objection based on religion (or any foundational belief for that matter).

As alluded to earlier, this study is of relevance primarily for the South African context, but also for other democratic and constitutional States, and therefore, States that either legalise many forms of euthanasia but do not have exemption clauses catering from conscientious objectors or that will consider such legislation in future, may also profit from this study. Having said this, and as stated earlier, it needs to be emphasised that the key argument of this study is that a medical practitioner should be allowed, as a matter of conscience based on religious belief, to object to administering euthanasia in South Africa (and other constitutional States). In light of the background that has been established, and the increasing prevalence of the euthanasia debate in modern society including South Africa, questions related to the rightness or wrongness of euthanasia remain firmly rooted in the moral and belief foundations of the individual (and to the traditions and narratives to which individuals are affiliated to), which in turn needs to be respected and protected in a society that prides itself on the protection, maintenance and furtherance of especially human dignity, freedom and diversity.

⁵⁵ M. Secundy & C. Sundstrom, “The Fiction of Neutrality”, cited in Ahdar & Leigh, *Religious Freedom in the Liberal State*, 319.

⁵⁶ C. Cowley, “The Conjoined Twins and the Limits of Rationality in Applied Ethics”, cited in Ahdar & Leigh, *Religious Freedom in the Liberal State*, 319.

Chapter Two of this study will focus on explaining the various types of euthanasia to clarify the parameters applicable to the protection of the conscience as argued for in this study (and as confusion often results from the different terms used). In this regard, the distinction between active and passive euthanasia will be elaborated upon, and specific attention will be given to what exactly constitutes physician-assisted suicide. Also, the relevance of living wills will be presented and following on this, a comparative investigation regarding the position of euthanasia in South Africa and other selected foreign jurisdictions, namely that of the Netherlands and Belgium, will briefly be described. This is preceded by arguments related to euthanasia with the aim of strengthening the argument in support of the protection of the medical practitioner's conscientious objection against the administering of euthanasia. A selected argument in favour of euthanasia for purposes of this study refer to the quality of life of a patient and (intolerable) suffering as well as the patient's personal autonomy (all these being inextricably related to one another). Arguments in opposition to euthanasia argue that human life should be viewed as a non-derogable right (and a sacred right) that cannot be ended at will where the person whose life is to be intentionally terminated is innocent. Consequently, a discussion of the moral views surrounding the importance of the right to life and its sanctity follows, and then, emphasis is placed on alleviating pain and suffering through adequate palliative care.

Chapter Three focuses on the right to freedom of religion. Religious freedom is an important right in a constitutional, democratic and by implication, plural society, and plays an important role in many social settings. Religious belief and expression is *per se* a foundational right and therefore deserves the required protection. Consequently, the position of religious rights in South Africa is expanded upon. So as to ensure a thorough understanding of terminology, the various meanings and interpretations attributed to the right to freedom of religion, belief, opinion as well as conscience are presented. In this regard, parallels are also drawn in light of foreign⁵⁷ jurisprudence as well as a number of international instruments. Given that the focus of this study falls on the right of a medical practitioner to exercise his rights in the context of his religiously informed conscience, specific focus is given to the meaning of conscience. Conscience has been recognised in other similarly contentious circumstances, such as military conscription and the participation in abortion practices (including referrals). In bringing Chapter Three to a conclusion, the importance of furthering pluralism is emphasised,

⁵⁷ Such as European and North American jurisprudence.

particularly in the context of liberal society's prevalence of substantively relegating religion to the private sphere. It is especially Western society's secular inclination pertaining to the public sphere that has given rise to several morally substantive matters, which raise particular challenges to specific religious interests, particularly in the context of health care provision.

Chapter Four focuses on the various rights at play throughout the entire debate at hand. The right to life will firstly be examined, emphasising its relationship with human dignity. Secondly, a thorough comparative investigation is conducted into the development of the right to privacy from the perspective of jurisprudence from especially South Africa and the United States of America. In addition to the rights to life and privacy, a detailed examination is conducted pertaining to the right to dignity in light of the two above-mentioned rights, as well as the relationship between dignity and religion. It becomes clear that at the foundation of religion one finds dignity. As dignity gives substance to religion and religion similarly gives substance to dignity, an individual finds substantive meaning in his religion. After having investigated the various rights at play, it is postulated that an unreasonable and unjustifiable infringement of the medical practitioner's basic rights indeed occurs. This is evident from a completion of, more specifically what is referred to as the proportionality test analysis taken from the perspective of whether it would be reasonable and justifiable to limit the medical practitioner's conscientious objection against the administering of euthanasia. This is accomplished by means of the five-step limitations test in terms of section 36 of the *Constitution of the Republic of South Africa*, of which the criteria prescribed are comprised of a determination as to the nature of the right to freedom of religion; the importance of religion and the role it plays in the lives of adherents and in society; the nature and extent of the infringement of the rights of the medical practitioner; the relationship between limiting religious freedom and maintaining the patient's rights; and lastly, the determination whether any less restrictive measures exist that would bring about a similar result for the patient. In light of the said test to be applied, and as stated earlier, it is concluded that the infringement of the basic rights of the medical practitioner does not amount to being 'reasonable' and 'justifiable' for a number of reasons.

Chapter 2

Meaning, History and Selected Arguments Pertaining to Euthanasia

2.1 Introduction

Euthanasia is a combination of two Greek words that refers to a ‘good death’. This term has been used throughout history by historians such as Cratinus, Menander of Athens and Philon the Jew to describe a death that is a good and easy death for someone who needs to die.⁵⁸ The word was defined, writes the Roman historian Suetonius, by Emperor Octavian August as “[a]n easy, painless, good death that follows a successful life.”⁵⁹ Then there is the modern day understanding of euthanasia that refers to the act of putting to death a person whose existence is perceived to be so bad that it would be better for such a person to be put to death; or it is believed that should a person’s life continue uninterrupted, it would be better if such life is ended because life would become unbearable.⁶⁰ The *Shorter Oxford English Dictionary* gives three meanings for the word euthanasia: the first, “a quiet and easy death”; the second, “the means of procuring this”; and the third, “the action of inducing a quiet and easy death.”⁶¹ However, according to Philippa Foot, none of these provide an adequate definition of the word as it is usually understood. The reason for this is that euthanasia means much more than “a quiet and easy death” (or the means of procuring it, or the action of inducing it). Such a definition only specifies the manner of the death, and if this, says Foot, were all that was, it can imply that a murderer, careful to drug his victim, could claim that his act was an act of euthanasia.⁶² Moreover, adds Foot, to merely signify that a death was quiet and easy, one has only to remember that Hitler’s ‘euthanasia’ programme traded on this ambiguity.⁶³

Francis Beckwith and Norman Geisler refer to euthanasia as the “intentional taking of a human life for some good purpose, such as to relieve suffering or pain. Commonly the word denotes

⁵⁸ D. Pavlovic, A. Spassov & C. Lehmann, “Euthanasia: In defence of a good, ancient word”, *Journal of Clinical Research and Bioethics*, Vol 2, 1(2011), 1, 3.

⁵⁹ Pavlovic, Spassov & Lehmann, “Euthanasia: In defence of a good, ancient word”, 1, 3.

⁶⁰ R. Young, "Voluntary Euthanasia", *The Stanford Encyclopedia of Philosophy* (Fall 2015), E. N. Zalta (ed.) www.plato.stanford.edu/archives/fall2015/entries/euthanasia-voluntary/ (Accessed on 12 March 2016).

⁶¹ P. Foot, “Euthanasia”, *Philosophy and Public Affairs*, Vol. 6, 2(1977), 85.

⁶² Foot, “Euthanasia”, 85.

⁶³ Foot, “Euthanasia”, 85.

the taking of an adult life, though it can refer generally to taking any life after birth for supposed benevolent purposes.”⁶⁴ One of the most prolific liberal jurists of recent times namely, Ronald Dworkin, simply defines euthanasia as “deliberately killing a person out of kindness”.⁶⁵ Belgian legislation defines it as “...intentionally terminating life by someone other than the person concerned, at the latter’s request.”⁶⁶ In the Netherlands, euthanasia is understood to be “ending the life of another person at their (the latter’s) express request.”⁶⁷ The eminent legal philosopher of current times namely, John Finnis states that voluntary euthanasia entails the ending of the life of a person by another person at the latter’s request,⁶⁸ and that non-voluntary euthanasia is comprised of “the unrequested putting to death of persons suffering from incurable and distressing disease.”⁶⁹

The renowned scholar on euthanasia jurisprudence namely, John Keown identifies three definitions,⁷⁰ and each of the three definitions share common characteristics namely, that euthanasia, as a concept, involves: (1) decisions regarding the end of a person’s life; (2) that it is limited to the medical context, as medical personnel are ordinarily the main actors; and (3) that it involves the belief that euthanasia benefits the patient.⁷¹ Thus in summary, euthanasia entails medical practitioners making decisions with the intention of not *possibly* shortening a patient’s life, but acting with the actual *intention* of doing so, in the belief that the patient would be in a better position dead, than alive.⁷² From these sprout different types related to ‘voluntary’, ‘non-voluntary’, ‘active’ and ‘passive’ as well as involuntary aspects, which will be elaborated upon below. A third category that does not always fully resort under active or passive forms of euthanasia, is physician-assisted suicide (PAS), which is sometimes called ‘assisted dying’.⁷³ Keown describes PAS by contrasting it with the function of the actor in

⁶⁴ F. J. Beckwith & N. Geisler, *Matters of Life and Death. Calm Answers to Tough Questions about Abortion and Euthanasia*, (Grand Rapids: Baker Book House, 1991), 141.

⁶⁵ J. M. Finnis, “Euthanasia, Morality, and Law”, (Fritz B. Burns Lecture, Loyola Law School, Los Angeles, 22 November 1996), *Loyola of Los Angeles Law Review*, Vol. 31(June 1998), 1125.

⁶⁶ *Belgian Act on Euthanasia of 28 May, 2002*, (Wet Betreffende de Euthanasie), section 2.

⁶⁷ H. Lindemann & M. Verkerk, “Ending the Life of a Newborn: The Groningen Protocol”, *Hastings Center Report*, Vol. 38, 1(2008), 44.

⁶⁸ Finnis, “Euthanasia, Morality, and Law”, 1125-1126.

⁶⁹ As referred to by Judge Reinhardt in the case of *Compassion in Dying v. Washington*, cited in Finnis, “Euthanasia, Morality, and Law”, 1125.

⁷⁰ J. Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*. (Cambridge: Cambridge University Press, 2004), 9.

⁷¹ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 10.

⁷² Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 11.

⁷³ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 9. Keown refers to an additional category termed “non-voluntary active euthanasia”, which refers to euthanasia performed on persons who do not have sufficient cognitive ability to agree thereto, or they can, in fact agree thereto, but are not given the opportunity to do so.

active euthanasia. Where a medical practitioner is the one ending the patient's life at the latter's request in voluntary active euthanasia, PAS entails the medical practitioner assisting the patient to commit suicide.⁷⁴

Ultimately, euthanasia is a broad concept fraught with various categories and definitions, and frequently, confusion exists as to what each definition refers to.⁷⁵ In many scholarly sources a distinction is made between active, passive, voluntary and involuntary euthanasia, but rarely in legislation is reference made to euthanasia in such detail. For example, Dutch euthanasia legislation⁷⁶ does not once refer to either active or passive euthanasia. In fact, the word 'euthanasia' is never mentioned. Rather, the phrase 'assisted suicide' frequently occurs. The Belgians simply use the word euthanasia.⁷⁷ Consequently, for purposes of this study, each category of euthanasia will be discussed separately with the intention of conveying a clear picture of what exactly is meant by the varying terms. A reason for this categorisation is, according to John Keown, useful for excluding confusion in debates on whether euthanasia should be decriminalised. If different parties in such debates understand euthanasia to mean quite different things, their discussion is likely to be fruitless and frustrating.⁷⁸ This is also especially of relevance to the study as this explains the various scenarios argued for, in which the medical practitioner may call upon for the protection of his right to conscientiously object to the specific form of euthanasia at hand as well as to the exercise of physician-assisted suicide.

The section on the various types of euthanasia is preceded by a historical background of euthanasia in South Africa so as to enhance the context of the matter at hand, after which a brief description is provided pertaining to the legal position in both the Netherlands and Belgium with the aim of providing a better orientation towards the study. This also confirms the reality accompanying the legalisation of many forms of euthanasia. The last section in this Chapter addresses an argument in support of as well as arguments in opposition to many forms

⁷⁴ Keown: *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 31.

⁷⁵ D. V. K. Chao, N. Y. Chan & W. Y. Chan, "Euthanasia Revisited", *Family Practice*, Vol. 19, 2(2002), 128.

⁷⁶ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*; H. Jochemsen & J. Keown, "Voluntary euthanasia under control? Further empirical evidence from the Netherlands", *Journal of Medical Ethics*, Vol. 25, 1(1999), 17. Jochemsen and Keown indicate that the Dutch view of euthanasia is quite narrow and define the concept simply as the intentional shortening of a patient's life at his explicit request. Therefore, in the Dutch context, euthanasia refers to active voluntary euthanasia, and does not include any reference to omissions or euthanasia without the request of the patient.

⁷⁷ *Belgian Act on Euthanasia*.

⁷⁸ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 9-10.

of euthanasia. Regarding those arguments in support of a wide range of categories related to euthanasia, only one was selected due to its relevance to the argument in support of the protection of the medical practitioner's right to conscientiously object against the administering of euthanasia. Needless to say, arguments in opposition to a wide application of euthanasia naturally assist an argument in support of the medical practitioner's right to conscientiously object to administering a wide range of euthanasia practices.

2.2 Types of euthanasia

Active euthanasia involves the administrator taking deliberate steps to end the life of a person who voluntarily requests such steps due to suffering from some ailment or disease, and where the administrator executes such steps out of compassion as primary motive for the termination of the requestor's life.⁷⁹ Active euthanasia can also be viewed in a non-voluntary sense where the medical practitioner executes steps that terminates the life of the patient out of compassion as primary motive. Francis Beckwith and Norman Geisler explain that active euthanasia refers to the taking of a human life, which, from a medical perspective, usually comprises the injection of a drug aimed at inducing death.⁸⁰ Stuart Beresford refers to the distinction between *voluntary euthanasia*, where the consent of the patient is first obtained, and *non-voluntary euthanasia*, where consent is not obtained for example, when a patient is in a persistent vegetative state or otherwise lacks the capacity to give informed consent.⁸¹ What sets active euthanasia aside from murder is the fact that the person ending the life of the requestor does so without any malicious motive, although the required intent to end life, thus murdering someone, is present.⁸² John Keown states that voluntary active euthanasia is generally understood as euthanasia at the request of the patient.⁸³ According to Keown, 'non-voluntary' active euthanasia is applied on a person who does not have the mental ability to request euthanasia (such as babies, adults with advanced dementia or those who, although competent, may not have been given the opportunity to consent to it).⁸⁴ Euthanasia against the wishes of a competent patient is often, says Keown,

⁷⁹ Such person can be the person seeking euthanasia or a person duly authorised to act on behalf of the person to be euthanised, such as a curator for a person in a persistent vegetative state.

⁸⁰ Beckwith & Geisler, *Matters of Life and Death. Calm Answers to Tough Questions about Abortion and Euthanasia*, 141-142.

⁸¹ S. Beresford, "Euthanasia, the Right to Die and the Bill of Rights Act", *Human Rights Research* (Online), Vol. 3(3), 5.

⁸² P. Singer, *A Companion to Ethics*, (Oxford: Blackwell Publishers Ltd., 1991), 294.

⁸³ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 9.

⁸⁴ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 9.

referred to as ‘involuntary’ euthanasia.⁸⁵ Keown adds that there are those who lump together the last two categories and classify all euthanasia without request as ‘involuntary’; whilst Keown is of the view that to avoid unnecessary confusion, the said two categories should be kept distinct.⁸⁶ Craig Paterson clearly distinguishes between non-voluntary and involuntary euthanasia by explaining that non-voluntary euthanasia entails “the intentional killing of a person not capable of granting his or her consent” whilst involuntary euthanasia entails “the intentional killing of a person who expressly withheld his or her consent.”⁸⁷ Then there is the doctrine of *double effect*, which covers the administration of drugs to relieve a terminally ill patient’s pain and suffering despite the physician knowing that this might have the incidental effect of hastening the patient’s death.⁸⁸ This could be understood as being inexorably connoted to active euthanasia, and may overlap with forms of both voluntary and non-voluntary active euthanasia.

Passive euthanasia is not the act of taking actual deliberate steps to end the life of the person through some procedure, but the omission to prolong life.⁸⁹ Passive euthanasia involves the cessation of treatment of a patient, such treatment being the sole cause of life continuation of the patient. The patient is removed from any life support equipment, such as any machine that assists a person to perform ordinary bodily functions, oftentimes breathing; and had it not been for such equipment, such as a respirator or ventilator, the patient would have succumbed already.⁹⁰ Passive euthanasia also includes the cessation of any medical procedures, treatments, feeding or medications.⁹¹ According to Beckwith and Geisler, passive euthanasia is allowing a death to occur without intervening, which constitutes the permitting of death and that, from a medical perspective, passive euthanasia usually involves withdrawal of extraordinary (or

⁸⁵ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 9.

⁸⁶ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 9; C. Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, (Burlington, England: Ashgate Publishing Company, 2008), 148-149. Paterson explains this by way of an example where a woman is a burn victim and where it is touch and go as to whether the severity of her burns will mean that she will live for more than a few weeks. However, the woman is lucid enough to insist that critical care be continued. The question that arises here is whether it would be reasonable to aver that the woman is mistaken in her judgment and that it would be better to withdraw critical treatment and therefore allow her to die? Paterson answers that this is not the case: “To deny her treatment against her will – by substituting for her judgment the judgment of others that her life is not worth living – would add the harm of thwarting her will to the harm of intentionally seeking to end her life because her very life is being deemed unworthy.” To end such a person’s life, says Paterson, qualifies as involuntary passive euthanasia.

⁸⁷ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 12.

⁸⁸ Beresford, “Euthanasia, the Right to Die and the Bill of Rights Act”, 5.

⁸⁹ E. Garrard & S. Wilkinson, “Passive euthanasia”, *Journal of Medical Ethics*, Vol. 31, 2(2005), 64.

⁹⁰ B. MacKinnon & A. Fiala, *Ethics: Theory and Contemporary Issues*, 9th Ed., (Boston: Cengage Learning, 2015), 206.

⁹¹ MacKinnon & Fiala, *Ethics: Theory and Contemporary Issues*, 206.

burdensome) medical treatment, which then results in the disease (or sickness) taking its natural course and causing death.⁹²

E. Garrard and S. Wilkinson⁹³ are of the opinion that there are three conditions that should be present for passive euthanasia to be an option namely: (1) life-prolonging treatment should be ceased or withheld; (2) the motive behind the cessation or withholding of treatment should be to ‘hasten’ the patient’s passing; and (3) the ‘hastening’ of the death of the patient should be to the patient’s benefit; to remove the possibility that the patient will suffer. The first condition literally means what the wording implies – a respirator connected to a person is switched off – ‘the plug is pulled’. Without the assistance of the respirator, the patient would have passed away the moment the respirator was needed. One can argue that passive forms of euthanasia may also be voluntary or non-voluntary. An example of this is where a medical practitioner, in following the stipulations of a patient’s living will (which is discussed below), causes the cessation of the provision of natural food or hydration to the said patient (who is not conscious). This may then be viewed as voluntary, whilst where the same omission is performed by the medical practitioner; but where there was no living will that confirms the patient’s intention to have his life terminated in such a situation, then non-voluntary passive euthanasia is applied.

Is there a rigid distinction between active and passive euthanasia? There is support from both scholars and the courts regarding the view that there is no substantial difference between administering a lethal drug (as is the instance with active euthanasia) and refusing life-sustaining treatment (as is the instance pertaining to passive euthanasia), which administration of a lethal drug or the refusing of life-sustaining treatment results in the death of a person.⁹⁴ Of relevance to the irrationality of having to distinguish between active and passive euthanasia in the sense that the former is deemed to be illegal whilst the latter is not, Steven Smith comments that

In one situation, at the patient’s request a doctor removes the intravenous tube by which a patient is supplied with food and water, thus allowing the patient to die. In the other situation, at a patient’s request a doctor prescribes a lethal drug and helps the patient to

⁹² Beckwith & Geisler, *Matters of Life and Death. Calm Answers to Tough Questions about Abortion and Euthanasia*, 141-142.

⁹³ Garrard & Wilkinson, “Passive Euthanasia”, 65.

⁹⁴ S. Smith, *The Disenchantment of Secular Discourse*, (Cambridge and London: Harvard University Press, 2010), 47.

inject the drug. In each case, the most *immediate* cause of death is in a sense biological and “natural” – the heart stops beating, the brain stops functioning – while in each case human decision and deliberate action figure conspicuously in the more extended causal sequence that leads to death.⁹⁵

This confirms the fact that there is not necessarily a rigid distinction between active and passive euthanasia. The implication in this regard is that for a country such as South Africa, where active euthanasia has not been legalised to date but where passive euthanasia is legal, questions related to why the one is legal whilst the other is not, may contain elements of credibility.

Stuart Beresford defines *physician-assisted suicide* (PAS) as the involvement of the medical practitioner in providing a lethal substance to a patient to self-administer in order to commit suicide in a painless manner.⁹⁶ Craig Paterson refers to PAS as “a third party action informed by the intended objective (at the very least), to furnish a potential suicide with the lethal means necessary to end his or her bodily life.”⁹⁷ The manner in which PAS can be differentiated from active euthanasia is that PAS is suicide facilitated by a medical practitioner.⁹⁸ This in turn is done by means or information such as a drug prescription, or an indication as to how certain drugs should be used in order to achieve the intended result, while being fully aware of how the patient intends to use such means or information.⁹⁹ What sets it apart from ‘ordinary active euthanasia’ is that it is referred to as ‘suicide’ in that, although the doctor assists the patient by providing the necessary paraphernalia,¹⁰⁰ the final step is ultimately taken *by the patient himself* to end his life.¹⁰¹ It should always be at the request and with consent of the patient; such consent is important because, in actual fact, even though the medical professional is merely ‘assisting’, both are responsible for the resulting death. The patient was fully aware that the actions would lead to death, and willed it so (and the medical practitioner as well, for the same reasons). Thus,

⁹⁵ Smith, *The Disenchantment of Secular Discourse*, 48; Finnis, “Euthanasia, Morality, and Law”, 1127. Finnis provides examples related to the act of murder also comprising an omission to do something for example, where a person omits to give a diabetic child his insulin so as to inherit the fortune or parents who murder children sometimes by omitting to feed them.

⁹⁶ Beresford, “Euthanasia, the Right to Die and the Bill of Rights Act”, 5.

⁹⁷ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 11.

⁹⁸ Or another member of the medical profession, such as a nurse or a pharmacist.

⁹⁹ Merriam-Webster Medical Dictionary. <https://www.merriam-webster.com/dictionary/physician-assisted%20suicide> (Accessed on 17 April 2016).

¹⁰⁰ Such as drugs, toxins or machines.

¹⁰¹ Z. Moss, Dignity in Dying, 10 April 2013. <http://www.dignityindying.org.uk/blog/assisted-dying-not-assisted-suicide/> (Accessed on 13 September 2016). According to the U.K. based organisation *Dignity in Dying*, there exists a distinction between assisted dying and assisted suicide. Assisted dying is when a terminally ill patient is assisted in determining when, where and how his or her life is to be ended. Assisted suicide is assisting a person to die who simply chooses death over life, *ibid.*

excluding the medical professional simply because the ‘final’ step was taken by the patient is misleading at best.¹⁰² PAS, according to Kamisar, entails a physician who acts only as an assistant, but the individual seeking death remains the final actor.¹⁰³

Ezekiel Emanuel explains that PAS entails a physician providing the death-causing means, for example, barbiturates, to a patient, but the patient is the actor (unlike voluntary euthanasia, where the doctor is the actor) performing the act that brings about his own death.¹⁰⁴ However, the term does not refer to the refusal to continue with life-support or artificial nutrition.¹⁰⁵ Bearing the above in mind, it needs to be noted that there are scholars who believe that there can be some overlap in meaning between active euthanasia and PAS. In this regard, Beckwith and Geisler explain that suicide in which someone other than the person who chooses to die “assists such a person who chooses to die, to die,” then this constitutes a form of active euthanasia. This makes sense against the background understanding that “suicide is an individual’s intentional ending of life, either by one’s own hand, another’s assistance, or by another’s hand.”¹⁰⁶

A fitting example illustrating PAS is the notorious Jack Kevorkian, or ‘Dr Death’, as he was dubbed by the media.¹⁰⁷ He constructed a ‘suicide machine’, which, when activated, would inject lethal substances into the recipient.¹⁰⁸ A famous example, and his first candidate, was one Janet Adkins, a sufferer of Alzheimer’s Disease. Being attached to the constructed machine, she pressed a button, which released the lethal poisons into her bloodstream.¹⁰⁹

¹⁰² D. W. Brock, “Voluntary active euthanasia”, *Hastings Center Report*, Vol. 22, 2(1992), 10.

¹⁰³ Y. Kamisar, “Physician assisted suicide: The last bridge to active voluntary euthanasia” in J. Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, (Cambridge, Cambridge University Press, 1995), 229.

¹⁰⁴ E. Emanuel, “Whose right to die?” *The Atlantic*, March 1997. <https://www.theatlantic.com/magazine/archive/1997/03/whose-right-to-die/304641/> (Accessed on 24 March 2016).

¹⁰⁵ Emanuel, “Whose right to die?” Emanuel goes as far to include another category, indirect euthanasia, which refers to a medical practitioner administering a certain amount of pain medication, with the *intent of relieving pain*, but bearing the knowledge that the dosage prescribed might have the secondary effect of causing the patient’s death.

¹⁰⁶ Beckwith & Geisler, *Matters of Life and Death. Calm Answers to Tough Questions about Abortion and Euthanasia*, 155.

¹⁰⁷ D. Rushe, “‘Dr Death’ Jack Kevorkian, advocate of assisted suicide, dies in hospital,” *The Guardian*, 4 June 2011. www.theguardian.com/world/2011/jun/04/dr-death-jack-kevorkian-suicide (Accessed on 25 May 2017).

¹⁰⁸ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 31.

¹⁰⁹ K. A. C. Wilson, “Washington woman who witnessed Jack Kevorkian’s first assisted suicide recalls her friend, Janet Adkins”, *The Oregonian*, 3 June 2011. http://www.oregonlive.com/pacific-northwest-news/index.ssf/2011/06/washington_woman_who_witnessed_jack_kevorkians_first_assisted_suicide_recalls_her_friend_janet_adkin.html (accessed on 16 September 2016).

Kevorkian was ultimately arrested and convicted of murder¹¹⁰ for administering substances himself to one of his or her patients as PAS was, and remains, illegal in many countries. Some prominent nations have specific legislation regulating assisted dying; these include the Swiss, the Dutch and the Belgians. In a federal government like the United States of America, only certain States¹¹¹ allow PAS.

Other scholars do not refer to euthanasia as such but rather to physician-assisted suicide (which includes active and passive euthanasia, as well as PAS as explained above) and in this regard, David Novak gives a rather succinct encompassing understanding of the different scenarios related to euthanasia (all of which can be considered as being authorised by patients exercising autonomy over their own lives and deaths) namely where: (1) At the behest of the patient, or at the behest of someone who claims to know what the wishes of a comatose patient would be, a medical practitioner causes the death of the patient or where a medical practitioner instructs someone else, such as a nurse, to kill the patient similarly; (2) A physician prescribes suicide for his patient, such as by telling the patient, “As your physician, I have determined that ending your life now is in your best interest and that of society, and this is how you can best do it”; (3) A medical practitioner provides a patient with the means for his own death; and (4) A physician indirectly advises a patient about how to kill himself, such as telling the patient, “Remember, when you take the pills I have prescribed for you, an overdose will be fatal.”¹¹²

Living wills also play a role against the background of euthanasia. For example, the patient in question is involved in a motor vehicle accident where the said patient had stipulated in his living will that in the event that he is left in for example, an irreversible unconscious state that no prolonging medical should be implemented, and that therefore, he should simply be allowed to pass away. In such a scenario there is the view that the expected quality of life of a patient should be so poor that death will be more preferable than life. According to Beckwith and Geisler, living wills may be wills to allow either active or passive euthanasia, and add, “For a living will to be ethically justified it would have to fall into the category of passive euthanasia

¹¹⁰ “‘The Kevorkian Verdict: A Chronology’”, *Frontline*, May 1996. <http://www.pbs.org/wgbh/pages/frontline/kevorkian/chronology.html> (Accessed on 16 September 2016).

¹¹¹ ‘Initiative Measure No. 1000, *The Washington Death with Dignity Act*’; The District of Columbia (Washington D.C.), see *D.C. Act 21-577*; Oregon, see *Oregon Death with Dignity Act* (Ballot Measure 16). See also Ballot Measure 15 as well as *Gonzales v. State of Oregon* 546 U.S. 243; Vermont, see ‘No. 39. *An Act Relating to Patient Choice and Control at end of Life*’; Montana, by virtue of *Baxter v. Montana* MT DA 09-0051, 2009 MT 449; California, see *ABX2-12 End of Life Option Act*; Colorado, see *Proposition 106: End of Life Options Act*.

¹¹² D. Novak, *The Sanctity of Human Life*, (Washington D.C.: Georgetown University Press, 2007), 115-116.

in cases of imminent death where only artificial or heroic means are withdrawn. It is never right to withdraw natural means of sustaining life – food, water, and air.”¹¹³ Added to this, there is the proportionality test. In this regard, Elizabeth Wicks supports John Keown’s view that when treatment may be “disproportionate” either because it would be “futile or excessively burdensome”, withdrawal of treatment would be apt. This study supports the above views namely, that natural means of sustaining life should be maintained. Added to this, where any futile or excessively burdensome treatment is required for the continuation of the patient’s life then withdrawal of life-sustaining treatment may take place.¹¹⁴

As a point of departure regarding “living wills,” the World Medical Association emphasises the principle that the primary goal of physicians is to heal and relieve suffering and that there exists no exception to this principle.¹¹⁵ Bearing this in mind, there is the view that health practitioners should respect the wishes of patients as expressed through a living will.¹¹⁶ Therefore, in light of the ethical responsibility resting upon a medical practitioner, the South African Medical Association (SAMA) recognises living wills, and defines one as “a declaration or an advance directive which will represent a patient’s wish to refuse any medical treatment and attention in the form of being kept alive by artificial means when the patient may no longer be able to competently express a view.”¹¹⁷ In principle, the concept of a living will is in line with the *National Health Act*¹¹⁸ regarding consent to health care in the event that patients mandate others to act on their behalf.¹¹⁹ In South Africa, as discussed elsewhere, living wills are not legally binding documents, but medical doctors are encouraged to act in accordance with the wishes of the patient as expressed therein.¹²⁰ It is commonly believed that once a living will is drafted, medical practitioners have to act in accordance with the will, regardless of any other circumstances.¹²¹ However, in the event that a patient is indeed unable to decide on care for himself, the first recommendation for doctors is to comply with the stipulations set out in

¹¹³ Beckwith & Geisler, *Matters of Life and Death. Calm Answers to Tough Questions about Abortion and Euthanasia*, 145.

¹¹⁴ E. Wicks, *The Right to Life and Conflicting Interests*, (Oxford: Oxford University Press, 2010), 208.

¹¹⁵ *World Medical Association Declaration on Terminal Illness* (as revised by the World Medical Association General Assembly at Pilanesberg, South Africa, 2006), <https://www.wma.net/policies-post/wma-declaration-of-venice-on-terminal-illness/> (Accessed on 15 October 2017), “Principles”, par. 4.

¹¹⁶ World Medical Association Declaration on Terminal Illness, “Principles”, par. 8.

¹¹⁷ *South African Medical Association, Living Wills and Advance Directive*, 2012, Preamble.

¹¹⁸ *National Health Act* 61 of 2003.

¹¹⁹ *National Health Act*, section 7(1)(a)(i): Subject to section 8, a health service may not be provided to a user without the user’s informed consent, unless – (a) the user is unable to give informed consent and such consent is given by a person – (i) mandated by the user in writing to grant consent on his or her behalf;

¹²⁰ *South African Medical Association, Living Wills and Advance Directive*, “Guidelines”, par. 3.

¹²¹ *South African Medical Association, Living Wills and Advance Directive*, “Guidelines”, par. 4.

the advance directive,¹²² but if there is no advance directive stipulating an acceptable course of action, the practitioner must consult with the patient's proxy, if he has one, and others' close to the patient. These individuals would hopefully provide the practitioner with some level of insight into the patient's best interests and last wishes. The practitioner must also ascertain whether the patient had possibly been previously consulted about the possible outcomes of his situation and whether he made his wishes clear in a living will.¹²³ This however, should not mean, as argued for in this study, that a doctor must execute the wishes of the patient if this clashes with the doctor's conscience.

Similarly, the British make allowance for care if a person can no longer speak for himself. It is referred to as either an 'advance decision' or an 'advance statement', and the two are not to be confused. An advanced decision is "a decision you can make ... to refuse a specific type of treatment at some time in the future."¹²⁴ Conversely, the *Mental Capacity Act*¹²⁵ defines an advance decision as "a decision made by a person, after he has reached 18 and when he has capacity to do so, that if at a later time and in such circumstance as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and at that time he lacks capacity to consent to the carrying out or continuation of the treatment, the specified treatment is not to be carried out or continued."¹²⁶ The *Mental Capacity Act* does not provide a definition for an advance statement, but the National Health Service (the NHS) holds an advance statement to be "a written statement that sets down your preferences, wishes, beliefs and values regarding... future care."¹²⁷ A surprising inclusion in SAMA's guidelines is a conscientious objection clause. If a doctor conscientiously objects to withholding treatment, he is not obliged to render performance in terms of the will.¹²⁸

Bearing the above in mind, and for the purposes of this study, euthanasia refers to euthanasia in the active (be it voluntary, non-voluntary or involuntary) or passive sense (be it voluntary,

¹²² *South African Medical Association, Living Wills and Advance Directive*, "Guidelines", par. 3; HPCSA, "Choosing between options: Patients who cannot decide for themselves", *Guidelines for the Withholding and Withdrawing of Treatment, Booklet 12*, par. 8.2.

¹²³ HPCSA, "Choosing between options: Patients who cannot decide for themselves", par. 8.2.

¹²⁴ End of Life Care – Advance decision (living will). www.nhs.uk/Planners/end-of-life-care/Pages/advance-decision-to-refuse-treatment.aspx (Accessed on 18 September 2016).

¹²⁵ *Mental Capacity Act*, 2005, c. 9.

¹²⁶ *Mental Capacity Act*, 2005, section 24(1)(a)-(b).

¹²⁷ End of Life Care – Advance statement about your wishes. www.nhs.uk/Planners/end-of-life-care/Pages/advance-statement.aspx#statement (Accessed on 18 September 2016).

¹²⁸ *South African Medical Association, Living Wills and Advance Directive*, "Guidelines", par. 7.

non-voluntary or involuntary) and has as its principle actor a medical practitioner. It is also clear from the above that PAS may also form part of the euthanasia exercise. The 'living will' is also of relevance in as far it covers relevant forms of active or passive euthanasia. It is important to note that there may be instances where a decision to withdraw further treatment that eventually leads to the death of the patient, may be morally justified, even in the eyes of the medical practitioner who generally objects to partaking in practices where euthanasia is exercised. In this regard, cognisance needs to be taken of the following view by Pope John Paul II:

Euthanasia must be distinguished from the decision to forego so-called 'aggressive medical treatment', in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations, when death is clearly imminent and inevitable, one can in conscience 'refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted'.¹²⁹

In the above, the various forms of euthanasia have been explained, which for purposes of this study, provides clarity on what forms of euthanasia should qualify for the argument that a medical practitioner's right to conscientiously object against the administering of euthanasia should be protected.

In conclusion to this section, it is important to investigate briefly the question: When does death set in? This is of relevance to euthanasia because in order to address matters related to the termination of life, one has to determine what life is, and this naturally includes views on when death is understood to set in as well. As will become clear in especially Chapter Four of this study, human life is to be viewed as the interconnected attributes of, on the one hand, experience, reason, emotions, communication, sentience and intellect, whilst also constitutive of biological life. This understanding stands in stark contrast to the view that there needs to be a distinction between the biological and non-biological attributes of a person and that the latter should enjoy priority in the determination as to whether the life of a person should be

¹²⁹ Pope John Paul II, *Evangelium Vitae* (To the Bishops, Priests and Deacons, Men and Women, religious lay Faithful and all People of Good Will on the Value and Inviolability of Human Life), 25 March 1995, par. 65.

maintained or terminated. Many of those in support of a wide spectrum of instances in which euthanasia should be exercised opine that pain and suffering of a person should qualify for the administering of euthanasia as a result of a loss of *good experiences and mental ability*. Therefore, what we understand by human life (and death) is most relevant to the matter pertaining to the legalisation and morality of the administering of euthanasia.

Bearing the above in mind, what should be understood regarding human life is also enriched in the quest towards determining when the death of a person is viewed to ensue. This is an important question because it directly relates to moral concerns regarding euthanasia, and by implication that which pertains to the parameters of protection related to the medical practitioner whose convictions dictate to him that no innocent life should be terminated intentionally. As pointed out by Craig Paterson, forty years ago the twin functions of breathing and heartbeat were understood to signify the “continued integrated life of a human being and their permanent cessation was taken to constitute human death.”¹³⁰ As medical technology improved, the focus of determining the point of death was directed towards the brain, as breathing and heartbeat could be artificially maintained. In other words, the whole brain or the brain stem could cease to function even though breathing and the functioning of the heart could be maintained; therefore, the view arose amongst some schools of thought, that extensive damage to the brain results in the loss of integral functioning of the human organism which in turn implies death.¹³¹ Therefore, some scholars view the cessation of critical brain functioning as indicative of the commencement of death, whilst others may be of the view that breathing and heart activity (even though artificially maintained) does not constitute death, irrespective as to whether cessation of critical brain functioning has taken place. In this regard, it is important to present a minimal threshold pertaining to an understanding of the commencement of death, as this will serve as an important factor to be taken into account when determining whether the medical practitioner, who conscientiously objects against the administering of euthanasia, should be exempted from such activities. In other words, what should the minimal or underlying measure be regarding an understanding of the commencement of death?

The commencement of death is to be understood in light of what Craig Paterson refers to as, “the irreversible destruction of the integral functioning of the organism as a whole.”¹³² This

¹³⁰ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 129.

¹³¹ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 129.

¹³² Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 130.

understanding of death comes into stark contrast to views for example, that the loss of ‘higher-brain neo cortex activities’ such as thought and feeling is indicative of death,¹³³ and therefore, supportive of the conception of death as non-biological.¹³⁴ Therefore, ‘death’ for purposes of this study, includes the belief that life only ceases to exist when there is an absence of integral functioning of the ‘organism as a whole’. In other words, absence of brain stem functioning or the functioning of the whole brain does not necessarily introduce a state of death. Therefore, anencephalic¹³⁵ infants and patients in a persistent vegetative state (PVS)¹³⁶ and even patients suffering from advanced senility should also be viewed as living.

2.3 South Africa’s history and current position

As mentioned earlier, euthanasia is by no means an unknown topic in South African jurisprudence. A substantial body of work regarding the concept was compiled by the Law Commission,¹³⁷ termed the *Law Commission Report on Euthanasia and the Artificial Preservation of Life*.¹³⁸ Initially, the investigation was intended to establish a position regarding cessation of treatment as well as possibly legislating living wills.¹³⁹ However, internationally, particularly in the Netherlands, the United States and Australia, the idea of euthanasia¹⁴⁰ developed rapidly.¹⁴¹ This prompted the Commission to investigate matters related to end-of-life care in its entirety.¹⁴²

¹³³ This slots in with the discussion later on in this chapter and also in proceeding chapters regarding the view that the human being is both a biological and an intellectual being and that these two attributes should not be separated from one another.

¹³⁴ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 130.

¹³⁵ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 130. Paterson explains this as follows: “This is a condition where the infant is born without a skull (cranium) and with a forebrain that is either absent or rudimentary”.

¹³⁶ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 130. Paterson explains that PVC is “A condition whereby neo-cortical functioning has been destroyed by disease or injury, so that the patient is in a chronic state of wakefulness without awareness”.

¹³⁷ Currently the Law Reform Commission.

¹³⁸ *Law Commission Report on Euthanasia and the Artificial Preservation of Life*, Project 86, Discussion Paper 71.

¹³⁹ *Euthanasia and the Artificial Preservation of Life*, par. 1.3.

¹⁴⁰ Particularly active euthanasia.

¹⁴¹ *Euthanasia and the Artificial Preservation of Life*, par. 1.3.

¹⁴² *Euthanasia and the Artificial Preservation of Life*, par. 1.3.

The report was drafted following an investigation into the possibility of euthanasia in South Africa, substantiated by public participation,¹⁴³ workshops¹⁴⁴ and submissions of opinions to the Commission.¹⁴⁵ Differing opinions came to the fore. It became clear that the majority of proponents regarded the law as an appropriate tool to govern end-of-life affairs.¹⁴⁶ Added to this, a determination was made that should legislation be enacted consistent with the Bill of Rights, legal certainty would prevail and patients (as well as those close to them, such as friends and family) would be comforted in knowing the options available to them.¹⁴⁷ As a result of the debate and discussion the report generated, the Commission drew up a Draft Bill,¹⁴⁸ containing steps doctors should follow should a patient request to be euthanised. The paper had not received too much consideration as it was submitted in November 1998, and the Department of Health deemed it prudent to put the matter aside for the time being as it needed to attend to other pressing issues, such as the AIDS epidemic that swept the country. However, in the judgement of *Stransham-Ford v Minister of Justice and Correctional Services and Others*, Fabricius J held:

It is now 16 years hence and although I cannot proscribe this ... the topic is in my view important enough, having regard to the relevant principles contained in the Bill of Rights, that serious consideration be given to introducing a Bill on the basis of the South African Law Commission's Report, which supported a number of options, but supported the development of the common law...¹⁴⁹

The said Bill determines that a person above the age of 18 years, and of sound mind, is capable of refusing life-sustaining treatment or the continuation of such treatment.¹⁵⁰ If it appears to the attending physician that the patient has carefully considered the matter, and that the patient's refusal is based on free, voluntary and careful consideration, then he must give effect to the wish of the patient even if it may "...cause the death or the hastening of death of such a

¹⁴³ *Euthanasia and the Artificial Preservation of Life*, par. 1.14. Readers of two popular South African weekly magazines, namely *You* and *Huisgenoot*, were invited to participate in the investigation by submitting letters in which they expounded their personal views regarding euthanasia..

¹⁴⁴ *Euthanasia and the Artificial Preservation of Life*, par. 1.13.

¹⁴⁵ *Euthanasia and the Artificial Preservation of Life*, par. 1.19.

¹⁴⁶ *Euthanasia and the Artificial Preservation of Life*, par. 1.23.

¹⁴⁷ *Euthanasia and the Artificial Preservation of Life*, par. 1.26.

¹⁴⁸ The intention of this Bill was "to regulate end of life decisions and to provide for matters incidental thereto."

¹⁴⁹ *Stransham-Ford v Minister of Justice and Correctional Services and Others* (27401/15) [2015] ZAGPPHC 230: 2015 (4) SA 50 (GP), par. 1.

¹⁵⁰ *Euthanasia and the Artificial Preservation of Life*, "Annexure C", section 3(1).

person.”¹⁵¹ The Bill further outlines that should a patient request death by some lethal agent, the attending physician has to be convinced of the following before any steps are taken, namely that the patient is suffering from a terminal illness; the patient is subject to extreme suffering; the patient is over the age of 18 and mentally competent; and the patient has been informed adequately as to the terminal illness from which he is suffering, the prognosis of his or her condition as well as of any treatment or care that may be available. Also, the attending physician has to be convinced that the request of the patient is based on an informed and well-considered decision; that the patient has had the opportunity to re-evaluate his request, and that he has persisted in his request; and that euthanasia is the only way for the patient to be released from his suffering.¹⁵² Lastly, the physician must, after the request has been made, consult with another, independent medical practitioner, knowledgeable in the terminal illness from which the patient suffers and who must agree with the conclusion reached by the attending physician.¹⁵³

Ultimately, euthanasia is not defined expressly in the Draft Bill. It is assumed by its writer that references to euthanasia refer to steps taken by a physician to actively end the life of a patient at his request, or to assist a patient to end his own life.¹⁵⁴ Therefore, the Draft Bill deals with both active voluntary euthanasia as well as physician-assisted suicide,¹⁵⁵ while it also affords the patient the ability to refuse either life-sustaining treatment or the continuation thereof,¹⁵⁶ which therefore introduces the administering of passive euthanasia. The Bill would also afford legal recognition to ‘living wills’ or directives, should the patient be unable to communicate his own wishes.¹⁵⁷ However, the Bill has not been enacted and thus the current position of euthanasia in South Africa remains as Fabricius J confirmed, illegal.¹⁵⁸ The said Bill overlaps in many ways with the legislation of other countries regarding the administering of euthanasia.

¹⁵¹ *Euthanasia and the Artificial Preservation of Life*, “Annexure C”, section 3(2).

¹⁵² *Euthanasia and the Artificial Preservation of Life*, “Annexure C”, section 5(1).

¹⁵³ *Euthanasia and the Artificial Preservation of Life*, “Annexure C”, section 5(2).

¹⁵⁴ *Euthanasia and the Artificial Preservation of Life*, “Annexure C”, section 5(1): “Should a medical practitioner be requested by a patient to make an end to the patient’s suffering, or enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall give effect to the request...” (Author’s emphasis); Section 5(1)(i): “...ending the life of the patient or assisting the patient to end his or her life is the only way for the patient to be released from his or her suffering.”

¹⁵⁵ *Euthanasia and the Artificial Preservation of Life*, “Annexure C”, section 5(4). The Bill explicitly determines that a medical practitioner is the only person authorised to end the life of the patient.

¹⁵⁶ *Euthanasia and the Artificial Preservation of Life*, “Annexure C”, section 3(1), par. 4.39-4.41. The Report also indicated support for administering medication to alleviate pain with the secondary characteristic of possibly ending a patient’s life.

¹⁵⁷ *Euthanasia and the Artificial Preservation of Life*, “Annexure C”, sections 6 & 7.

¹⁵⁸ *Stransham-Ford v Minister of Justice and Correctional Services and Others*, par. 10.

In what follows, a brief overview of selected foreign law pertaining to the administering of euthanasia will be looked at, with specific reference to the Netherlands and Belgium, so as to provide some orientation regarding the legal frameworks in which euthanasia is administered in health care facilities. This also brings to the fore the reality of the wide approach taken regarding the legalisation of the administering of euthanasia and by implication the need to protect those medical practitioners who vehemently oppose participation in such practices.

2.4 Selected foreign law and the administering of euthanasia

2.4.1 The Netherlands

The first nation in the world to formally exempt medical practitioners from any criminal liability regarding euthanasia and assisted-suicide was the Netherlands. Originally, Dutch law prohibited euthanasia; however, the position has since changed since the introduction of legislation¹⁵⁹ granting Dutch doctors the ability to euthanise patients. Dutch medical doctors are exempted from criminal liability if they terminate life at the request of the person concerned, or if they assist in such a person's suicide, provided that due cognisance was given to the requirements set forth in legislation.¹⁶⁰ It is important to understand that euthanasia is *in principle* still an illegal action if these statutory requirements are not complied with.¹⁶¹ Compliance with the requirements will result in medical doctors not being liable for prosecution.¹⁶² These procedural steps are set out in the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*¹⁶³ which holds that the request made by the patient was made by the patient voluntarily and after proper consideration¹⁶⁴ and that the physician is

¹⁵⁹ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*.

¹⁶⁰ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, Preamble.

¹⁶¹ The Dutch Penal Code (*Wetboek van Strafrecht*), Art. 293 reads as follows: "(1) Hij die opzettelijk het leven van een ander op diens uitdrukkelijk en ernstig verlangen beëindigt, wordt gestraft met een gevangenisstraf van ten hoogste twaalf jaren of geldboete van de vijfde categorie." Author's translation: "He who deliberately terminates the life of another person on his express and serious request, shall be punished with a term of imprisonment not exceeding twelve years or a fine of the fifth category."

¹⁶² Dutch Penal Code, Art. (2): "Het in het eerste lid bedoelde feit is niet strafbaar, indien het is begaan door een arts die daarbij voldoet aan de zorgvuldigheidseisen, bedoeld in artikel 2 van de Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding en hiervan mededeling doet aan de gemeentelijke lijkschouwer overeenkomstig artikel 7, tweede lid, van de Wet op de lijkbezorging." (Author's translation: "The offence referred to in paragraph 1 shall not be punishable if it is committed by a physician who meets the due diligence requirements referred to in Article 2 of the Act on Termination of Life on Request and Assisted Suicide (Review Procedures) Act and informs the municipal coroner in accordance with Article 7, second paragraph, of the Burial and Cremations Act.)

¹⁶³ In Article 2.

¹⁶⁴ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, Preamble, Art. 2 (1)(a). "The requirements of due care, referred to in Article 293 second paragraph Penal Code mean that the physician: holds the conviction that the request by the patient was voluntary and well considered."

satisfied that there was nothing that could be done to end the patient's pain and suffering.¹⁶⁵ The patient should have been informed about his current situation, as well as any future prospects with regard to his condition, and the patient should then, by his own retrospection reach the conclusion that there is no other reasonable solution.¹⁶⁶ Finally, the patient should have consulted with at least one other physician who has thus far been an independent party.¹⁶⁷

The Act further makes provision for minors who have attained the age of 16 and wish to have their lives terminated. Such a minor should be deemed to have an understanding of the nature of the request and its consequences, and the parents or guardians should be consulted and included in the decision-making process.¹⁶⁸ Should such a minor patient be unable to communicate his request, but has made a written statement previously, being fully aware of the nature of his request and its consequences, and pertinently request termination of life, then a physician may proceed to terminate his life.¹⁶⁹ Lastly, provision is made for children between the ages of 12 and 16 years of age. Should a request be forthcoming from such a patient, and the physician is satisfied that the child is well aware of the nature of the request, and the child's parents or guardians agree to the child's demand, then the physician may terminate such child's life.¹⁷⁰

¹⁶⁵ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, Preamble, Art. 2 (1)(b). "...holds the conviction that the patient's suffering was lasting and unbearable."

¹⁶⁶ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, Preamble, Art. 2 (1)(c)-(d). "...has informed the patient about the situation he was in and about his prospects ... and the patient hold the conviction that there was no other reasonable solution for the situation he was in."

¹⁶⁷ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, Preamble, Art. 2 (1)(e). "...has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a-d."

¹⁶⁸ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, Preamble, Art. 2 (3). "If the minor patient has attained an age between sixteen and eighteen years and may be deemed to have a reasonable understanding of his interests, the physician may carry out the patient's request for termination of life or assisted suicide, after the parent or the parents exercising parental authority, and/or his guardian have been involved in the decision process."

¹⁶⁹ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, Preamble, Art. 2 (2). "If the patient aged sixteen years or older is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may carry out this request. The requirements of due care, referred to in the first paragraph, apply mutatis mutandis."

¹⁷⁰ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, Preamble, Art. 2 (4). "If the minor patient is aged between twelve and sixteen years and may be deemed to have a reasonable understanding of his interests, the physician may carry out the patient's request, provided always that the parent or the parents exercising parental authority, and/or his guardian agree with the termination of life or the assisted suicide. The second paragraph applies mutatis mutandis."

In 2004, a group of doctors and a lawyer developed a protocol to identify when infants can be euthanised.¹⁷¹ This was with regard to two matters the Dutch courts had to deal with in 1995. In April that year, a District Court in Alkmaar formally found the physician, Henk Prins guilty of murder. At the request of the baby's parents, he had administered a lethal injection to a baby girl who suffered from a severe case of *spina bifida*. Although the court found the doctor guilty, it refused to punish him for the crime. The case¹⁷² was confirmed later that same year by the Amsterdam Appeals Court¹⁷³ and held that the doctor adhered to the guidelines regulating euthanasia.¹⁷⁴ A week after the appeal was heard, the District Court in Groningen similarly found a physician guilty of murder under similar circumstances with a similar outcome.¹⁷⁵

These cases involved infants that were severely disabled, and both had very short and grim projected lifespans. In both cases, the parents of the infants had requested the physician involved to end the infant's life.¹⁷⁶ This led to the creation of a document termed the *Groningen Protocol*, which has been ratified by the Paediatric Association of the Netherlands.¹⁷⁷ This controversial document sets out the criteria to be followed when an infant is to be euthanised.¹⁷⁸ Three groups of newborns, or 'neonates', are identified. The first group of infants constitutes infants that have absolutely no chance of surviving; they will die soon after being born, regardless of the quality of care they receive.¹⁷⁹ The second group constitutes infants that are placed in intensive care immediately after being born. There are slim chances of survival, but survival is dependent on the intensive treatment received. There is a possibility that the infants might survive, but their prognosis and quality of life is poor at best.¹⁸⁰ The final group pertains to infants who are deemed by parents and medical personnel to suffer unbearably. Infants that have survived intensive treatment but are predicted to suffer continuously into the future and live a very poor quality of life, can have treatment discontinued.¹⁸¹ Infants ordinarily die

¹⁷¹ J. Nicol & M. Tiedemann, *Euthanasia and Assisted Suicide: The Law in Selected Country*, (Ottawa: Library of Parliament, 2015), 11.

¹⁷² Rb Alkmaar 26 April 1995, TvGR 1995/41. Commonly referred to as 'the Prins Case'.

¹⁷³ Hof Amsterdam 7 November 1995, TvGR 1996/1.

¹⁷⁴ N. Cica, *Euthanasia – the Australian Law in an International Context. Part 2: Active Voluntary Euthanasia*, Research Paper, Parliament of Australia.

¹⁷⁵ I. Bij de Vaate, "Levensbeëindiging bij pasgeborenen: Een heroverweging", *Wetenschappelijk Bijdragen*, (2014), 65-66. Hof Leeuwarden 4 April 1996, TvGR 1996/35.

¹⁷⁶ Bij de Vaate, "Levensbeëindiging bij pasgeborenen: Een heroverweging", 63-66.

¹⁷⁷ Lindemann & Verkerk, "Ending the life of a newborn: The Groningen Protocol", 42.

¹⁷⁸ Lindemann & Verkerk, "Ending the Life of a newborn: The Groningen Protocol", 42. "The purpose of the protocol is to set a standard of practice for doctors to responsibly end the lives of severely impaired newborns..."

¹⁷⁹ E. Verhagen & P. Sauer, "End-of-Life decisions in newborns: An approach from the Netherlands", *Pediatrics*, Vol. 116, 3(2005), 959.

¹⁸⁰ Verhagen & Sauer, "End-of-Life decisions in newborns: An approach from the Netherlands", 959.

¹⁸¹ Verhagen & Sauer, "End-of-Life decisions in newborns: An approach from the Netherlands", 959-960.

immediately after treatment has been terminated.¹⁸² The Protocol is subject to certain requirements that have to be fulfilled: the newborn's diagnosis and prognosis has to be established. The newborn must be suffering unbearably and the situation should be hopeless. An independent doctor must be able to confirm the preceding two requirements and both parents should give their informed consent. Lastly, the procedure of euthanising the newborn should be performed in line with accepted medical practice.¹⁸³

In conclusion, as the first nation in the world to practise euthanasia formally, the Netherlands sets an interesting standard in the manner through which it is applied. Contrary to popular belief (and as referred to earlier), it remains a crime in terms of the *Dutch Penal Code*, but medical doctors are exempted from criminal proceedings if they comply with certain requirements set forth in the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*. Interestingly, euthanasia is not limited to major persons only, as minors from the age of 12 are also eligible to have their lives terminated in terms of the same Act, provided they understand the gravity of the situation, and their guardians have been consulted properly regarding the matter.¹⁸⁴ Lastly, the Dutch practise infant euthanasia through the *Groningen Protocol*, the established criteria to be complied with when euthanising infants. As controversial as the Protocol might seem, it has been ratified by the Paediatric Association of the Netherlands. Following the standard set by the Dutch, an examination of euthanasia as applied by their southern neighbours, the Belgians, follows.

2.4.2 Belgium

The Belgians, like their neighbours to the north, also practise euthanasia by virtue of the *Belgian Act on Euthanasia of 28 May, 2002*.¹⁸⁵ In Chapter II, the Act sets out the conditions under which a medical practitioner will not be held criminally accountable¹⁸⁶ when a request

¹⁸² Verhagen & Sauer, "End-of-Life decisions in newborns: An Approach from the Netherlands", 959-960.

¹⁸³ Lindemann & Verkerk, "Ending the life of a newborn: The Groningen Protocol", 45.

¹⁸⁴ T. Baklinski, "Dutch pediatricians; Allow euthanasia for children under 12", *LifeSiteNews*, 22 June 2015. <https://www.lifesitenews.com/news/dutch-pediatricians-allow-euthanasia-for-children-under-12> (Accessed on 30 September 2017). However, it appears that calls are mounting to have the age limit of patients scrapped.

¹⁸⁵ *Belgian Act on Euthanasia*, 28515.

¹⁸⁶ W. de Bondt, "The new Belgian legislation on euthanasia", *International Trade and Business Law Review*, Vol. 12, 8(2003), 301. De Bondt holds that, "...the act whereby a physician takes the patient's life, at the request of the latter, is still legally qualified as murder. Only the application of the legal concept of the *state of emergency* allows the judge not to condemn the physician. The latter concept, however, is subjective and is established on a case by case basis." The Act itself holds in Chapter II, Art. 3 (1): "De art die euthanasie toepast, pleegt geen misdrijf..."

for euthanasia is made. Usually the physician had to ensure that patients had attained the age of majority and he has to ensure that the patient has made the request after properly considering the matter, and not making the decision based on coercion. He must also be satisfied that the patient is in a medically futile position, wracked by physical or *mental* suffering (thus a terminal illness is not a prerequisite) that cannot be alleviated, caused or as a condition of a serious disease or accident.¹⁸⁷ These requirements disqualify a physician from criminal prosecution once he has euthanised a person. However, comprehensive additional requirements have to be adhered to prior to administering euthanasia. A physician must first discuss the patient's health and possible life expectancy. The physician should discuss the request for euthanasia, and he must also inform the patient of possible alternatives, such as therapeutic and palliative treatments and what the consequences of such treatments might entail. In light of the aforementioned, a patient can only qualify for euthanasia if the physician and the patient together reach the conclusion that the request has been completely voluntary.¹⁸⁸ The physician is further required to assess the patient's mental and physical position, and ascertain whether the patient is in constant suffering, be it mental or physical.¹⁸⁹ Lastly, another physician¹⁹⁰ should be consulted regarding the position of the patient, upon which he conducts his own investigation. This physician must compile his findings and should be certain that the patient is suffering unbearably either mentally or physically.¹⁹¹

If it is found that the patient is apparently not expected to die in the near future, two additional requirements come into play. Firstly, a second physician must be consulted, either a psychiatrist or a specialist in the field of the disorder. This physician should be brought up to speed with the patient's condition and voluntary as well as repeated request for euthanasia. This consultant is to follow much the same procedure as the second physician previously consulted in that he must independently review the patient's medical record, examine the patient and be certain of the fact that the patient suffers unbearably either mentally or physically, and that such pain is beyond being alleviated. The consultant must compile his findings and report back to the patient.¹⁹² The next step is that the patient must write his request. The patient must draw up and sign the document himself. The date must also be indicated. Should he be unable to do so, a

¹⁸⁷ *Belgian Act on Euthanasia*, Art. 3 (1), 28515.

¹⁸⁸ *Belgian Act on Euthanasia*, Art. 3 (2)(1), 28515.

¹⁸⁹ *Belgian Act on Euthanasia*, Art. 3 (2)(2), 28515.

¹⁹⁰ *Belgian Act on Euthanasia*, Art. 3 requires that this physician has to be independent from both the attending physician and the patient. He must also be competent to give an opinion about the disorder.

¹⁹¹ *Belgian Act on Euthanasia*, Art. 3 (2)(3), 28515.

¹⁹² *Belgian Act on Euthanasia*, Art. 3 (3)(1), 28515.

designated person can draw up the document on the patient's behalf. This request must be attached to the patient's medical record and the patient is free to revoke the request at any time.¹⁹³ It is legally required that all requests for euthanasia made by the patient should be included in the medical file of the patient.¹⁹⁴ The second requirement is that once the request had been set down in writing, the physician must allow for a period of one month to elapse before administering euthanasia.¹⁹⁵

The patient's request is not compulsory. A physician may not be compelled to perform euthanasia, and no other person may be compelled in assisting with the euthanasia procedure. The physician must explain his reason for refusing to perform euthanasia to the patient, and if the reasons for doing so are medical, these must be noted in the patient's medical file. However, the physician is required to communicate the patient's medical record to a physician designated by the patient or by his 'person of confidence' in the event of an advance directive.¹⁹⁶

Unlike the Dutch, with the exception of the *Groningen Protocol*, age is not limited by Belgian law.¹⁹⁷ If it is determined that a minor is suffering unbearably, whether mentally or physically, a request may be acted upon.¹⁹⁸

In summation, Belgian medical practitioners, like their Dutch counterparts, practise euthanasia in terms of legislation, which exempt medical practitioners from any criminal proceedings. However, there are a few subtle differences between Dutch and Belgian legislation. Firstly, it appears that age is apparently not a factor governed by Belgian legislation as no limit with regards to age is indicated, whereas the Dutch still excludes minors below the age of 16, excepting, of course, the *Groningen Protocol*.¹⁹⁹ Secondly, in comparison, only Belgian medical practitioners are afforded the right of refusing the patient's request. With regard to

¹⁹³ *Belgian Act on Euthanasia*, Art. 3 (4), 28515.

¹⁹⁴ *Belgian Act on Euthanasia*, Art. 3 (5), 28515.

¹⁹⁵ *Belgian Act on Euthanasia*, Art. 3 (3)(2), 28515

¹⁹⁶ *Belgian Act on Euthanasia*, Chapter VI, Art. 14, 28515

¹⁹⁷ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, Art. 2 (4): Age is limited at 12 years.

¹⁹⁸ *Belgian Act on Euthanasia*, 28515, as amended by the *Belgisch Staatsblad* of 12 March 2014, to cause Art. 3 (1) to include: "de minderjarige patiënt die oordeelsbekwaam is, zich in een medisch uitzichtloze toestand bevindt van aanhoudend en ondraaglijk fysiek lijden dat niet gelenigd kan worden en dat binnen afzienbare termijn het overlijden tot gevolg heeft, en dat het gevolg is van een ernstige en ongeneeslijke, door ongeval of ziekte veroorzaakte aandoening."

¹⁹⁹ G. Herderscheë, "Kinderartsen: 'Sta lijdend kind euthanasie toe'", *De Volkskrant*, 19 June 2015. <https://www.volkskrant.nl/binnenland/kinderartsen-sta-lijdend-kind-euthanasie-toe~a4082152/> (Accessed on 10 November 2017).

similarities, it appears that, like the Dutch, procedural mechanisms in the *Belgian Act on Euthanasia of 28 May, 2002* attempt to safeguard the practice, so as to prevent any abuses. As already indicated, certain guides regulating medical practice in the Netherlands indicate that Dutch medical practitioners are not obliged to act in accordance with the wish of a patient, but they do have an obligation to refer the patient to a non-objecting medical practitioner. However, no explicit reference to conscientious freedom is evident from legislation. In contrast, the Belgians make specific provision for conscientious objection of medical practitioners by including specific legislative provisions in the *Wet Betreffende de Euthanasie*.²⁰⁰ In what follows, a number of arguments will be discussed pertaining to euthanasia, which is of relevance when arguing for the protection of the medical practitioner's conscientious objection against the administering of euthanasia.

2.5 Selected arguments pertaining to euthanasia

2.5.1 Introduction

As stated earlier, the subject of the validity of euthanasia is highly contentious. This is fuelled by deeply layered views, which include moral and religious considerations. In fact, moral and religious views are inextricably connected with one another. Opponents and proponents of a wide inclusion of euthanasia practices constantly battle forth, raising contentions for and against euthanasia. In what follows, arguments pertaining to euthanasia are presented. This is an important exercise in the context of this study as it provides more clarity on the credibility of the medical practitioner's conscientious objection towards the administering of euthanasia. This is also of relevance to the test as to whether there can be a reasonable and justifiable limitation of the rights of the medical practitioner in accordance with the *Constitution of the*

²⁰⁰ *Belgian Act on Euthanasia*, Art. 14: "Het verzoek en de wilsverklaring bedoeld in de artikelen 3 en 4 van deze wet hebben geen dwingende waarde. Geen arts kan worden gedwongen euthanasie toe te passen. Geen andere persoon kan worden gedwongen mee te werken aan het toepassen van euthanasie. Weigert de geraadpleegde arts euthanasie toe te passen, dan moet hij dit de patiënt of de eventuele vertrouwenspersoon tijdig laten weten waarbij hij de redenen van zijn weigering toelicht. Berust zijn weigering op een medische grond dan wordt die in het medisch dossier van de patiënt opgetekend. De arts die weigert in te gaan op een euthanasieverzoek moet, op verzoek van de patiënt of de vertrouwenspersoon, het medisch dossier van de patiënt meedelen aan de arts die is aangewezen door de patiënt of de vertrouwenspersoon." (Author's translation: "The request and the advance directive referred to in articles 3 and 4 of this Act have no compelling value. No doctor can be forced to administer euthanasia, nor can any other person be forced to cooperate in its administration. If the physician consulted refuses to administer euthanasia, he must inform the patient or any trusted person in a timely manner, explaining the reasons for his refusal. If his refusal is based on medical grounds, then it should be recorded in the patient's medical record. A physician who refuses to accept a request for euthanasia must, at the request of the patient or confidant, communicate the patient's medical record to the doctor appointed by the patient or the confidential adviser.")

Republic of South Africa.²⁰¹ Here it also needs to be clarified that the focus of this study is primarily to argue for the protection of the medical practitioner's right to conscientiously object against administering euthanasia, which, by implication, includes arguments in support of the morality of the prohibition of euthanasia (regarding the types of euthanasia highlighted in this study). This means that this study should not be viewed as primarily an encompassing rationale in opposition to many types of euthanasia practices. This has, in any event, been tackled by numerous adept scholars ranging from the fields of law, ethics, theology and philosophy. It is against this background that the description of arguments regarding euthanasia should be understood. More specifically (and as alluded to earlier), addressing arguments related to euthanasia contribute towards securing a reasoned argument for the protection of the medical practitioner's conscientious objection to administering euthanasia. The relevance of mentioning this is to prevent expectations that such a study might attract in that it may be understood as having to provide a concise exposition of all the arguments pertaining to the morality or immorality of euthanasia. This study does not exclude a rationale in opposition to the legalisation of a very wide category of euthanasia, a development that is unavoidable when making a case in defence of a medical practitioner being allowed to conscientiously object against the administering of euthanasia.

Only those arguments that are viable to supporting the protection of the conscience of the religious medical practitioner are awarded focus in this study. This is illustrated in for example, the *slippery slope argument*, which, although being an important argument in defence of the prohibition against many forms of euthanasia, is irrelevant to the argument pertaining to the topic at hand. By the 'slippery slope argument', according to John Keown, is meant amongst others, that regardless of the attempts made to regulate the effective administration of euthanasia, a slide will occur, as the safeguards put in place cannot be maintained effectively.²⁰² The 'slippery slope argument' can also be understood against the background of Robert George and William Porth's view that a right to assisted suicide would result in acceptance of 'mercy killing' with or without the victim's consent, "and even to the disposal of those who desire to cling to life but whose desire is deemed selfish or irrational."²⁰³ Therefore, bearing the above in mind and against the background of the topic of this study, the 'slippery slope argument' does not relate directly to the medical practitioner's conscientious aversion towards

²⁰¹ See Chapter Four.

²⁰² Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 72.

²⁰³ R. P. George & W. Porth, Jr., "Death, be not proud", *National Review*, 26 June 1995, 52.

administering euthanasia as such. A practitioner's aversion in this regard, is not based upon the primary concern that euthanasia may enter upon a slippery slope, but rather on the religious and moral convictions of the medical practitioner that innocent human life is inviolable (sacred) and that consequently it may not be terminated upon the patient's request (and even in some instances where the patient is not able to respond).

Although the fact that life has inherent dignity (and therefore is worthy of protection) is universally accepted, arguments in favour of euthanasia contend that it is not *always* wrong to end the life of a person intentionally, whether by omission or commission.²⁰⁴ This may undoubtedly make sense in, for example, a scenario where the intentional killing of a person is executed by someone whose life was seriously threatened by the person that had been killed. However, when the intentional killing of an innocent person takes place within the confines of health care laws and hospitals, where the person himself for example, consents to his life being terminated by a physician because of unbearable pain, then the issue becomes riddled with moral and ideological differences. This is unlike the situation pertaining to the intentional killing of someone else in self-defence. Consequently, the inevitability of arguments for and against the legal administering of euthanasia arise.

Supporters of the legal administering of euthanasia by medical practitioners argue, for example, that allowing a person a means of escape from a life of suffering is compassionate and gives due regard and protection to his personal autonomy and, inextricably connected to this, his dignity as a human. Proponents are also confident that euthanasia can be regulated effectively through legislation, as is perceivably being done, for example, in the Netherlands and Belgium (as described above). Opposed thereto, opponents of euthanasia, for example, argue that life is substantively inviolable (sacred). They also allege that other treatments, such as efficient palliative care and effective pain relief, are available. Robert Araujo states, "If, in contemporary society, there is freedom for 'choice' exercised by an individual to take the life of her baby in utero, why should the same society prevent freedom of choice for an individual who does not wish to participate in this action? ... If there is freedom for a person to take one's own life, should there not also be the freedom to protect those who refuse to participate in taking life?"²⁰⁵

²⁰⁴ W. A. Landman, *End-of-life Decisions, Ethics and the Law: A Case for Statutory Legal Clarity and Reform in South Africa*, (Pretoria: Ethics Institute of South Africa, 2012), 48.

²⁰⁵ R. J. Araujo, "Conscience, totalitarianism, and the positivist mind", *Mississippi Law Journal*, Vol. 77, (2007), 612.

Bearing the above in mind, the following section will focus firstly on the argument in support of the personal autonomy of an individual. This argument is generally representative of the patient's position. However, the principles discussed are of equal relevance to the medical practitioner. Subsequently, two other arguments are presented, the first of which focuses on the inherent sanctity of human life. The second argument, which discusses the state of palliative medical care in South Africa, focuses on certain social implications involved, which adds further support of the right of a medical practitioner to conscientiously object against the administering of euthanasia. A more elaborate description of the said arguments regarding euthanasia now follow.

2.5.2 A selected argument in favour of euthanasia

2.5.2.1 Introduction

Arguments in favour of euthanasia have as their foundation the inviolability of the patient's will.²⁰⁶ Traditionally, medicine involved the physician making decisions in the patient's interest. However, modern medicine affords a patient the right to determine the best course of action from his own perspective.²⁰⁷ Therefore, as will be seen in the following section, it appears that apparent respect for a patient involves giving due regard to his personal autonomy. The view is therefore heralded that if a patient is entitled to consent to or reject medical procedures or treatment, the same should apply to euthanasia. Bearing the above in mind, it would be prudent to consider, before some of the arguments often invoked in support of euthanasia are elaborated upon, the observation made by Wallis JA in *Minister of Justice and Correctional Services and Others v Estate Late Stransham-Ford and Others* namely, that an excessively emotional image is often portrayed into the minds of the public when it comes to patients in end-of-life situations, which in reality amounts to a far cry from the actual position.²⁰⁸ Therefore, in light of this brief introduction, a deeper discussion regarding these matters follow.

²⁰⁶ J. Williams, F. Lowy & D. Sawyer, "Canadian physicians and euthanasia: 3. Arguments and beliefs", *Canadian Medical Association Journal*, Vol. 148, 10(1993), 1700.

²⁰⁷ Williams, Lowy & Sawyer, "Canadian physicians and euthanasia: 3. Arguments and beliefs", 1700.

²⁰⁸ *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others* (531/2015) [2016] ZASCA 197 (2016), par. 35: "It appears... that the spectre commonly conjured up of a helpless patient confined to a hospital bed and attached to an array of machinery is, in the vast majority of end of life situations, not what occurs, even with patients suffering from extremely grave diseases. It did not apply to Mr Stransham-Ford."

2.5.2.2 Personal autonomy

Craig Paterson explains that arguments in support of a wide range of euthanasia practices place great emphasis on the individual's freedom from "undue paternalistic interference, especially the imposition of coercive sanctions."²⁰⁹ In the words of Paterson, "If an individual demands a particular right and if the right primarily affects only himself or herself then what good reason can there be for denying the recognition of this right?"²¹⁰ This relates especially to voluntary forms of euthanasia and PAS. Personal autonomy, often referred to as self-determination says Dan Brock, refers to the ability to make decisions about yourself, *yourself*, in line with your own convictions or your own concept of a good life.²¹¹ There is the understanding that personal autonomy and freedom are the hallmarks of a democratic society.²¹² There seems to be, on the face of it, nothing strange or unwanted regarding this understanding of personal autonomy and freedom.²¹³ A democratic society is focused on the protection of individual freedom and requires that any violation thereof be justified.²¹⁴ American jurisprudence portrays this ability as a sacred concept underlying an individual's very existence; it is at the heart of liberty.²¹⁵ The insights related to autonomy serve in many instances as justifications for the legalisation of euthanasia within health care.²¹⁶ There is the argument that should a person 'desire' euthanasia, then the relevant 'administrator', whether a specifically assigned individual or a medical practitioner, should comply with their wishes, even if it is at the cost of their own consciences

²⁰⁹ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 21.

²¹⁰ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 21.

²¹¹ Brock, "Voluntary active euthanasia", 11.

²¹² U. de Vries, "A Dutch perspective: The limits of lawful euthanasia", *Annals of Health Law*, Vol. 13, 2(2004), 390. Autonomy, writes De Vries, is "... a shield against unlawful invasion of the body, not a sword by which people can demand the invasion of the body".

²¹³ J. Feinberg, *Harm to Self*, (New York: Oxford University Press, 1986), 47-48. Feinberg compares the meaning of an individual's autonomy with those of nations being "sovereign nations". If a particular nation were to be afforded true autonomy it would amount to a sovereign, independent state. If a nation receives independence from a colonial power, for instance, such colonial power is obliged to recognise its sovereignty. The independent state now has the sovereign right of self-determination. This principle of sovereign self-determination can be transposed to the manner in which an individual lives his life, conducts his own personal affairs and realises his own choices. See Feinberg's references to "personal sovereignty" and "local autonomy", *ibid*.

²¹⁴ P. J. Hurwitz, J. Picard & A. Steinberg (eds.), *Jewish Ethics and the Care of End-of-Life Patients*, (Jersey City: KTAV Publishing House Inc., 2006), 60.

²¹⁵ *Planned Parenthood of Southeastern Pa. v. Casey* 505 U.S. 833 (1992), 851: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."

²¹⁶ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 52. A number of courts throughout Europe confirm this principle: *Pretty v United Kingdom* Application Number 2346/02; *Haas v Switzerland* (2011) 53 EHRR 33; *Koch v Germany* (2014) 58 EHRR 6; *Gross v Switzerland* (2014) 58 EHRR 7.

and beliefs.²¹⁷ Then there are those scholars who recognise that the same principles of self-determination and autonomy apply equally to the requestor as well as to the one providing assistance.²¹⁸ The reason why self-determination or autonomy is such an important aspect is because of the understanding that people take responsibility for their own lives and for the individuals they ultimately become.²¹⁹ The ability to take responsibility for one's life then extends to the point where individuals wish to control the time and manner of their deaths; such need only intensifies if a terminal illness causes suffering or hastens death. The point is reached where an individual believes that the best course of well-being will be to end his life, and this as such, will be better than any continued suffering.²²⁰ The Canadian Court determined that each individual's manner in which he deals with serious pain and suffering is unique to him.²²¹ Therefore, by deciding that he has had enough of his illness and seeks a way to end it, he is exercising his rights to personal liberty and security of the person, because his determination of when he lives and when he dies is rooted from "... a deeply personal and fundamental belief about how [he] wish[es] to live, or cease to live."²²²

²¹⁷ De Vries, "A Dutch perspective: The limits of lawful euthanasia", 388. De Vries points out that patients indeed have the right to personal autonomy, but not necessarily *total autonomy*. Autonomy in the context of the request for euthanasia should be understood from the perspective of the relationship between a patient as a bearer of rights and privileges, and a medical doctor. In the medical context, autonomy refers to the right an individual has to bodily integrity, and that requests (or demands) made by the patient will be honoured by the medical doctor. Thus, the relationship between the patient and his doctor is such that a patient is the one that determines his needs, and the manner in which those needs will be satisfied, while at certain stages the medical doctor can determine what the best course of action would be, and the patient agrees or disagrees thereto, commonly known as 'informed consent'. Herein lies rooted the idea of refusing or withholding treatment. In this regard, see De Vries, "A Dutch perspective: The limits of lawful euthanasia", 389-390. Irrespective, what De Vries is implying here is that medical practitioners do not have full freedom to conscientiously object to the administering of euthanasia. Then there are those authors who are clear on their opposition to such conscientious objections. In this regard, see for example, J. H. R. Torres, "The right to die with dignity and conscientious objection", *Colombia Médica*, Vol. 46, 2(2015), 52-53.

²¹⁸ Brock, "Voluntary active euthanasia", 11. "The value of self-determination does not entitle patients to compel physicians to act contrary to their moral or professional values. Physicians are moral and professional agents whose own self-determination or integrity should be respected as well." See Sachs J in *Minister of Home Affairs and Another v Fourie and Another* 2006 (3) BCLR 355 (CC). Although the matter pertained to discrimination experienced by same-sex couples, the respected Justice indicated at par. 94 the need for balance when determining a clash of rights: "In the open and democratic society contemplated by the Constitution there must be mutually respectful co-existence between the secular and the sacred. The function of the Court is to recognise the sphere which each inhabits, not to force the one into the sphere of the other... I stress the qualification that there must be no prejudice to basic rights." At par. 95: "The objective of the Constitution is to allow different concepts about the nature of human existence to inhabit the same public realm, and to do so in a manner not mutually destructive and that at the same time enables government to function in a way that shows equal concern and respect for all."

²¹⁹ Brock, "Voluntary Active Euthanasia", 11. Chochinov holds: "When individual autonomy is conflated with the notion of dignity, the inability to maintain independence while dying may be experienced as a fundamental loss of dignity, undermining the value of life itself," H. Chochinov, "Dying, dignity, and new horizons in palliative end-of life care", *CA: A Cancer Journal for Clinicians*, Vol. 56, 2(2006), 92.

²²⁰ Brock, "Voluntary active euthanasia", 11.

²²¹ *Carter v Canada (Attorney General)* SCC 5, [2015] 1 S.C.R. 331, par. 68.

²²² *Carter v Canada (Attorney General)*, par. 68, citing from the initial trial.

This understanding and support related to autonomy may resonate with certain sections of the *Constitution of the Republic of South Africa*, which guarantees everyone the right to freedom and security of the person²²³ and includes the right not to be treated in a cruel, degrading or inhumane way.²²⁴ Further, bodily and psychological integrity is guaranteed²²⁵ as is security and control over one's body.²²⁶ The most relevant part of these protections is the right to security and to be in control of one's body. This creates a zone of individual inviolability with regards to a person's body, as the words 'security' and 'control over' are not to be seen as synonymous.²²⁷ The right to control over one's body refers to the ability one has, as an individual, to choose the course of life one intends to live.²²⁸ Also, the right to *psychological* integrity refers to the ability to use one's mind freely. Thus, psychological integrity is the ability to make unbiased and uninfluenced, free decisions to the benefit of oneself. In essence, it is free control of one's mind.²²⁹ This exercise of free choice finds particular relevance in the viability of legalising regulated euthanasia. When determining the patient's wish to be euthanised,²³⁰ it is of cardinal importance to ensure the patient is of sound mind as a person should at least be in a position to use minimum decision-making capabilities to express a competent request.²³¹ Therefore, should a patient request a prescription from a medical doctor, with the intent of obtaining toxins or medication to terminate his (the patient's) life, such prescription, when issued, will serve as proof that the patient is regarded as a mentally sound person, and that the request was made "on a deliberate exercise of the free will of the person concerned."²³² The free will of an individual is viewed as a fundamental right and therefore, according to the argument, it is of utmost importance that a person remains in control of the time, manner and circumstances of his death, or the process of his dying.²³³ Therefore,

²²³ *Constitution of the Republic of South Africa*, section 12(1).

²²⁴ *Constitution of the Republic of South Africa*, section 12(1)(e).

²²⁵ *Constitution of the Republic of South Africa*, section 12(2).

²²⁶ *Constitution of the Republic of South Africa*, section 12(2)(b).

²²⁷ I. Currie & J. de Waal, *The Bill of Rights Handbook*, 5th Ed., (Claremont: Juta, 2005), 308.

²²⁸ Currie & de Waal, *The Bill of Rights Handbook*, 309.

²²⁹ Currie & de Waal, *The Bill of Rights Handbook*, 310.

²³⁰ De Vries, "A Dutch perspective: The limits of lawful euthanasia", 398. In light of the argument that patients harbour the inherent right to self-determination, on account of their personal autonomy to request euthanasia when they wish, the question needs to be answered whether one's personal autonomy can be extended to include the actions of others? The argument follows that prohibiting another from acting on the wish of the requestor amounts to a limitation on the autonomy of the requestor. This was part of the dilemma in *Stransham-Ford v Minister of Justice and Correctional Services and Others*. Upon appeal, Wallis JA held: "So the focus of the inquiry was not on his entitlement to commit suicide, or what is sometimes called the right to die, but on a right to select a method of doing so that was acceptable to him", *Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others*, par. 30.

²³¹ Brock, "Voluntary active euthanasia", 11.

²³² *Gross v Switzerland Judgement* Application no. 67810/10, par. 14. (European Court of Human Rights).

²³³ Brock, "Voluntary active euthanasia", 11.

autonomy in light of the argument for euthanasia means that a patient should have the freedom to discuss with a medical doctor the different options of end-of-life care, and make a request for an option of choice, knowing full well that in all eventuality, death is part, or the outcome, of the equation.²³⁴

Nonetheless, autonomy is not a singular concept. In light of what has been discussed thus far, an important concept closely related to personal autonomy is privacy. These two concepts are often so intimately connected that it often becomes a difficult task to separate them. Although the right to privacy is discussed in detail elsewhere in this study, the purpose of its relationship to personal autonomy warrants mention at this stage as well. The reason why privacy and personal autonomy are intricately connected is on account of an important foundational principle namely, personhood. David Richards encapsulates this relationship between autonomy, privacy and personhood by indicating its relevance to human flourishing. Richards indicates that certain traits unique to humans are the foundations of autonomy, such as language and the ability to reason empirically. But one of the most decisive traits is the ability to make a rational choice, based on normative principles, regarding an outcome best suited to the decision-maker.²³⁵ This results in an additional exceptionally relevant consideration, which will only be mentioned briefly, as it is discussed in greater detail elsewhere: an individual's inherent human dignity. Dignity, privacy, personhood and personal autonomy all share the singular characteristic that human beings are capable of making choices regulating the course of their lives.²³⁶ No individual can be described as truly free if he is denied the basic freedom of making a choice that would be towards his own benefit. This ability to choose is a fundamental aspect in terms of this argument for euthanasia as it encapsulates the essence of privacy, personal autonomy and personhood. Consequently, the first argument pertains to the ability of an individual to make his own choices. If the patient determines that the best course of action for him is to end his life, then the argument follows that the state, regardless of its obligations toward the promotion and protection of human life, should acquiesce, as such a determination arises from the patient's inherent ability to make determinations, which he deems to be in his own best interest. The same holds true for any person, such as a medical practitioner,

²³⁴ De Vries, "A Dutch perspective: The limits of lawful euthanasia", 390.

²³⁵ D. A. J. Richards in *Sex, Drugs, Death and the Law* Vol. 8(1982), cited in S. Fisk, "The last place to die", *Montana Law Review*, Vol. 59, 2(1998), 327.

²³⁶ M. Clifford & T. Huff, "Some thoughts on the meaning and scope of the Montana Constitution's 'Dignity' clause with possible applications", *Montana Law Review*, Vol. 61, 2(2000), 303: "... human beings have dignity because they have intrinsic worth as individuals, and their dignity is found, in one form or another, in their capacity to live self-directed and responsible lives."

required to euthanise a patient. The argument follows that they, too, should act in accordance with the patient's wish, regardless of any personal objections.

How does the above relate to the topic at hand? Firstly, the above is indicative of the relativeness and arbitrariness coupled to the importance of human life. Although this is elaborated upon in Chapter Four, this needs to be taken cognisance of when considering the arguments for and against euthanasia. The emphasis on the autonomy of the individual, which is inextricably related to the personhood, self-determination and privacy of the individual, and consequently each and every individual's free and subjective choice, naturally leads to prioritising the distinction between experience, thought, emotions and intellectual ability on the one hand, with biological human life on the other hand. Craig Paterson rightly points out that rationality, consciousness, self-awareness, moral agency, communication, emotionality and the capacity to feel pain as the selected criteria in deciding on death, results in a plethora of critical questions such as for example: What level of self-awareness is required? What does it really mean to be self-aware? Does loss of memory mean that someone lacks critical awareness of the self? Which of the above criteria should be prioritised or do they all carry the same weight?²³⁷ In the words of Craig Paterson: "Threshold definitions of persons seem so contrived precisely because they do resort to such arbitrary and vague stipulations when seeking to 'pick' and 'select' features and levels for determining the category of persons from the category of non-persons."²³⁸

This complexity consequently unveils weaknesses in the argument presented by proponents of euthanasia, and which, as a result, leaves those who oppose euthanasia with a competitive and credible argument that the mind and the biological make-up of the human being are not to be distinguished from one another. By no means does this imply that the latter's argument is not also complex. However, the weaknesses presented above (and discussed later on) provides a better levelling of the playing field, which naturally strengthens the position of the opponent to euthanasia. Secondly, if the emphasis and importance was to be solely placed on the autonomy of the individual, then all the more reason that the medical practitioner whose convictions (religious) dictate to him that the administering of euthanasia is a substantive moral wrong, may also rely on his right to personal autonomy, self-determination and privacy, which in turn

²³⁷ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 134.

²³⁸ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 35.

includes reason, emotions, moral agency, self-awareness and sentience; by not partaking in any activity regarding euthanasia. The fact that euthanasia concerns the intentional termination of innocent human life (even though the patient may voluntarily intend this) elevates this argument to even higher levels of credibility and rationality.

2.5.3 Arguments opposed to euthanasia

2.5.3.1 Introduction

Here it is also important to note that the primary focus of this study is not an argument in opposition to euthanasia but rather, as reflected in the title, an argument in defence of the protection of the medical practitioner's conscientious objection (based on religion) against the administering of euthanasia. The arguments for and against euthanasia comprise voluminous scholarly postulations; spanning a range of philosophical, ethical, religious and scientific thought. This does not imply a separation between arguments in opposition to euthanasia (as well as arguments in support thereof) and the topic of this study. In fact, to argue in support of the protection of conscientious objection against the administering of euthanasia necessitates a substantial delving into thought on the morality or immorality of euthanasia. Having said this, and as stated earlier, the primary focus of this study is on the importance of the protection of the medical practitioner's religious (and therefore also moral) belief that the administering of euthanasia is substantively wrong, which in turn is inextricably related to especially arguments in opposition to euthanasia. In what follows is an examination into two particular and relevant arguments opposing euthanasia. The first argument entails respect for the importance (sanctity) of human life. Given the respect towards human life that has traditionally been enjoyed throughout history and up and to the present, the importance (or sanctity) of life is undoubtedly an important insight regarding the debate on euthanasia. The second argument involves the practical aspects of promoting sanctity of human life through examining palliative care in the medical field. Both these arguments serve to bolster the credibility of the medical practitioner to not administer euthanasia.

2.5.3.2 Sanctity of life²³⁹

John Keown is of the view that the sanctity of a person's life regarding euthanasia can be viewed from three perspectives: vitalism, inviolability of life and quality of life.²⁴⁰ Each of these three offers competing views as to the value of a person's life, which influences the arguments in opposition to euthanasia. Firstly, *vitalism* is a school of thought that focuses on 'life' as both physical existence and as a concept bearing absolute moral value with absolute moral worth. On account of its absolute worth both physically and morally, it is quite simply just as wrong to shorten life or to fail in lengthening it.²⁴¹ *Vitalism* requires the life of a human being to be preserved without any reservation, no matter the cost.²⁴² The second school of thought, *inviolability of life*, views human beings as the possessors of dignity, which is inherent by nature. This school of thought is underpinned in for example, the Judeo-Christian worldview that mankind is created in the image of God and such inherent human dignity is directly derived from God.²⁴³ Humans then, by nature, have the ability, on account of their human dignity, to make rational choices. This capacity does not necessarily mean a person has the immediate ability to do something, but the capacity to do remains regardless.²⁴⁴ These capabilities are what every person should, at all times, be presumed to possess, and there should never exist a time where a person can be removed from these capabilities, and therefore from his inherent dignity;²⁴⁵ and therein lies the reason why *innocent*²⁴⁶ life is considered substantively and inviolably sacred. Human life is distinct from, for example, that of an animal, precisely because of this capability to make a rational decision or act in accordance with reason. Human beings are distinct because of the ability to exhibit concepts such as restraint and self-control or to

²³⁹ The principle of the sanctity of life is also discussed in Chapter Four.

²⁴⁰ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 39.

²⁴¹ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 39.

²⁴² Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 39; R. Malherbe & R. Venter, "Die reg op lewe, die waarde van menslike lewe en die eutanasië-vraagstuk (The right to life, the value of human life and the question related to euthanasia)", *Tydskrif van die Suid-Afrikaanse Reg*, Vol. 2011, 3(2011), 469. See Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 45 for an example of a certain Mary, being subjected to treatment provided by Dr V, a medical practitioner prescribing to the vitalist school of thought. Although Mary had previously suffered a number of heart attacks, Dr V steadfastly emphasises the prompt provision of cardiovascular pulmonary resuscitation. Her life, although clearly in reclining state, should be sustained by any means possible, regardless of the time, effort and costs involved.

²⁴³ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 40; D. Clarke & A. Egan, "Euthanasia – Is there a case?", *South African Journal of Bioethics and Law*, Vol. 2, 1(2009), 26; A. Hawthorn, *Submission Against Legalisation of Physician-Assisted Suicide and Euthanasia*, Submission 787, 1.

²⁴⁴ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 40.

²⁴⁵ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 40.

²⁴⁶ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 40. As Keown indicates, the term 'innocent' has traditionally been understood to exclude those who unjustly act in aggression to others, which is why it can never be an offence to act in self-defence of oneself or one's country, or why capital punishment of certain offenders is often advocated.

conceive of transcendental matters. Human life is inherently sacred because of this inherent capacity. However, the terms ‘sacred’ or ‘sanctity’ are often connoted to religion. To rid the discussion from the realm of religion and shine a more universal light on the discussion, the term ‘inviolability’ is more appropriate.²⁴⁷ Keown holds that this term is fitting as it casts a more adequate picture of the original establishment and intention of European pre-Christian medical ethics. Through, for example, the Hippocratic Oath,²⁴⁸ the value of life and the prohibition on intentional deprivation of life is affirmed. Even in modern settings this principle is still evident, by virtue of various international instruments,²⁴⁹ whereby the inherent right to life is guaranteed and the deprivation thereof is prohibited.

However, regardless of the roots of its recognition, and whether capabilities or disabilities play a role, it is evident that human life cannot only be an instrumental good, but also an inherent, basic good – something that is good in and of itself.²⁵⁰ It is not simply a means to an end, but an end in itself – something of inherent worth.²⁵¹ However, it is not the same as the *vitalist* school of thought as life is not a supreme good. Thus, the distinction between vitalism and inviolability of life is clear: Vitalism views human life as an absolute human good that should never be subject to compromise, whereas inviolability of life understands that human life is indeed sacred, but all other basic goods cannot be sacrificed to cater for life as the supreme good.²⁵² For this reason, the possibility of withdrawing life support, or the prescription of palliative medication in possible life-ending quantities is permitted. Thus, it is a prohibition on intentionally killing an innocent, rationally endowed human being as opposed to killing in general, or preservation of life.²⁵³

Keown’s third distinction is based on the quality of life of the person concerned, not simply on the worth thereof.²⁵⁴ The argument follows that on account of disease or disability, a person’s quality of life is lessened, and therefore the inherent worth also lessens. The argument follows

²⁴⁷ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 40.

²⁴⁸ Keown *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 41. The Oath is particular in prohibiting physicians from using medical knowledge to end lives. See also Hawthorn, *Submission Against Legalisation of Physician-Assisted Suicide and Euthanasia*, 2.

²⁴⁹ For example, the European Convention on Human Rights, the *International Covenant on Civil and Political Rights* or the *Convention on the Rights of Persons with Disabilities*.

²⁵⁰ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 41.

²⁵¹ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 41.

²⁵² Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 41.

²⁵³ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 41.

²⁵⁴ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 43.

that if the quality of life of a person has declined to a certain point, there cannot be anything wrong with ending it.²⁵⁵ Thus, there is a ‘scale of worth’ attached to the life of a person. If the quality of life falls beneath the predetermined ‘acceptable’ worth, the life in question has lost its meaning and efforts to continue preserving life would be wasteful and fruitless; death remains the only beneficial option.²⁵⁶ It is especially this school of thought that is used by supporters of euthanasia to argue for the legalisation of euthanasia.

These three schools of thought are best explained through examples. Keown uses the example of a newborn with Down’s syndrome and intestinal blockage.²⁵⁷ Down’s syndrome is not an uncommon phenomenon in society, but people harbour their own preferences towards it. The intestinal blockage can be rectified by a relatively easy operation, but if left unattended, will cause the infant’s eventual death. Three doctors, each an adherent to the above-mentioned schools of thought, are called upon to decide upon an appropriate cause of action: should they remove the blockage? They set about exploring the options available. The first, a vitalist, is of the opinion that life is absolutely sacred, and all efforts should be made to ensure the infant’s (continued) survival. The second doctor adheres to the school of thought that life is inviolable, and argues that the child’s mental capacity or any contributing factors should be set aside; she should be treated like any other ordinary person of her age. Having the operation would clearly benefit her life.²⁵⁸ The third doctor adheres to the quality of life school of thought, and is of the view that although the intestinal blockage can be rectified rather easily, Down’s syndrome does not amount to a life worth living. From his perspective, treatment is useless as the child would end up living a worthless life. His only focus is on the quality of life the infant would end up having. Therefore, the intestinal blockage should be left alone, allowing the child to die.²⁵⁹

Keown is of the view that these three schools of thought are at least representative of three different outlooks on the valuation of human life, and herein lies the continual disagreement on whether a medical practitioner can ever be allowed to terminate the life of a patient (whether

²⁵⁵ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 43.

²⁵⁶ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 44. Applying the same example referred to above with Mary and Dr V, Keown introduces Dr Q, who views Mary’s situation from a utilitarian perspective. He asks: “For what values is life, unless as a *vehicle* for a life which is *worth living*?” Given Mary’s current state, he recommends that her life be ended, as it is not a life worthwhile, Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 46.

²⁵⁷ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 48.

²⁵⁸ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 48-49.

²⁵⁹ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 49.

directly or indirectly).²⁶⁰ However, regardless of merely stating that patients are better off dead in certain circumstances, the sanctity of life cannot be circumscribed by such reasoning.²⁶¹ Such reasoning would be ‘arbitrary and unjust’ as it implies that only certain patients with arbitrary cognitive abilities would possess the right not to be intentionally killed.²⁶² In contrast, the inviolability approach enshrines the right to life, particularly because of a person’s *humanity*, not because of a person’s humanity dependent on particular cognitive capacities and abilities.²⁶³

Regarding the emphasis placed on individual autonomy and therefore, on the freedom of the choice of the individual then, if a blind assertion validates a right that an individual can conduct himself in a certain (often prohibited) manner simply *because his choice is his choice*, why, can the same not be applied to paedophilia or bestiality?²⁶⁴ Consider the example provided by Keown: Person A, by exercising his free will, determines to murder Person B. He certainly acted in an autonomous way, but it can under no circumstances be tolerated – the outcome of his unfettered autonomy merits no respect. On the contrary, it warrants condemnation.²⁶⁵

Therefore, considering the above, it is clear that life and its fundamental importance or sanctity (or inviolability) is precious and worth preserving on account of its inherent connection to human dignity, regardless of the school of thought from which life is viewed. But aside from religious considerations,²⁶⁶ its inviolability is emphasised even in secular circles. This understanding of the importance of human life will be elaborated upon in Chapter Four.

2.5.3.3 Suffering is resultant of inadequate palliative care

²⁶⁰ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 49.

²⁶¹ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 51.

²⁶² Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 51.

²⁶³ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 51.

²⁶⁴ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 53.

²⁶⁵ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 53.

²⁶⁶ The right to freedom of religion and its relationship with other rights is discussed in Chapter Three.

According to Broude (writing three decades ago), “pain²⁶⁷ is one of the most feared consequences of terminal disease, particularly cancer. Changing attitudes towards the effective use of narcotic analgesics, the development of new routes and methods of administration, and a clinical approach based on scientific principles and humane care offer the promise of improved management of pain in terminally ill patients.”²⁶⁸ According to Robert George, what is required is seeking to heal the challenges, where possible, directed at those in disabled conditions, and that every effort should be made to lighten their suffering. Added to this, should be efforts at discouraging those who are tempted to regard his life as valueless or merely burdensome to himself or/and to others, from thinking in this manner.²⁶⁹

John Finnis refers to Peter Admiraal, a leading Dutch exponent (and practitioner) of euthanasia who stated (in the mid-1980s) that “pain is never a legitimate reason for euthanasia because methods exist to relieve it.”²⁷⁰ This qualifies the medical practitioner’s ‘duty to care’ even more so, where the medical practitioner provides added attention towards the alleviation of pain rather than opting for the administering of euthanasia. It is argued that the purpose of euthanasia is not necessarily to choose the manner of one’s death, but to end what is viewed as a situation of experiencing a continuous state of unbearable pain. Patients are in many instances, or so it is alleged, not relieved of their pain through the use of conventional methods, but continue their lives in a drugged state. Some patients might have a higher pain threshold than others; and an extremely painful experience might not be quite as painful for another.²⁷¹ Regardless of what has been said thus far, it needs to be noted that the medical profession is inherently related to serving human life. In this regard, Pope John Paul II states:

A unique responsibility belongs to health-care personnel: doctors, pharmacists, nurses, chaplains, men and women religious, administrators and volunteers. Their profession calls for them to be guardians and servants of human life. In today’s cultural and social context, in which science and the practice of medicine risk losing sight of their inherent ethical dimension, health-care professionals can be strongly tempted at times to become

²⁶⁷ Pain is defined by the International Association for the study of Pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage...” <https://www.iasp-pain.org/> (Accessed on 20 September 2016).

²⁶⁸ A. M. Broude, “Pain control in terminal disease”, *South African Medical Journal*, Vol. 72, 8(1987), 543.

²⁶⁹ R. P. George, “Terminal Logic”, *Touchstone*, March 2006, 33.

²⁷⁰ Finnis, “Euthanasia, Morality, and Law”, 1141; J. M. Finnis, *Human Rights and Common Good*, Collected Essays: Vol. 3, (Oxford: Oxford University Press, 2011), 266.

²⁷¹ *HPCA Clinical Guidelines*, 2012, 11. These guidelines recommend that when dealing with pain, to accept each patient’s description of pain as being uniquely real to him.

manipulators of life, or even agents of death. In the face of this temptation their responsibility today is greatly increased. Its deepest inspiration and strongest support lie in the intrinsic and undeniable ethical dimension of the health-care profession, something already recognized by the ancient and still relevant Hippocratic Oath, which requires every doctor to commit himself to absolute respect for human life and sacredness.²⁷²

By their very nature, medical personnel ascribe to the maxim *Primum non nocere* – ‘first, do no harm’ – the principle of non-maleficence.²⁷³ This is an established principle in the field of medicine, and, considering the Hippocratic Oath, appears to stretch as far back as the time of the Ancient Greeks. This principle has led to the development of what is called ‘Palliative care’. The Clinical Guidelines of the Hospice Palliative Care Association of South Africa (HPCA) refers to the World Health Organization’s definition of palliative care:

Palliative Care is an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.²⁷⁴

According to the HPCA, South Africa regards palliative care as a means to provide relief from pain. It recognises and protects the value of life, and it considers dying to be a normal process through which everyone must go. As such, it neither intends to “hasten [n]or postpone death”.²⁷⁵ Palliative care aims to provide affectionate care to patients, through the use of support systems incorporating, together with physical care, psychological and spiritual aspects of patient care. It is aimed at enhancing the quality of life experienced by the patient and is therefore especially applicable during the early stages of the illness concerned, in conjunction with other methods of treatment or therapies that are implemented with the intention of prolonging life.²⁷⁶ Accordingly, it is shown that proper palliative care ensures that 75 to 80 percent of patients are effectively alleviated of pain. In this regard, the following words of Pope John Paul II rings true: “Human life finds itself most vulnerable when it enters the world and

²⁷² Pope John Paul II, *Evangelium Vitae*, par. 89.

²⁷³ J. Bernheim, R. Deschepper & W. Distelman, “Development of palliative care and legislation of euthanasia: Antagonism or synergy?”, *British Medical Journal*, Vol. 336, 7649(2008), 864; *HPCA Clinical Guidelines*, 9. Beneficence, non-maleficence, respect for autonomy and justice are the recognised principles of medical ethics.

²⁷⁴ *HPCA Clinical Guidelines*, 10.

²⁷⁵ *HPCA Clinical Guidelines*, 10.

²⁷⁶ *HPCA Clinical Guidelines*, 10. Support is equally offered to the family members of patients.

when it leaves the realm of time to embark upon eternity. The word of God frequently repeats the call to show care and respect, above all where life is undermined by sickness and old age.”²⁷⁷

Regarding the palliative approach, the physical pain of the patient needs to be addressed first. Treatment is dependent on the severity of pain experienced by the patient, not the stage of the terminal illness. Depending on the pain in question, the World Health Organization recommends the ‘Three-Step Analgesic Ladder’, starting with non-opioids, such as aspirin, paracetamol or other non-steroidal anti-inflammatory drugs. If the pain persists, weak opioids are recommended, such as administering codeine with non-opioid pain medication. If the pain is still unbearable then strong opioids are administered, such as morphine, together with non-opioids.²⁷⁸

Some terminal patients reach the stage called ‘difficult pain’. This stage is indicative of chronic pain, compounded by the patient’s psychological or emotional state of mind. In cases such as these, patients should receive palliative care, preferably in a hospice, where they can receive not only physical care, but also emotional and spiritual support. Different symptoms of pain can be experienced by the patient and it is the carer’s duty to identify the type of pain in question. Pain syndromes can be nociceptive or neuropathic. Nociceptive pain refers to pain that exists as a result of actual tissue damage to the patient’s body, such as the skin, organs or deep tissue. This pain responds well with nonsteroidal anti-inflammatory drugs or corticosteroids. On the other hand, neuropathic pain is quite problematic and is often experienced by terminally ill and end-of-life patients. Neuropathic pain is pain caused due to damage to the nervous system itself; the pain persists even if the original injury has healed. It results in chronic pain as the nerve fibres themselves are dysfunctional or damaged.²⁷⁹ As a result, these damaged nerves constantly send signals to pain centres, causing patients to experience constant pain in the form of aching, burning, shooting or stabbing sensations. Some patients also experience allodynia. The problem is exacerbated by poor response to opioid

²⁷⁷ Pope John Paul II, *Evangelium Vitae*, par. 44. Particularly with regard to euthanasia, Catechism 2276 of the Catholic Church determines, “Those whose lives are diminished and weakened deserve special respect. Sick or handicapped persons should be helped to lead lives as normal as possible.”

²⁷⁸ *HPCA Clinical Guidelines*, 13.

²⁷⁹ *HPCA Clinical Guidelines*, 18.

medication, however tricyclic antidepressants and anticonvulsants are effective to alleviate at least some of the pain experienced.²⁸⁰

Terminal and end-of-life patients are frequently administered strong opioids, such as morphine, without fear of addiction, if the pain becomes unbearable. Some patients seek answers in faith, either as a long-lost prodigal son or as a person who seeks answers through faith for the first time. A minister of religion or religious support might be invaluable in providing a terminal patient with hope for the dark period ahead.²⁸¹ The patient's physical health will obviously debilitate, further deteriorating the patient's mental wellbeing. Urinary and faecal incontinence become common causes for rapid emotional distress, and may lead to further physical harm.²⁸² Immobility and dependence on others severely drain the morale of a patient. It is the caregiver's duty to relieve such pains and discomfort to the best of his ability.²⁸³

The understanding of true 'pity' also needs to be emphasised as this may not only be of fundamental importance towards how societies today deal with a true understanding of pity, but it may also be of importance in the eyes (and heart) of the health practitioner who conscientiously objects against the administering of euthanasia. In this regard, Budziszewski states:

True pity is a heartfelt sorrow for the suffering of another, seen or not, moving us to render what aid we can ... The purpose of pity is to prime the pump of loving-kindness, but when we refuse to use it in that way the impulse is merely displaced. While in true pity we move closer to the sufferer, in degraded pity we move farther. While in true pity we try to change the painful sight, in degraded pity we merely try to make it go away ... In a society like ours, with no more frontier and hardly enough room to turn around, killing the sufferer may well be the cheapest and easiest way of making the painful sight go away.²⁸⁴

²⁸⁰ *HPCA Clinical Guidelines*, 18.

²⁸¹ A. Balboni, M. Balboni & A. Enzinger, "Provision of Spiritual Support to Patients with Advanced Cancer and Religious Communities and Associations with Medical Care at the End of Life", *JAMA Intern Med.*, Vol. 173, 12(2013), 1109-1117.

²⁸² *HPCA Clinical Guidelines*, 50.

²⁸³ A. Aswegan, September 2007. Our Ethical Duty Is to Relieve Pain and Suffering. *American College of Emergency Physicians*. <https://www.acep.org/Clinical---Practice-Management/Our-Ethical-Duty-Is-to-Relieve-Pain-and-Suffering/#sm.0000hslkdtypudhq8x1s9odyu1tm> (Accessed on 15 November 2017).

²⁸⁴ J. Budziszewski, *The Revenge of Conscience: Politics and the Fall of Man*, (Dallas: Spence Publishing Company, 1999), 127.

According to Robert George, solidarity should be maintained with those persons who are disabled and that one should always seek to heal or relieve the suffering of such persons. This should be understood against the background of discouraging persons that are experiencing pain from believing that their life is valueless or burdensome to others.²⁸⁵ This in turn, says George, should not mean that dying patients should be kept alive at all costs.²⁸⁶ In this regard, George states that key to this understanding is “the distinction between what traditionally has been called ‘direct killing’ where death is sought ‘either as an end in itself or as a means to some other end’, and ‘accepting death as a foreseen side effect of an action (or omission) whose object is something other than death – some good that in the circumstances cannot be achieved in ways that do not result in death or the shortening of life.’”²⁸⁷ This, George explains by referring to a patient who is suffering from a painful condition and consequently takes palliative medication, which he knows will lead to his death sooner than he would otherwise. In this regard, death is not the object of the patient’s act.²⁸⁸ Similarly, says George, where a patient is refused fluid and food due to the fact that the administration of fluids and food would cause harm to the patient, then such fluids and food should be withheld from the patient even where such an omission may lead to the death of the patient.²⁸⁹ This “duty to care, never to kill” is aligned with the ‘religious wisdom’ that is so eloquently expressed in the following:

As Christians and Jews, we have learned to think of human life – our own and that of others – as both gift and trust. We have been entrusted to one another and are to care for one another. We have not been authorized to make comparative judgments about the worth of lives or to cut short the years that God gives to us or others. We are to relieve suffering when we can, and to bear with those who suffer, helping them to bear their suffering, when we cannot. We are never to ‘solve’ the problem of suffering by eliminating those who suffer. Euthanasia, once established as an option, will inevitably tempt us to abandon those who suffer. This is especially the case when we permit ourselves to be persuaded that their lives are a burden to us or to them. *The biblical tradition compels us to seek and exercise better ways to care. We may think that we care when we kill, but killing is never caring.*

²⁸⁵ R. P. George, *Conscience and its Enemies. Confronting the dogmas of liberal secularism*, (Wilmington: ISI Books, 2013), 227.

²⁸⁶ George, *Conscience and its Enemies. Confronting the dogmas of liberal secularism*, 227.

²⁸⁷ George, *Conscience and its Enemies. Confronting the dogmas of liberal secularism*, 228.

²⁸⁸ George, *Conscience and its Enemies. Confronting the dogmas of liberal secularism*, 228-229.

²⁸⁹ George, *Conscience and its Enemies. Confronting the dogmas of liberal secularism*, 230.

*Whatever good intentions we might invoke to excuse it, killing is the rejection of God's command to care and of his help in caring.*²⁹⁰

In conclusion, it is clear that pain and suffering play an important role considering the termination of life by means of euthanasia; however, this is the very reason for palliative care: to assist those terminally ill patients in coping with their pain and suffering. It is submitted that pain should never be used as a justification to intentionally end another innocent person's life even if the latter requests it. In this regard, Craig Paterson comments:

Quality-of-life concerns should always be focused on the ways and means in which humanitarian resources can be deployed to improve the health of patients and should not be conflated with attempts to assess the overall 'benefits of living' versus the 'benefits of death' as if the two can really be rationally weighed and compared to one another. Let me be quite clear that I am not seeking to trivialize in any way the burdens on life imposed by illness ... Yet, notwithstanding the heavy toll those burdens inflict on patients, the only reasonable way to respond to those burdens is to do all we can to cure or diminish the pain and suffering of patients *as best we can*. We constantly need to remind ourselves that a life that is severely diminished in 'quality' is still capable of realizing and participating in a wide array of primary and secondary human goods – friendship, family, beauty, truth, etc.²⁹¹

On the contrary, pain and suffering places greater emphasis on the roles medical practitioners play in the lives of their patients, particularly in light of the dual physical-nonphysical nature of pain. Often the possibility might arise where a medical practitioner concedes to the patient's request, but would the medical doctor, should he end the patient's life, honour the medical profession? By not assuming the role of executioner, the medical practitioner confirms his commitment to the traditions and principles of the medical profession, which is founded upon a service and discipleship of care.

²⁹⁰ Ramsey Colloquium of the Institute on Religion and Public Life in New York City, "Always to Care, Never to Kill", *First Things*, February 1992 (Author's emphasis). <https://www.firstthings.com/article/1992/02/006-always-to-care-never-to-kill> (Accessed on 10 January 2017).

²⁹¹ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 107.

2.6 Conclusion

An argument in support of the protection of the conscientious objection of a medical practitioner against the administering of euthanasia needs to be clear on the meanings to be ascribed to euthanasia. In this regard, two main categories of euthanasia have been brought to the fore, namely that of active and passive euthanasia (in either a voluntary, non-voluntary or involuntary sense) and added to this the category pertaining to physician-assisted suicide. It was also explained that these three categories greatly overlap one another. As stated at the outset, by clarifying these various categories, it becomes clear as to not only the instances applicable to euthanasia, but also, and more importantly for this study, the instances when a medical practitioner should be allowed to conscientiously object against the administering of euthanasia. Both active and passive euthanasia, as well as physician-assisted suicide lend themselves towards protection related to the conscientious objection by a medical practitioner. Here it should be noted that not all forms of euthanasia are viewed as morally despicable, even by the moral teachings of many of the traditional religions. What was also addressed was clarification on the commencement of death, which needless to say, has implications for the euthanasia debate. In this regard, it was confirmed that the “meaningfulness of death should be related to the integral functioning of the human body as a whole, and not a conception of death that is non-biological.” This implies that whole-brain death does not mean that a person is dead, and the same understanding applies to an absence of brain stem function as well as to an absence of ‘higher brain’ functioning such as communication and emotion.

There are also prominent scholars on the religious and conservative side who support some forms of euthanasia as was brought to the fore earlier on in this Chapter, but in this regard, such activity should not entail death as an end goal. Having said this, there are many instances of euthanasia that are believed to be morally wrong and rightly so. This is evident not only from the above but also from the arguments in this study as a whole. It has also been shown that the euthanasia debate has been given some momentum of late in South Africa, and pre-empting a most probable development towards euthanasia as evidenced in for example, the Netherlands and Belgium (as illustrated earlier on), the need for an informative study regarding a qualification of the protection of the conscience pertaining to medical practitioners who do not want to partake in activities related to euthanasia, becomes evident.

As explained earlier, the purpose of this study is to present convincing arguments as to why medical practitioners should be allowed to object to certain procedures, such as euthanasia on grounds of their religious (or moral, ethical) beliefs. Part of this exercise is to extract those arguments of relevance whether for or against euthanasia, which assist in providing convincing reasons, read together with other arguments presented in this study, as to why a medical practitioner's right to conscientiously object against the administering of euthanasia should be protected. As referred to earlier, there are certain arguments that are not applicable in this regard, for example the 'slippery slope argument'. On the other hand, arguments related to personal autonomy, the sanctity of life and suffering as a result of inadequate palliative care, assist in arguing a convincing case for the medical practitioner who does not want to participate in practices related to euthanasia.

The first argument in favour of euthanasia, personal autonomy, entails the patient being able to assert his wishes. This argument emphasises the capacity of an individual to conduct his own affairs in a manner he considers appropriate from his own perspective and according to his own judgement. The argument asserts further that a patient, just like any well-informed consumer, should be in a position to request euthanasia, and the service provider, like any ordinary service provider, should provide the consumer with that which he seeks. However, this simply cannot be accepted. The medical practitioner remains a human being with all the attributes other human beings possess (including belief), and as has been indicated elsewhere, is entitled to an equal protection of his personal autonomy. In the words of Edmund Pellegrino:

Respecting a physician's conscience claims, however, does not mean that the physician is empowered to override the patient's morally valid claim to self-determination. Both the physician and the patient as human beings are entitled to respect for their personal autonomy. Neither one is empowered to override the other. The protection of freedom of conscience is owed to both.²⁹²

Consider that once a medical practitioner graduates from medical school and enters the medical profession, surely it cannot be said that he agrees to waive some of his rights, whether tacitly or expressly, as set forth in the Constitution? The practitioner is endowed with rights in the same manner as the patient. He is a person first, then a medical practitioner, just as the patient

²⁹² E. D. Pellegrino, "The physician's conscience, conscience clauses, and religious belief: A Catholic perspective", *Fordham Urban Law Journal*, Vol. 30, 1(2002), 241.

is a person first, then a patient. However, as has been discussed in the preceding arguments, one of the reasons why an individual's autonomy amounts to such an important principle is because an individual assumes responsibility *for himself*; he claims who he has developed into as a person. These principles have already been discussed above, but uniquely from the patient's perspective, particularly bearing in mind the motivations involved regarding pain and suffering. If this argument is to be applied in a similar fashion to the medical practitioner, pain and suffering would obviously not play a role, but to even the odds, the right to freedom of religion can be added. The right to freedom of religion will be discussed in depth in the following Chapter, where its relevance to an individual is discussed in detail. But for the purposes of the arguments discussed above, it is sufficient at this stage to simply indicate that the sincere religious convictions of an individual cannot simply be set aside or 'switched-off', because these religious considerations are deeply intertwined with an individual's human dignity, his personality and as such his autonomy. This is especially relevant to actions resulting in the termination of human life, and where the protection of life constitutes the most fundamental human right.

Can it truly be said an individual is free, free to make choices toward his own benefit, if his choices are limited by the whims of another person? If a medical practitioner is free to conduct himself in line with his convictions *except* if his convictions clash with the wishes of another person, can he truly be considered as an individual endowed with personal autonomy and consequent freedom in the true sense of the word? Consequently, the first argument can be applied to the medical practitioner's situation on much the same basis as the patient, substantiated by the practitioner's religious considerations. By this stage it has become abundantly clear that an individual cannot be regarded as truly free, therefore truly autonomous, if his will is constrained by the whims and wishes of another.

A patient's pain and suffering are indeed a worthy concern. No individual should be confined to an unbearable and inescapable existence. However, many medical practitioners view their profession as that which represents the provision of care, even in times of pain and suffering, especially in a medical profession that generally has the capacity to deal substantively with the challenges related to the alleviation of pain and suffering. Implied in this is a distinction between, on the one hand, the administering of medication with 'death' as a goal and which results in death, and on the other hand, the administering of medication with 'the alleviation of pain' as a goal and which may result in death. It is especially the former that a medical

practitioner may not want to partake in rather than the latter. Also, relying on pain and suffering as a substantiation for blatantly circumscribing, across the board, deeply held beliefs of medical practitioners on the basis of extraordinary occurrences, cannot be in line with the values sought by the Constitution. These values cherish plurality and encourage diversity in both individuals as well as society. By compelling medical practitioners to ignore their deeply held beliefs will not assist in furthering South Africa's constitutional democracy. What is more, is that medical science has evolved to such a degree that it is able to provide effective medication so as to lighten the burden of pain and suffering. It is indeed true that patients themselves ought to determine subjectively their quality of life and subsequent end-of-life decisions. But it cannot be done at the cost of the convictions of not only a vast amount of South Africans, but many medical practitioners as well who might harbour religious or conscientious objections against euthanasia.²⁹³ Blatantly denying physicians the right to object is an affront to their conscience, autonomy and human dignity, and can have no place in a constitutional and democratic society, which in turn implies the attainment of flourishing and higher levels of diversity.

Many believe that a human being is a creation of God and therefore, the conviction that the life of such an innocent human being needs to be protected at all costs, especially pertaining to euthanasia. International human rights instruments as well as the Constitutions of many democratic countries confirm the importance and sanctity of the right to life. Coupled to this should be the understanding that life *per se* is not a means to an end but is inherently something good, important and sacred – it is an end in itself. Added to this is the understanding that it is not only the non-biological attribute of a person that needs to be protected but also biological life. There should be no distinction between life understood as the mind, emotions, thought and intellect on the one hand, and on the other hand, life understood as the body. The body and mind are inextricably connected and together constitute life. All these insights that were presented in the above arguments support the merit underlying the medical practitioner's reasons so as to justify the protection of such a medical practitioners conscientious objection against the administering of euthanasia.

²⁹³ Statistics South Africa, Statistical Release P0318: General Household Survey, 2016 <https://www.statssa.gov.za/publications/P0318/P03182016.pdf> (Accessed on 18 October 2017). A survey conducted by Statistics South Africa determined 85.6% of South Africans identify as Christian, while 2% as Muslim and a further 1% as Hindu.

Chapter 3

The Right to Freedom of Religion and Conscientious Objection

3.1 Introduction

The importance of the right to freedom of religion is a given. Robert George refers to the natural law argument for religious liberty, which is based on the obligation of each person to pursue the truth about religious matters.²⁹⁴ In this regard, George comments:

This obligation is, in turn, rooted in the proposition that religion – considered as conscientious truth seeking regarding the ultimate sources of meaning and value – is a crucial dimension of human well-being and fulfillment. It is among the basic human goods that provide rational motivation for our choosing. The right to religious liberty follows from the dignity of man as a conscientious seeker.²⁹⁵

George adds that religion pertains to ultimate matters; religion representing our efforts to bring ourselves into a “relationship of friendship with transcendent sources of meaning and value.” Religion assists us to view our lives as a whole and forms an essential component of our flourishing as human beings.²⁹⁶ The Constitutions of democratic societies around the world, the relevant international human rights instruments as well as many of the judgments by the highest courts in constitutional paradigms (and of regional human rights courts) are indicative of the importance of the protection of religious rights and freedoms. Alan Brownstein fittingly states:

The free exercise of religion is essentially a dignitary right. It is part of that basic autonomy of identity and self-creation which we preserve from state manipulation, not because of its utility to social organization, but because of its importance to the human condition. Along with sexual autonomy, intimate association, and the dignitary aspects of speech, property

²⁹⁴ Second Vatican Council II, *Declaration on Religious Liberty: Dignitatis Humanae*, reprinted in A. Flannery (ed.), *Vatican Council II: The Conciliar and Post-Conciliar Documents* OP, revised Ed. (Northport: Costello, 1988), sections 2-3, 800-801, cited in R. P. George, *Conscience and its Enemies. Confronting the dogmas of liberal secularism*, (Wilmington: ISI Books, 2013), 91.

²⁹⁵ George, *Conscience and its Enemies. Confronting the dogmas of liberal secularism*, 91.

²⁹⁶ George, *Conscience and its Enemies. Confronting the dogmas of liberal secularism*, 118, 123. In this regard, George refers to J. M. Finnis', *Natural Law and Natural Rights*, 2nd Ed. (Oxford: Oxford University Press, 2011).

and procedural due process, this is a right of self-determination and fulfillment, not social order and policy.²⁹⁷

The Constitutional Court in South Africa has made no secret of the importance of the right to religious rights and freedoms, also against the background of a tolerant and plural society.²⁹⁸ As recalled by the European Court of Human Rights in the case of *Eweida and Others v. The United Kingdom*,²⁹⁹

... as enshrined in Article 9, freedom of thought, conscience and religion is one of the foundations of a ‘democratic society’ within the meaning of the Convention. In its religious dimension it is one of the most vital elements that go to make up the identity of believers and their conception of life, but it is also a precious asset for atheists, agnostics, sceptics and the unconcerned. The pluralism indissociable from a democratic society, which has been dearly won over the centuries, depends on it.³⁰⁰

Due to the fact that the argument regarding the protection of conscientious objection in this study finds itself on the rights of believers to specifically rely on their constitutionally protected religious liberties, the importance of religion in South Africa will be discussed, especially in light of current developments, such as the drafting of the *South African Charter of Religious Rights and Freedom* (currently lobbying parliamentary approval) as well as various cases discussed from both a local and international context. The different religious and non-religious (or secular) insights related to section 15(1) of the Constitution will be attended to. Considering the extent to which South African society has been subjected to regulation and constraint in the past, the value of these rights can accordingly not be overstated. Their value becomes glaringly evident through local and international jurisprudence indicating particular protections, which pertain specifically to the expression in accordance to a religious belief. The right to freedom of religion is inextricably related to the protection of the conscience and

²⁹⁷ A. Brownstein, “Harmonizing the Heavenly and Earthly Sphere: The Fragmentation and Synthesis of Religion, Equality, and Speech in the Constitution”, cited in Ahdar & Leigh, *Religious Freedom in the Liberal State* (Oxford, Oxford University Press, 2013), 76.

²⁹⁸ *S v Lawrence* 1997(4) SA 1176 (CC); *Prince v President, Cape Law Society* 2002 (2) SA 794 (CC); *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC); *MEC for Education: KwaZulu-Natal and Others v Pillay* 2008 (1) SA 474 (CC). More specifically, see for example, *Prince v President, Cape Law Society*, par. 38; *Christian Education South Africa v Minister of Education*, par. 19; *S v Lawrence* par. 92; and *Minister of Home Affairs and Another v Fourie and Another*, par. 89.

²⁹⁹ *Eweida and Others v. The United Kingdom*, [2013] ECHR 37.

³⁰⁰ *Eweida and Others v. The United Kingdom*, par. 79. In this regard, the court referred to its 1993 decision namely that of *Kokkinakis v. Greece* (25 May, §31, Series A no. 260-A) that confirms this understanding.

consequently this study also takes an in-depth investigation as to the meaning and importance of the believer's conscience. The importance of both the right to freedom of religion as well as the consequent protection of the conscience is further bolstered by the right to human dignity, which in turn also requires some investigation. The conclusion is therefore, that the medical practitioner who conscientiously objects against the administering of euthanasia based on religious belief or conviction should qualify for protection. Accordingly, the discussion commences by examining religion, and the rights that accompany it, in South Africa.

3.2 Religion and the South African context

As has already been mentioned, religion is of major relevance to the South African context. Many aspects in society are governed by some or other belief (whether religious or non-religious), and most South Africans identify themselves with some or other religion. At least 79,8% of South Africans regard themselves as being Christian,³⁰¹ while various other religions such as Islam, Hinduism and African traditional beliefs constitute a large portion of South African society. Due to South Africa's strong affiliation to religion, the *South African Charter of Religious Rights and Freedoms* was drafted and subsequently unveiled in 2008.³⁰² This is a ground-breaking³⁰³ document drafted by substantially representative religious organisations and individuals with the purpose of defining the freedoms, rights and responsibilities of the citizens of South Africa and their relationship with the State regarding their various religious beliefs. It describes religion and its corresponding beliefs from a South African perspective, which includes "the right of citizens to make choices according to their convictions... and the right to refuse to perform certain duties or assist in activities that violate their religious beliefs."³⁰⁴ Numerous signatories³⁰⁵ have signed the *Charter* and it is estimated that the total

³⁰¹ Pocket Guide to South Africa. South Africa's People (2011/2012). http://gcis.gov.za/sites/default/files/docs/resourcecentre/pocketguide/004_saspeople.pdf (Accessed on 17 September 2017).

³⁰² In 2012, official recognition was petitioned to the Commission for the Promotion and Protection of Cultural, Religious and Linguistic Communities, a Chapter 9 Institution.

³⁰³ This *Charter* is the first of its kind in the world.

³⁰⁴ *South African Charter of Religious Rights and Freedoms*, "Background Information", 2; I. T. Benson, "Religious interfaith work in Canada and South Africa with particular focus on the drafting of a South African Charter of Religious Rights and Freedoms", *HTS Teologiese Studies/ Theological Studies*, Vol. 69, 1(2013), 1-13.

³⁰⁵ Representative of all the major religions and prominent organs in South Africa were present at the signing in 2010, such as the Elected School of the Amadlozi, South African Tamil Federation, Sri Sathya Sai Baba Council, Roman Catholic Church, Bahá'í Faith, Commission for Cultural, Religious and Language Rights, Islamic Judicial Council, National House of Traditional Leaders, Jami'atul 'Ulamâ (Council of Muslim Theologians), South African Broadcasting Corporation and Lutheran, Anglican and various Reformed Churches. For a full list of signatories, see *South African Charter of Religious Rights and Freedoms*, "Background Information", 6-8.

number of citizens represented by the signatories is 10,5 million. Although the *Charter* has not been promulgated into legislation to date, it is, needless to say, popularly referred to in much legal (and other) scholarship related to the right to freedom of religion for especially the South African context. This *Charter* is what has been envisioned by the honourable Albie Sachs J, a former judge of the Constitutional Court of the Republic of South Africa, when he said, “Ideally in South Africa, all religious organisations and persons concerned with the study of religion would get together and draft a charter of religious rights and responsibilities... it would be up to the participants themselves to define what they consider to be their fundamental rights.”³⁰⁶

Although the doctrine of separation of church and state is prevalent in any liberal society, the drafters of the post-apartheid Constitution were well aware of the consequences of a strict implementation of separation of church and state, especially considering the religious adherence of the diverse South African population.³⁰⁷ Section 15 was included in the Constitution, which guarantees the right to freedom of conscience, religion, thought, belief and opinion. In addition, section 31 makes provision for the promotion and protection of religious groups, to freely practise and observe religion. There have been instances in South Africa where religion has been placed in the spotlight, and where the judiciary has provided exceptional clarity and support pertaining to the protection of religious freedom in South Africa. However, before these cases can be examined the meanings of ‘religion’, ‘thought’, ‘belief’, ‘conscience’ and ‘opinion’ need to be elucidated.

The right to freedom of religion is not limited to established religions like Christianity or Hinduism. Rather, ideologies and beliefs like agnosticism or atheism, or even cultural adherences that are saturated with religious undertones are also included within the confines of ‘belief’ and ‘conscience’ as intended by section 15, and warrants protection.³⁰⁸ This inclusive approach is reminiscent of Andrew Koppelman’s reference to the American case of *United States v Seeger*,³⁰⁹ which quoted with approval David Saville Muzzey’s definition of religion as “the devotion of man to the highest ideal that he can conceive” and Paul Tillich’s description

³⁰⁶ A. Sachs, *Protecting Human Rights in a New South Africa (Contemporary South African Debates Series)*, (Cape Town: Oxford University Press, 1990), 46-47.

³⁰⁷ I. Currie & J. de Waal, *The Bill of Rights Handbook*, 5th Ed., (Claremont: Juta, 2005), 337.

³⁰⁸ Currie & de Waal, *The Bill of Rights Handbook*, 338; *International Covenant on Civil and Political Rights*, Art. 18; *Universal Declaration of Human Rights*, Art. 18.

³⁰⁹ *United States v. Seeger* 326 F.2d 846, 848 (2d Cir. 1964) *aff’d*, 380 U.S. 163 (1965).

of God as “the depths of your life, of the source of your being, of your ultimate concern, of what you take seriously without any reservation.”³¹⁰

There is also the inextricable link between a religious belief and the conscience. Conscience envisages judgement based on morals. Conscience is an English word derived from Latin – *conscientia* – which refers to an “awareness” or “a joining of knowledge”. It refers to a person’s inner knowledge, such as an internal conviction.³¹¹ It can also refer to an observance or a practice based on, or that conforms to, what is right,³¹² which serves as a warning mechanism, exerting an effect on a person that a particular thought, action or feeling is wrong or evil.³¹³ It is that which compels a person to feel bad for committing a wrongful action; in the words of Immanuel Kant: “Prudence leads us to self-reproach, but conscience accuses us.”³¹⁴ The Supreme Court of Canada declared freedom of conscience to be akin to that of religion,³¹⁵ as both entail the manifestation of practices and beliefs. In such a context, then, freedom cannot be usurped by constraint or coercion.³¹⁶ This affirms the assertion by some that ‘freedom of conscience’ should be a fundamental right on its own;³¹⁷ all human beings are endowed with a conscience. Such has been recognised as far back as antiquity and today is expressed in Article 1 of the *Universal Declaration of Human Rights*.³¹⁸ Section 15 of the *Constitution of the Republic of South Africa*, undoubtedly caters for the protection of a moral objection, or an objection based on one’s conscience. Succinctly put:

The right to freedom of thought, conscience and religion (which includes the freedom to hold beliefs) in article 18.1 [of the *International Covenant on Civil and Political Rights*] is far-reaching and profound; it encompasses freedom of thought on all matters, personal conviction and the commitment to religion or belief, whether manifested individually or in community with others. The Committee draws the attention of States parties to the fact that the freedom of thought and the freedom of conscience are protected equally with the

³¹⁰ A. Koppelman, “Conscience, volitional necessity, and religious exemptions”, *Legal Theory*, Vol. 15, 3(2009), 243-244.

³¹¹ R. A. Haigh & P. Bowal, *Whistleblowing and Freedom of Conscience: Towards a New Legal Analysis*, Osgoode Centre for Professional Legal Education (CPLÉ) Research Paper, 23.

³¹² Haigh & Bowal, *Whistleblowing and Freedom of Conscience: Towards a New Legal Analysis*, 23.

³¹³ Haigh & Bowal, *Whistleblowing and Freedom of Conscience: Towards a New Legal Analysis*, 23.

³¹⁴ I. Kant, *Lectures on Ethics*, (Cambridge: Cambridge University Press, 1997), 132.

³¹⁵ *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295, 1985 CanLII 69 (SCC) [Online], par. 120.

³¹⁶ *R. v. Big M Drug Mart Ltd.*, par. 95.

³¹⁷ *R. v. Morgentaler* [1988] 1 SCR 30, 1988 CanLII 90 (SCC), 37.

³¹⁸ *Universal Declaration of Human Rights*, Art. 1: “All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.”

freedom of religion and belief. The fundamental character of these freedoms is also reflected in the fact that this provision cannot be derogated from, even in time of public emergency...³¹⁹

South African case law contains invaluable support of religious rights and freedoms. Having a religious belief and subsequently acting in accordance therewith is a core ingredient of any person's human dignity.³²⁰ Acting in accordance with one's belief is precisely what fuels a believer's actions; believers view the world from the perspective of their religious adherence and interact with things and people around them in accordance with their beliefs.³²¹ Although the question can rightly be asked: In a society in which religion and conscience are appropriately regarded with due seriousness, to what extent can religious observers reject laws they are in disagreement with? In answering this question, the State has the obligation to ensure that religious believers are not subjected to painful and agonising choices to either remain true to religious convictions or submit to the law,³²² as religious adherence is ingrained in the lives, cultures and temperaments of large swathes of people throughout society.³²³ Having said this, it also remains true that government has a duty to intervene where a religious practice threatens or violates the public order. In *S v Lawrence*,³²⁴ Chaskalson J quoted from *R. v Big M Drug Mart Ltd.*³²⁵ the following excerpt:

The essence of the concept of freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination.³²⁶

This gave official clarity that freedom of religion in South Africa grants the freedom to have a religion and to participate in the public sphere in accordance with one's religious conviction. What is of particular importance is what the learned judge added to the above:

³¹⁹ Human Rights Committee, General Comment 22, Art. 18 (Forty-eighth session, 1993), U.N. Doc. HRI/GEN/1/Rev.1 at 35 (1994).

³²⁰ *Christian Education South Africa v Minister of Education*, par. 36.

³²¹ *Christian Education South Africa v Minister of Education*, par. 33.

³²² *Christian Education South Africa v Minister of Education*, par. 35.

³²³ *Christian Education South Africa v Minister of Education*, par. 33.

³²⁴ *S v Lawrence*.

³²⁵ *R. v. Big M Drug Mart Ltd.*, par. 97.

³²⁶ *S v Lawrence*, par. 92.

I cannot offer a better definition than this of the main attributes of freedom of religion. But as Dickson CJC went on to say freedom of religion means more than this. In particular he stressed that freedom implies an *absence of coercion or constraint* and that freedom of religion may be impaired by measures that force people to act or refrain from acting in a manner contrary to their religious beliefs. This is what the Lord's Day Act did; it compelled believers and non-believers to observe the Christian sabbath.³²⁷

In addition, the South African Constitutional Court held in *Christian Education* that there are other provisions (as already mentioned) that are intended to protect the religious (and non-religious) diversity of South Africa. If they are "taken together, they affirm the right of people to be who they are without being forced to subordinate themselves to the cultural and religious norms of others."³²⁸ It "...highlight[s] the importance of individuals and communities being able to enjoy what has been called the 'right to be different'."³²⁹ This compels the State to recognise and acknowledge the value of religious diversity and pluralism.³³⁰ By doing so, the State furthers its own ideals of ensuring that the dignity of its citizens are protected, as per Sachs J in *Christian Education*: "Religious belief has the capacity to awake concepts of self-worth and human dignity which form the cornerstone of human rights."³³¹

An important fact regarding *Christian Education* is that the Constitutional Court had the opportunity of restraining the free exercise of religion and religious practices, but chose not to.³³² Rather, the court highlighted the importance of religion in the context of an individual and a group's religious affiliation, and stated that these individuals or groups can, through their right to religious freedom, act in accordance with their beliefs. In *Wittman v Deutscher Schulverein, Pretoria*,³³³ the South African High Court held that religion entails: "Human recognition of superhuman controlling power and especially of a personal God or gods entitled to obedience and worship."³³⁴ This confirms the recognition of a God against the background of the right to freedom of religion. A person claiming to be an adherent of religion would be expected to act in accordance with his convictions. As a matter of fact, believers often refer to

³²⁷ *S v Lawrence*, par. 92 (Author's emphasis).

³²⁸ *Christian Education South Africa v Minister of Education*, par. 24.

³²⁹ *Christian Education South Africa v Minister of Education*, par. 24.

³³⁰ Currie & de Waal, *The Bill of Rights Handbook*, 339.

³³¹ *Christian Education South Africa v Minister of Education*, par. 36.

³³² L. du Plessis, "Religious Freedom and Equality as Celebration of Difference: A Significant Development in Recent South African Constitutional Case-Law", *Potchefstroomse Elektroniese Regsblad*, Vol. 12, 4(2009), 19.

³³³ *Wittman v Deutscher Schulverein, Pretoria and Others*, 1999 (1) BCLR 92 (T) 1998.

³³⁴ *Wittman v Deutscher Schulverein, Pretoria and Others*, par. 74.

the act of expressing their faith as “manifesting their belief.”³³⁵ This right to ‘manifest’ belief is the direct expression and ‘living out’ of one’s convictions. To manifest one’s belief means to live out one’s convictions freely with little regard to the whims of others, as long as it is not contrary to the public order. It is often held that religion should be confined to the private sphere, but such motions are utterly unrealistic, unfair and discriminatory. A religious believer cannot separate himself from the rest of the world, and this is of relevance to the workplace as well. Such was the case in *Eweida*.³³⁶ A British Airways staff member wore a crucifix during the course of performing her duties. Her employer, British Airways, informed her that their dress code requires female employees to refrain from displaying jewellery such as necklaces. It was held that should she claim discrimination through Article 9 of the *European Convention on Human Rights*,³³⁷ on the basis of being denied to manifest her religion through wearing of a crucifix, she should be able to prove how the wearing of a crucifix is central to her religious convictions. The wearing of a crucifix should be compulsory to her beliefs. This position was accepted, as set forth by Lord Nicholls of Birkenhead in *R (Williamson & Others) v Secretary of State for Education and Employment*:

... a belief must satisfy some modest, objective minimum requirements ... the belief must be consistent with the basic standards of human dignity ... the belief must relate to matters more than merely trivial. It must possess an adequate degree of seriousness and importance... it must be a belief on a fundamental problem.³³⁸

Thus, Eweida had to prove how the wearing of a crucifix was adequately serious and important with regard to her religion. However, Lord Nicholls continued by saying:

But, again, not too much should be demanded in this regard [in proving the seriousness and importance of wearing a crucifix]. Typically, religion involves belief in the supernatural. It is not always susceptible to lucid exposition or, still less, rational justification... depending on the subject matter, individuals cannot always be expected to

³³⁵ *European Convention on Human Rights*, Art. 9; *Universal Declaration of Human Rights*, Art. 18.

³³⁶ *Eweida and Others v. The United Kingdom* [2013] ECHR 37.

³³⁷ *European Convention on Human Rights*, Art. 9: “1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance. 2. Freedom to manifest one’s religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.”

³³⁸ *R (Williamson and Others) v Secretary of State for Education and Employment* [2005] UKHL 15, par. 23.

express themselves with cogency or precision. Nor are an individual's beliefs fixed and static. The beliefs of every individual are prone to change over his lifetime. Overall, these threshold requirements should not be set at a level which would deprive... beliefs of the protection they are intended to have under the Convention...³³⁹

Conversely, Eweida averred that her manifestation of her religious beliefs had been infringed, even though there is no express commandment in terms of Christianity that crucifixes should be worn. The reasons for wearing a crucifix are hers, and subjectively give expression to her religious views. Eweida does not necessarily have the capability to express her reasons for her particular adherence, but her adherence is affected in particular through wearing a crucifix. The court in *R (Williamson & Others) v Secretary of State for Education and Employment* held:

... in deciding whether ... conduct constitutes manifesting a belief in practice for the purposes of Article 9 one must first identify the nature and scope of the belief. If ... the belief takes the form of a perceived obligation to act in a specific way, then, in principle, doing that act pursuant to that belief is itself a manifestation of that belief in practice. In such cases the act is 'intimately linked' to the belief ...³⁴⁰

Eweida determined the wearing of a crucifix to be central to her expression and 'living out' of her beliefs and her faith; it was an intimate act of religious observance between herself and her God. Thus, it can accurately be held that she manifested her faith through wearing a crucifix. This is in line with how the court approached the issue:

In order to be viewed as a 'manifestation' within the meaning of Article 9, the act in question must be intimately linked to the religion or belief. An example would be an act of worship or devotion which forms part of the practice of a religion or belief in a generally recognized form. However, the manifestation of religion or belief is not limited to such acts; the existence of a sufficient close and direct nexus between the act and the underlying belief must be determined on the facts of each case. In particular, there is no requirement on the applicant that he or she acted in fulfilment of a duty mandated by the religion in question.³⁴¹

³³⁹ *R (Williamson and Others) v Secretary of State for Education and Employment*, par. 23

³⁴⁰ *R (Williamson and Others) v Secretary of State for Education and Employment*, par. 32.

³⁴¹ *Eweida and Others v. The United Kingdom*, par. 82.

The court determined that by wearing the crucifix, while not an express duty mandated by her religious observance, a ‘manifestation’ of her own religious commitments had been entailed. South African jurisprudence shares this view. The South African Constitutional Court held in *MEC for Education: Kwazulu-Natal and Others v Pillay* that it is

... convinced that the [wearing of a nose ring for religious and cultural purposes] was a peculiar and particularly significant manifestation of her... identity. It was her way of expressing her roots and her faith. While others may have expressed the same faith, traditions and beliefs differently or not at all, the evidence shows that it was important for Sunali to express her religion and culture through wearing the nose stud.³⁴²

Religious freedom is guaranteed to all, and its importance is evident through jurisprudence (local and foreign) and various international instruments. But the right to freedom of religion, although often and rightly associated with concepts such as thought, conscience and belief, is worthy to be deemed as a right on its own. Religion, although endowed with various protections, is quite often publicly denounced as worthy of protection and is relegated to the private sphere and as a result, removed from society.³⁴³ But when leaving for work in the morning and upon entering the public domain, it is quite impossible to sever one’s religious fervour from one’s being effectively. A person cannot leave his religious conceptions at home, so as to be free to interact with the non-religious world in a non-religious manner. Compelling an individual to do so, effectively limits a host of fundamental rights, such as religious freedom as well as freedom of thought, conscience, belief, association and so forth.

Civil society represents morally-driven discourses, or norms, on specific beliefs,³⁴⁴ and it provides various forms of persuasion to justify the various actions undertaken and committed by the different segments and individuals in society.³⁴⁵ The autonomy of these individuals (and associations) are protected through sensitivity towards the particular rationale used to justify

³⁴² *MEC for Education: KwaZulu-Natal and Others v Pillay*, par. 90.

³⁴³ M. Rosenfeld, “Introduction: Can constitutionalism, secularism and religion be reconciled in an era of globalization and religious revival?”, *Cardozo Law Review*, Vol. 30, 6(2009), 2333.

³⁴⁴ S. de Freitas, “Religious associational rights and sexual conduct in South Africa: Towards the furtherance of the accommodation of a diversity of beliefs”, *Brigham Young University Law Review*, Vol. 2013, 3(2013), 430-431.

³⁴⁵ De Freitas, “Religious associational rights and sexual conduct in South Africa: Towards the furtherance of the accommodation of a diversity of beliefs”, 426.

certain modes of conduct,³⁴⁶ and this consequently establishes true diversity within a society. The protection of diversity accordingly necessitates recognition of specific religious modes of understanding, as this is foundational to the adherent's self-identification, expression and realisation.³⁴⁷ In a post-modern society it can be argued that the laws emanating from the State authorities should be respectful of other normative systems that are not aligned to that of the State,³⁴⁸ or to the ideology of the time and place that may be popular. This bodes true for especially conscientious objection, Edmund Pellegrino commenting: "Except for the amoral sociopath, conflicts of conscience are a regular feature of the moral life. Even for extreme relativists, resolving these conflicts is a constant challenge. Any society purporting to serve the good of its members is therefore obliged to protect the exercise of conscience and conscientious objection."³⁴⁹

In closing, this section indicated a number of fundamental aspects surrounding the right to freedom of religion in South Africa. A large number of South Africans are adherents of some or other religion, which has prompted the drafting of the *South African Charter of Religious Rights and Freedoms*. As discussed, the *Charter* gives religious adherents certain particular freedoms encompassing every aspect of their lives. This is a sensible approach as religion encompasses every aspect of an adherent's existence. Therefore, this *Charter* is a welcome addition to the observance of religious freedom in South African society. It is particularly encouraging to understand that the *Religious Charter* came into existence as a result of the direct words of one of South Africa's most prominent and influential jurists, Justice Sachs. However, regardless of instances such as the drafting of the *Religious Charter*, any liberal society remains careful in its views regarding the separation of church and state, and South Africa is no exception.

The Constitution guarantees specific protections pertaining to the expression of religion, but these protections are not limited to the traditional understanding of religion. Essentially, these protections cover every aspect of intellectual human interaction by guaranteeing protections to

³⁴⁶ De Freitas, "Religious associational rights and sexual conduct in South Africa: Towards the furtherance of the accommodation of a diversity of beliefs", 427.

³⁴⁷ De Freitas, "Religious associational rights and sexual conduct in South Africa: Towards the furtherance of the accommodation of a diversity of beliefs", 427.

³⁴⁸ H. Arthurs, "The re-constitution of the public domain" in D. Drache (ed.), *The Market or the Public Domain? Global Governance and the Asymmetry of Power* (London: Routledge, 2001), 87-88.

³⁴⁹ E. D. Pellegrino, "The physician's conscience, conscience clauses, and religious belief: A Catholic perspective", *Fordham Urban Law Journal*, Vol. 30, 1(2002), 221.

the expression of one's thoughts, opinions, beliefs and religious adherence. The views of the non-religious are also covered by these protections and what is especially heartening about these protections are that they are applicable at any stage, even in times of emergency. The fact that religious freedom (and accordingly, opinion, conscience and belief) is protected so strongly underlines the ideals of human dignity and personal autonomy. This much was made clear locally by the Constitutional Court in cases such as *Christian Education, Lawrence and Pillay* and in foreign and international law through cases like *R. v Big M Drug Mart* and *Eweida*. The reason why these freedoms are held in such high esteem is, as was discussed, because it governs in many aspects the manner in which a religious (or non-religious) believer interacts with society. The zealous Christian is afforded the right to preach on the corner of a street whilst the atheist is afforded the right to openly voice his disagreement in public. However, it would appear that this protection requires of the State to provide religious adherents with an escape option by ensuring that they are not confronted by situations that would compel them to contravene the law on account of their religious adherence, and implied in this is the medical practitioner who objects to administering euthanasia.

Compelling individuals to choose between their beliefs and the law is unfortunately a problematic scenario. However, various judgements indicate a favourable attitude toward religion in this regard, by emphasising that the right to religious freedom entails specifically the freedom from and absence of coercion, restraint, hindrance or reprisal. Again, this freedom emphasises the values of personal autonomy and therefore, by implication, the right to privacy but it provides particularly strong support to an individual's human dignity as it provides an avenue for individuals to be who they want to be, or as held in *Christian Education*, to enjoy the right to be different. This right to be different means a religious individual expresses himself in a manner different to others on account of his religious observance; this is also known as 'manifesting a belief.' Various courts, as discussed, have recognised this principle as being fundamental to the true meaning of religious freedom. Additionally, acting in accordance with one's religious views, thereby manifesting one's belief, is a deeply subjective and personal affair. It has to be intimately connected to the religious belief in question, but does not have to be prescribed by the particular religion in question. The reason for this is that the individual subjectively worships through the particular action, whether prescribed or not. It is a subjective expression of religious adherence and loyalty. In some instances, such as in *Pillay*, particular religious manifestations create the opportunity to further express one's identity. Society will only truly attain the values of true diversity and plurality by affording every person the

opportunity to express who they are in their own unique way. Some individuals express their identity through particular modes of conduct, such as only eating certain foods or strictly dressing in a certain manner, while others necessitate the observance of religion to truly express their true unsuppressed identity. The survival and progression of South Africa's post-apartheid democracy is dependent on this vitally important freedom: the right to freedom of religion, belief and opinion.

Therefore, the above section clarified the position of religion in South Africa. Being an exceptionally diverse nation demographically, such diversity is furthered through different religious practices. Apart from constitutional protection afforded to religion, the relevance of specific religious adherence has been compiled in the *Religious Charter*. Through drawing up such a charter, read in conjunction with the *Constitution of the Republic of South Africa*, the message is communicated clearly that religion is a prevalent and necessary concept in South African society, and warrants specific protection. In addition hereto, the South African Constitutional Court, as well as numerous other courts across diverse nations, have equally recognised the importance of religion and have provided a number of substantial judgements promoting religious rights. It had been recognised that religious observers are not above the law and cannot simply invoke religious adherence around every corner. However, the State also has the obligation to ensure that religious believers are not, without good cause, placed in such an intolerable position that they would have to choose between their own convictions and adherence to the laws of the State. The need for religious protection, as with other rights discussed, hinges on human dignity and the right to personal autonomy: the right to be different and free from unjust coercion by others. By viewing the right to religious freedom from the perspective of a person's inherent human dignity, it becomes clear why sincere public religious manifestation and expression cannot be relegated to the private sphere. By understanding that religion entails the complete subjugation of an individual's personal autonomy to religious conviction sketches a clearer picture of an individual whose worldview is radically altered to such an extent that every step taken is done from the perspective of complete religious obedience, regardless of whether it appears rational to any other person. It is in this position that the religious medical practitioner finds himself. In an open and free society founded upon the principles of human dignity, freedom and equality, the medical practitioner voluntarily subjects himself to a certain moral code of conduct, which is not contrary to public policy or violent in nature, and navigates his life around such a moral code, knowing that both local and international law guarantees him the right to do so. By being faced with a situation whereby he

would be coerced into abandoning this commendable mode of conduct, through threat of the law, can most certainly not be construed as being the product of a truly free and open democratic society. Freedom from coercion, particularly regarding a fundamental human right as basic as religious freedom, is supremely vital in ensuring a tolerant, plural and free society. However, it is submitted that such vital religious protection can only be afforded when sincere religious beliefs are threatened. The following section examines sincerity in greater detail.

3.3 Conscientious objection and the sincerity test

Scholarly insights related to the meaning to be ascribed to ‘conscience’ are varied.³⁵⁰ Also, as reminded by Robert Vischer, “Conscience is susceptible to argument precisely because its authority is grounded in the person’s conception of reality, rational or not.”³⁵¹ Also (and as alluded to earlier), although religion may be a qualification as to the claim for the protection of the conscience, the ‘religious’ reasons may be based on various factors (many of them not necessarily of substantive urgency and gravity.) In this regard, Andrew Koppelman comments that a substantial number of people engage in religious practice “out of habit, adherence to custom, a need to cope with misfortune, injustice, temptation, and guilt, curiosity about a religious truth, a desire to feel connected to God, or happy religious enthusiasm rather than a sense of obligation or fear of divine punishment.”³⁵² What is more, the claim for the protection of the conscience may also transcend theistic beliefs and both theism and atheism may expose themselves to questionable practices that seek protection under the banner of “the conscience.”³⁵³

All of this surely proves to be challenging when the conscience is called upon for protection. Be as it may, what requires priority in this regard is what Vischer explains, “The state’s interference should be limited to protecting vulnerable persons from readily discernible, serious harm (such as physical or sexual abuse of a child; financial fraud by church officials).”³⁵⁴ According to Mark Wicclair, many conceptions of the conscience incorporate the notion that

³⁵⁰ Koppelman, “Conscience, volitional necessity, and religious exemptions”, 225-233 and M. R. Wicclair, *Conscientious Objection in Health Care. An Ethical Analysis* (New York: Cambridge University Press, 2011), 1-4.

³⁵¹ R. Vischer, *Conscience and the Common Good. Reclaiming the space between person and state*, (Cambridge: Cambridge University Press, 2010), 21.

³⁵² Koppelman, “Conscience, volitional necessity, and religious exemptions”, 222-223.

³⁵³ Koppelman, “Conscience, volitional necessity, and religious exemptions”, 221-222.

³⁵⁴ Vischer, *Conscience and the Common Good. Reclaiming the Space between Person and State*, 308.

matters of conscience involve “a particularly important subset of an agent’s ethical or religious beliefs – *core* moral beliefs.”³⁵⁵ Wicclair further explains: “Core moral beliefs are an agent’s fundamental moral beliefs. They comprise the subset of an agent’s moral beliefs that matter most to the agent. They are integral to an agent’s understanding of who she is ... Accordingly, acting contrary to core moral beliefs is perceived by the agent as an act of self-betrayal.”³⁵⁶ Bearing this in mind, Wicclair states that “conscience-based refusals” constitutes the following: “(1) the agent has a core set of moral (i.e. ethical or religious) beliefs; (2) providing the good or service is incompatible with the agent’s core moral beliefs; and (3) the agent’s refusal is based on her core moral beliefs.”³⁵⁷

In this regard, and for purposes of this study, it needs to be emphasised that conscientious objection against the administering of euthanasia constitutes an *inherent, serious* and *sincere* aversion by a medical practitioner to participate in an act that overlaps with deep religious (or moral non-religious) convictions pertaining to a matter that is inherently of serious concern namely, the intentional taking of innocent human life. Stated otherwise, and to use Wicclair’s understanding, conscientious objection takes place when a medical practitioner, by having to administer euthanasia, finds it incompatible with his core set of moral beliefs. This inherent aversion and refusal pertaining to the administering of euthanasia is deeply fundamental due to its inextricable connection to the sanctity of life, resulting in this also being constitutive of high moral concern. This conscience-driven aversion has enjoyed substantive support throughout history.

The seriousness of the matter regarding the administering of euthanasia is also confirmed when one compares this to matters related to conscientious objection against for example, the refusal to do military service due to a conscientious objection against partaking in any action of conflict. Not that the latter type of conscientious objection should not be taken seriously or protected, but it is opined that the context surrounding a medical practitioner who objects towards administering euthanasia differs in degree of moral importance when compared to a person who is obligated to help defend his country by partaking in military service. Although both examples may involve the taking of lives, the actual taking of a life in these two scenarios differ in the degree regarding the violation of the conscience. The former form of conscientious

³⁵⁵ Wicclair, *Conscientious Objection in Health Care. An Ethical Analysis*, 4.

³⁵⁶ Wicclair, *Conscientious Objection in Health Care. An Ethical Analysis*, 4-5.

³⁵⁷ Wicclair, *Conscientious Objection in Health Care. An Ethical Analysis*, 5.

objection is surely of greater moral concern than the latter. Defending one's country or one's own life or the lives of family members may require the taking of a life or lives due to the moral qualification of self-defence. This however, is not the case regarding the administering of euthanasia where a medical practitioner partakes in an act that allows for an innocent patient to die. Conscientious objection levelled against the administering of a spectrum of practices constituting euthanasia, transmits a similar amount of substantial weight and consequent seriousness as is the case regarding conscientious objection against partaking directly or indirectly in abortion practices. This is because of the deep moral relevance when it comes to questions related to the origins of human life, especially when considering the scientific rationality that is inexorably connected to an argument that supports the view that human life begins before birth. In both euthanasia and abortion practices, one is not acting in self-defence, but rather intentionally terminating life that poses no fatal threat to those who find themselves in the presence of the patient.

The marriage officer who refuses to solemnise a marriage between persons of the same sex may also be, due to such an officer's conscientious objection, based on religion. However, although it is important to also be supportive towards the protection of such an officer's conscience, the act of solemnising a marriage is not nearly as grave as having to intentionally terminate the life of an innocent patient who wants to die. Therefore, it is not only the moral gravity *per se* that is inextricably connected to euthanasia but also the gravity of conscientious objection against the administering of euthanasia when compared to other, less weightier forms of conscientious objection (as explained above). No wonder that even the liberal legal scholar Ronald Dworkin (who was generally supportive towards abortion and euthanasia) was of the view that abortion and euthanasia comprise two key areas of value conflict:

Deep principled disagreement over the value of life plus respect for liberty of conscience, empowers individuals to make their own choices. The meaning of the value of life is such a deeply contestable topic, open to many divergent viewpoints – viewpoints that can express sophisticated defences – that it is unreasonable for one viewpoint to seek to impose its account over all other viewpoints.³⁵⁸

³⁵⁸ R. Dworkin's *Life's Dominion* cited in C. Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, (Burlington: Ashgate Publishing Company, 2008), 35.

It is precisely this disagreement regarding the value of life, which confirms that the matter at hand is not clear-cut, and which in turn lends credibility to the convictions of the medical practitioner as well. According to Vischer, the feasibility of the conscience frequently depends on the feasibility of the relationships through which conscience is formed. This implies that the law, in aiming towards imbuing a concern for conscience, must also aim towards showing a concern for those interest groups that hold and manage the shared moral commitments of individuals.³⁵⁹ Vischer elaborates: “If my conscience tells me that lying is wrong, even if that judgment does not emanate from my adherence to the tenets of a religious community, it still derives from something outside myself. Most likely, it is based on my perception and evaluation of the social conditions necessary for human well-being.”³⁶⁰ This relational attribute of conscience also entails, in addition to the believer’s accountability to moral truth, an accountability to “those who are the source of the demand to recognize the moral truth, whether that is another person, a community, God, or one’s self.”³⁶¹ This in turn implies, “By forcing a person to act contrary to what they perceive as a moral obligation, the state jeopardizes the coherence of a life narrative built on certain moral claims, along with a deeper accountability of the person to the source of those claims.”³⁶²

Therefore, this is why, when concerned about the protection of the conscience, one must also be concerned about “the interpersonal paths by which conscience is formed”, as our moral convictions emerge from “authorities and experiences that, although not always universally or rationally accessible, are susceptible to being engaged by others. Conscience is not a self-contained or isolated construct.”³⁶³ Albie Sachs J emphasises the importance of this ‘relational element’ by commenting, “[F]reedom of religion goes beyond protecting the inviolability of the individual conscience. For many believers, their relationship with God or creation is central to all their activities. It concerns their capacity to relate in an intensely meaningful fashion to their sense of themselves, their community and their universe.”³⁶⁴ It is also of fundamental

³⁵⁹ Vischer, *Conscience and the Common Good. Reclaiming the Space Between Person and State*, 71.

³⁶⁰ Vischer, *Conscience and the Common Good. Reclaiming the Space Between Person and State*, 76-81. Vischer states, “Imagined or not, the believer’s perception of God’s voice calls her outside herself, to some moral or spiritual reality, and that reality tends to be embedded in the framework of an overarching worldview made possible by a faith tradition. Rarely does the ‘still small voice within’ speak in isolation”, *ibid.*, 77. Also see *ibid.*, 80-81 namely, “Claims of conscience, by their very nature, call the claimant into relationship with the world outside herself. The claimant may be relating to God, or to the teachings of her community, to critical reflection on her own past experience, or to the opinion of the world at large.”

³⁶¹ Vischer, *Conscience and the Common Good. Reclaiming the Space Between Person and State*, 91.

³⁶² Vischer, *Conscience and the Common Good. Reclaiming the Space Between Person and State*, 73.

³⁶³ Vischer, *Conscience and the Common Good. Reclaiming the Space Between Person and State*, 78.

³⁶⁴ *Christian Education South Africa v Minister of Education*, par. 36.

importance to take cognisance of the views of the medical practitioner who conscientiously objects to the administering of euthanasia, bearing in mind the following words by Pope John Paul II:

Abortion and euthanasia are thus crimes which no human law can claim to legitimize. There is no obligation in conscience to obey such laws; instead there is a grave and clear obligation to oppose them by conscientious objection. From the very beginnings of the Church, the apostolic preaching reminded Christians of their duty to obey legitimately constituted public authorities ... but at the same time it firmly warned that ‘we must obey God rather than men’ (Acts 5:29). In the Old Testament, precisely in regard to threats against life, we find a significant example of resistance to the unjust command of those in authority ... It is precisely from obedience to God – to whom alone is due that fear which is acknowledgment of his absolute sovereignty – that the strength and the courage to resist unjust human laws are born. It is the strength and the courage of those prepared even to be imprisoned or put to the sword, in the certainty that this is what makes for ‘the endurance and faith of the saints’ (Rev 13:10).³⁶⁵

Therefore, this conscientious objection that the medical practitioner may have, becomes even more credible and sincere when taking into cognisance the said practitioner’s intense belief that the administering of euthanasia constitutes murder and therefore a violation of the Divine Commandment, “Thou shall not kill”.³⁶⁶

As alluded to earlier, the freedom to act or not to act based on the conscience most certainly has limits. Calling upon the moral justification of an act or omission based on the conscience, as stated by Robert Araujo, should not be based on “the freedom to believe in whatever one chooses to believe in simply because an interior directive says so.”³⁶⁷ To do so would be purely subjectivity such as for example, to rely on the conscience to rape or murder.³⁶⁸ Having said

³⁶⁵ Pope John Paul II, *Evangelium Vitae* (To the Bishops, Priests and Deacons, Men and Women, religious lay Faithful and all People of Good Will on the Value and Inviolability of Human Life), 25 March 1995, par. 73.

³⁶⁶ For confirmation of this Biblical precept see for example Pope John Paul II’s *Evangelium Vitae*, paras. 41, 48, 53, 77. Pope John Paul II refers to the following section of the *Donum Vitae* namely, “Human life is sacred because from its beginning it involves the ‘creative action of God’, and it remains forever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life ... Precisely for this reason God will severely judge every violation of the commandment ‘You shall not kill ...’”, *ibid.*, par. 53. Also see par. 55 (which includes the exception of taking a life when it is in self-defence).

³⁶⁷ R. J. Araujo, “Conscience, totalitarianism, and the positivist mind”, *Mississippi Law Journal*, Vol. 77, (2007), 582.

³⁶⁸ Araujo, “Conscience, totalitarianism, and the positivist mind”, 582-583.

this, the protection of the conscience regarding an act or omission remains an important freedom that should be protected as it inexorably connects to the protection of human dignity as has to do with what Steven Smith refers to as “being a full person” or what Martin Belsky considers the conscience and free exercise thereof to be comprised of the “ability of individuals ... to be free from coercion so that they can act or not act in accordance with some ‘core personal beliefs or principles.’”³⁶⁹

Coupled to the importance of the right of a medical practitioner to conscientiously object against the administering of euthanasia, should be the requirement that such a conscientious objection must reflect true sincerity. Langa CJ, in the South African Constitutional Court judgment of *Pillay* states, “A religious belief is personal, and need not be rational, nor need it be shared by others. A court must simply be persuaded that it is a profound and sincerely held belief”.³⁷⁰ Although the South African Constitutional Court has not elaborated upon the precise meaning or requirements related to *sincerity* in the context of conscience objections (and other matters related to religious freedoms) sincerity has been referred to, in addition to that of the *Pillay* judgment, in the judgment of *Minister of Home Affairs v Fourie*.³⁷¹ As indicated by the court in *Pillay*, with specific reference to religious sincerity:

Firstly, this judgement only applies to *bona fide* religious... practices... The possibility of abuse should not affect the rights of those who hold sincere beliefs. Secondly, if there are other[s]... who hitherto were afraid to express their religions... and who will now be encouraged to do so, that is something to be celebrated, not feared. As a general rule, the more learners feel free to express their religions... the closer we will come to the society envisaged in the Constitution. The display of religion ... is not a “parade of horrors” but a pageant of diversity which will enrich our schools and in turn our country.³⁷²

³⁶⁹ Araujo, “Conscience, totalitarianism, and the positivist mind”, 584.

³⁷⁰ *MEC for Education, KwaZulu-Natal and Others v Pillay*, par. 146. This understanding is equally understood in jurisprudence emanating from the United States; *Burwell v. Hobby Lobby Stores, Inc.* 134 S. Ct. (2014), 2805 (quoting from *United States v. Lee* 455 U.S. 252, 263 n.2 (1981): “There is an overriding interest, I believe, in keeping the courts ‘out of the business of evaluating the relative merits of differing religious claims,’ ... , or the sincerity with which an asserted religious belief is held. Indeed, approving some religious claims while deeming others unworthy of accommodation could be ‘perceived as favoring one religion over another...’”

³⁷¹ *Minister of Home Affairs and Another v Fourie and Another*, par. 159.

³⁷² *MEC for Education, KwaZulu-Natal and Others v Pillay*, par. 107.

As confirmed by Mark Wicclair, the worth of protecting the exercise of conscience is the protection of the individual's moral integrity.³⁷³ Wicclair refers to Jeffrey Blustein's observation that when one acts against one's conscience, "one violates one's own fundamental moral or religious convictions, personal standards that one sees as an important part of oneself and by which one is prepared to judge oneself."³⁷⁴ This moral integrity, if not protected may result in: (1) the harming of a person's conception of a good or meaningful life; (2) feelings of guilt, remorse, shame and self-respect; and (3) a decline in a person's moral character (which is especially undesirable for a medical practitioner).³⁷⁵ This is undoubtedly of relevance to the medical practitioner who conscientiously objects to the administering of euthanasia.

In the above, it has been indicated that conscience in itself is a concept deeply subjective, and reliance on its protection might not always be as noble as it appears. Regardless, an important factor when relying upon conscience remains the sincerity of the individual in question. The religious believer must exude a truly urgent, substantively concerned and committed attitude in response to a threat towards, or violation of, his religious convictions. This, as indicated, means an individual should be able to substantiate his views by showing how his objection forms part of his core beliefs. These core beliefs are those which form the substance of the individual's character and influences his human nature. As has already been mentioned elsewhere, this would in turn influence how the individual interacts with the world around him; it becomes the basis of his personal identity. Acting, particularly under duress, contrary to these values amounts to an 'act of self-betrayal'. In the words of Edmund Pellegrino:

In every belief system, fidelity to conscience is closely identified with the preservation of personal moral integrity. To arrive at a conclusion that something must be done or avoided, and to act accordingly, is to exhibit the kind of person one is, and wants to be. That act provides evidence that the individual is the kind of person she says she is ... Often, to act against conscience is to violate personal identity so directly as to lead to severe psychosocial and emotional sequelae. Therefore, conscience clauses are firmly rooted in what it is to be a human person morally, intellectually, and psychologically. Every

³⁷³ Wicclair, *Conscientious Objection in Health Care. An Ethical Analysis*, 25-26.

³⁷⁴ J. Blustein, "Doing what the patient orders: Maintaining integrity in the doctor-patient relationship", cited in Wicclair, *Conscientious Objection in Health Care. An Ethical Analysis*, 26.

³⁷⁵ Wicclair, *Conscientious Objection in Health Care. An Ethical Analysis*, 26.

individual, by virtue of being human, has a moral claim to the free exercise of conscience.³⁷⁶

Therefore, it has been indicated that the foundation of conscientious objection involves three concepts, the first being the understanding that an individual lives according to a certain established standard of moral and ethical beliefs; secondly, the requested service this individual is to render is incompatible with these beliefs; and thirdly, the individual accordingly refuses to act upon the request because his personal beliefs do not allow it. It is fundamentally important to understand that he cannot act contrary to his beliefs as these beliefs are *sincere*, which means he harbours no ulterior motive upon which his refusal is based; it is of a sufficiently *honest* and *serious* nature, which simply means it would cause great distress if the individual is forced to act contrary to these views, as the penalty for contravening his beliefs far exceed those of staying true to his own values. Lastly, the belief has to be *inherent* to the belief in question, which means that acting as required would directly contravene in a blatantly arrogant manner a foundational principle of the belief. This brings the argument in line with the increasingly relevant principles of an individual's human dignity and personal autonomy. This is because an individual's beliefs are his own, whether they might seem rational to other people or not. If the argument above is to be viewed from the spectacles of euthanasia, the religious (or ethical) medical practitioner refuses to act in accordance with the patient's request to die because such a request, in the practitioner's personal view, is of a sufficiently *serious* nature that would cause him to contravene an *inherent* principle of his religious (or ethical) views, which he *sincerely* subscribes to. His refusal is not based on a vengeful notion, but on a deeply honest and personal set of norms. If the medical practitioner is compelled to assist in terminating the life of the innocent patient who wishes to die, it would be substantively harmful towards the dignity and integrity of the medical practitioner as he would be subjected to extreme feelings of amongst others, shame and guilt. Taken further, it may be added that the refusal of intentionally terminating an innocent life is surely not reflective of some or other 'abnormal' belief or of an irrational insight. Instead, it represents a universally logical and caring approach.

3.4 Furthering plurality

³⁷⁶ Pellegrino, "The physician's conscience, conscience clauses, and religious belief: A Catholic perspective", 228.

The debate on the inclusion of conscientious objection against the administering of euthanasia is inextricably connected to matters related to the relationship between religion and the public sphere, the public sphere for purposes of this study, denotes a state-subsidised health care institution. This is focused upon with due cognisance of the relevance of this study also regarding private hospitals. However, the focus here is on public hospitals where there is generally a higher risk of enforcement of non-religious values. In modern-day democratic paradigms, the influence of liberalism on the relegation of religion to the private sphere is clear. Liberalism in this sense denotes the view in support of the autonomy of the individual and that each individual is an end in itself and this coupled to the understanding that man's reason is superior. This in itself introduces a negative sentiment towards religious authority. Also, the result of this line of thinking is that government, so as to endeavour the accommodation of this multitude of individual and group interests, is necessitated to shy away from being viewed as supportive to only a section of these interests lest it be accused by the community of being partisan, subjective and non-accommodative. This in turn necessitates government to aspire towards maintaining neutrality in its drive towards serving the public good. The same applies to government's approach to religion in that it would not want to be seen as supportive towards a specific religion (or religion in general) and that is why one finds a substantive separation of church and state in many Western societies. This is indicative of an unwelcome attitude towards the flourishing of religion in the public sphere. In this regard, religion is viewed as something subordinate to the public good; and that religion is understood as more of that which has to do with a sense of 'preference'.

It is common knowledge amongst those scholars who ascribe to a higher level of inclusion of religion in the public sphere that the scholarship emanating from the thinking of prominent liberal legal and political theorists of the latter half of the twentieth century, such as that of John Rawls (1921-2002) and Ronald Dworkin (1931-2013), attest to this relegation of religion from the public sphere; religion rather being viewed as at home in the private sphere. Peter Berger comments that Dworkin's thinking is "symptomatic of liberalism's view that meaning (understood as meaning love, preference, and belief) is something that is embraced within the private sphere whilst the public sphere is consecrated to reason."³⁷⁷ These theorists generally support a neutral public sphere that needs to be managed in neutral terms, which in turn, introduces the belief in the authority of a universal reason that is believed to result in consensus

³⁷⁷ B. L. Berger, "Law's religion: Rendering culture", *Osgoode Hall Law Journal*, Vol. 45, 2(2007), 301.

amongst all differing opinions (including those which have their origin in religion). What one finds is therefore, as described by Frederick Gedicks, support by liberalists of the private sphere “as the place for religion and the public sphere is believed to ‘denote objectivity and reason while private life is the realm of subjectivity and passions.’”³⁷⁸

This liberal approach is therefore of relevance and more importantly, of urgent concern, when bringing morally substantive contemporary challenges pertaining to specific religious interests (which naturally invite difference, emotions and contentiousness). Examples in this regard are conscientious objection by medical practitioners against participating in abortions; the refusal by pharmacists to dispense abortifacients; government subsidisation of public schools that have a religious ethos; the accommodation of passive religious forms of expression in the public sphere; and government subsidisation of religious service providers that may discriminate in certain ways (for example, Roman Catholic adoption agencies that exclude services to same-sex couples). Included in this list of examples, and of relevance to this study, is the matter related to the conscientious objection by medical practitioners against the administering of euthanasia.

Conscientious objection by medical practitioners has given rise to a multitude of disputes over the span of the last few decades and there are no signs of a dwindling in this regard. These types of disputes and their solving require a deep and urgent sense of consideration of the inclusion of the plethora of interests in societies that pride themselves (and that reflect this in their Constitutions) in the maintenance, protection and flourishing of diversity. Consequently, questions related to the parameters of the exercise of religious freedoms in the public sphere need to be addressed, more specifically, and for purposes of this study, the freedom that medical practitioners should have to conscientiously object to the administering of euthanasia in especially State hospitals.

In this lies the threatening potentiality of the law itself acting as a medium that converges over society those normative meanings that do not always ascribe to meanings held by individuals

³⁷⁸ F. M. Gedicks, “Public Life and Hostility to Religion”, cited in Ahdar & Leigh, *Religious Freedom in the Liberal State*, 67-68. Here it needs to be noted that there are many different views on what is to be understood regarding liberalism, however, for purposes of this section, the liberalism referred to has, as its main attributes the following: Individualism; non-religious rationalism and the view that the public sphere should be neutral towards religion (which in turn, results in the relegation of religion to the private sphere). For more on this see Ahdar & Leigh, *Religious Freedom in the Liberal State*, 54-69. This aversion towards the inclusion of religion in the public sphere is inextricably connected to the meaning of secularism.

(or groups of individuals sharing the same interests), which in turn poses a risk towards the attainment of true diversity. This naturally implicates the potential clash between religious and non-religious interests (yet both sides are based on fundamental beliefs). The law itself should have limits when called upon to assist in the protection of religious rights and freedoms, especially when taking into cognisance a suitable understanding pertaining to the role of the Constitution in the protection and development of true diversity in South Africa's relatively young democratic context. This is necessitated due to the foundational role that belief (whether religious or non-religious) plays in any liberal and plural society where the individual's (or religious association's) normative understanding or interpretation of reality would not always overlap with only those of others, but also with the law's potential subjective and exclusivist approaches to interpretations pertaining to, for example, life, human dignity, equality and freedom.

Of concern is that there are scholars who believe that the medical practitioner must leave his 'faith issues' at home once he is working in a hospital.³⁷⁹ Applying this understanding to the matter at hand, the conscientious objection by a medical practitioner against the administering of euthanasia based on religious conviction may only be allowed in the private sphere (such as a private hospital funded for example by the Catholic Church). However, this entails an erroneous (and anti-pluralist) picture in that any sphere (whether public or private) includes support of some or other belief whether religious or non-religious. Iain Benson warns that when discussing the relationship between religion and other aspects of society, one needs to be careful to avoid setting up false dichotomies. In other words, religion discussed *in relation to the state* or *within* society is a far cry, according to Benson, from the frequently used "religion and the state."³⁸⁰ According to Benson, using the *State* to mean the order of government and the law, and *society* to mean citizens at large, including both religious and non-religious citizens, cognisance needs to be taken of the fact that religion, in some sense, is within both, since religious and non-religious citizens make up both the State and society.³⁸¹

³⁷⁹ Rebecca Cook *et al*, "Healthcare responsibilities and conscientious objection", cited in S. de Freitas, "Freedom of conscience, medical practitioners and abortion in South Africa", *International Journal for Religious Freedom (IJRF)*, Vol. 4, 1(2011), 84.

³⁸⁰ I. T. Benson, "The freedom of conscience and religion in Canada: Challenges and opportunities", cited in De Freitas, "Freedom of conscience, medical practitioners and abortion in South Africa", 83.

³⁸¹ I. T. Benson, "Taking pluralism and liberalism seriously: The need to re-understand 'Faith' 'Beliefs' 'Religion' and 'Diversity' in the public sphere", cited in De Freitas, "Freedom of conscience, medical practitioners and abortion in South Africa", 83.

In closing, it needs to be noted that the free expression of one's religion can possibly be relegated to the private sphere with the State's approval, often because the State wants to appear impartial and unbiased. This is because of the liberal train of thought that true autonomy can only be achieved if each individual is free to decide for himself, according to his reasoning, what is best for him. No authority, whether religious or through the State, should dictate the course in which an individual steers his life. The only way government can do this, follows the argument, is if religion is removed from the public sphere, as it hampers the development or growth of society. Therefore, it is evident that conflict arises when a medical practitioner relies on the protections provided by religious rights when euthanasia comes into play. The real challenge that comes to the fore here is not so much the practitioner's refusal, but the State's obligation to ensure diversity and plurality. The State should be able to protect a citizen relying on his religious rights in the public sphere. The reason for this is because the right to entertain beliefs and convictions is a critical foundational element of a truly democratic and plural society. This in turn assists in the attainment of the promotion and protection of ideals surrounding other fundamental human rights, such as dignity, life, equality and freedom. This rings especially true for matters pertaining to the intentional termination of innocent life.

The recognition of these rights and values makes it impossible for a medical practitioner, or any religious person as matter of fact, to relegate his religious (or ethical) concerns solely to the private sphere. As such, the recognition of a right to conscientiously object to euthanasia by a medical practitioner cannot be relegated only to the private sphere, such as his home environment or a private, religiously-based hospital, but should find warranted protection equally in public spheres. In a country such as South Africa, the State runs the risk of setting a very dangerous precedent if the concerns of religious individuals are merely discarded; it openly establishes the fact that the concerns and belief systems of millions of South Africans are incompatible with the standards of public interaction and that any form of religious expression in the public sphere should be relegated to the private sphere. This is exceedingly incompatible with the society envisioned by the Constitution. The protection of religious expression and conscience therefore establishes six important insights that are vital to the functioning of South Africa's constitutional democracy. It assures that the personal autonomy of individuals are respected and maintained; that South Africa's inherently rich diversity and plurality is furthered; that plurality is furthered through epistemic humility; that the health care system in South Africa is not placed under additional stress by denying morally sensitive individuals from becoming medical practitioners; that this sensitivity will in itself create much

needed diversity in South Africa's health care and lastly, it cements social stability through social tolerance in an ever-increasing intolerant society.

3.5 Conclusion

Religion plays a formidable role in society, and interference in its functioning should not be taken lightly. Religion plays a fundamental role in the freedom and development of human beings, their interactions with one another and ultimately empowers individuals through the establishment and consequent practise of an individual's dignity. These ideas have been recognised and affirmed by many democratic and plural jurisdictions across the world, including South Africa. Various international instruments also recognise the importance of the right to freedom of religion and consequently emphasise the relevance and importance of the protections offered. Also, the importance of religion to the South African context was emphasised. The vast majority of South Africans ascribe to some or other religion and the nation's religious fervour is further highlighted by the drafting of the unique *Charter*, which guarantees specific protections to religious believers and associations, and affords them the unique opportunity, as proposed by Sachs J, to determine for themselves what they would regard as being fundamental interests in terms of religion. This is an important principle as it was argued that religion is closely related to the ideas of conscience, thought, belief and opinion. These ideas all involve deeply subjective and personal conceptions through which an individual identifies, understands and interacts with the world around him.

Local, foreign and international jurisprudence support this understanding and confirms that the State has the duty to not only ensure that religion and its adherents are afforded their rightful place in society but also the obligation to ensure that the daily functioning of society does not cause an impediment to religious believers to freely (of course, within the bounds of reason and maintenance of the public order) exercise their beliefs, in *both* private and public settings. If the religious believer is required to refrain from expressing his religiosity in the public sphere, he would have to assume a different persona; he is denied being who he is. As has been discussed, a truly free society, one that is based on values encouraging diversity and plurality will enable any individual to express his religious views. in a manner encouraging respectful

interaction; he will be able to conduct himself in line with his reasonable convictions *without fear of hindrance or reprisal, coercion or constraint*.³⁸²

However, a valid concern was raised regarding a boundless free exercise of religious freedom. This concern, as appropriately addressed, can be allayed by indicating the sincerity of the adherent's belief. Dubbed the 'sincerity test', the adherent should be able to indicate that the belief in question is not simply some religious affair he happens to habitually (or preferably) conduct without any true concern for its worth. Rather, he should be able to indicate that he truly conducts his lifestyle in line with a set of moral principles, which comes into conflict with requested conduct because his religious code prohibits him from acting in accordance with such a request. For this reason, the entire debate surrounding euthanasia is so contentious, and why conscientious objection is so vital. The medical practitioner's religious values are based on the understanding that life is immeasurably precious as it is an inherent conviction derived directly from God. This foundational principle of his religion is what forms the basis of his objection.

This however, does not exclude the added qualifier that rationally speaking, the said medical practitioner is also in the clear as questions surrounding euthanasia have to do with the intentional termination of innocent life. This is not for example, about the accommodation of the smoking cannabis or placing a copy of the Ten Commandments against a court room wall.³⁸³ The argument might be raised that adherents ascribing to the same religion do not follow the same views. However, this has no merit as it has been confirmed through cases like *Eweida* and *Pillay* that religious practices and forms of expression (whether through actual conduct or through other forms of manifestation) are fundamentally subjective and intimate matters relevant only to the adherent in question, regardless of whether it seems rational or logical to outsiders. This is stated bearing in mind what was said earlier as to the rational nature of a scenario where someone does not want to partake in the termination of the life of an innocent person, even where the latter requests it. Within the confines of this deeply intimate understanding, the objecting medical practitioner (as alluded to earlier) finds his identity, dignity and personal fulfilment. Should he be compelled to act contrary to his reasonable

³⁸² *R. v. Big M Drug Mart Ltd.*, par. 97.

³⁸³ By this should not be implied that these issues should not be accommodated, only that they are not linked to questions pertaining to such deeply layered and weighty matters such life and death and how these should be understood against the background of the importance and sanctity of human life.

religious views and kill, from his perspective murder, a patient, the resultant damage would be catastrophic to his entire being.³⁸⁴

³⁸⁴ The extent of this is discussed below.

Chapter 4

The Test for a Reasonable and Justifiable Limitation

4.1 Introduction

The euthanasia debate, by its very nature, leads to the conflict between the rights of both the patient and the medical practitioner. The test to determine whether there is a reasonable and justifiable limitation of rights therefore finds apt application in light of this study. This route is most certainly not a simple exercise, one of the reasons being (as discussed earlier) the different interpretations based on different foundational beliefs related to the relevant rights; this is of special relevance to the study at hand. Stuart Woolman and Henk Botha explain that the purpose behind the idea of a limitations clause serves a number of purposes. The first purpose is to indicate that the rights in the Bill of Rights are not absolute,³⁸⁵ whereas the second purpose indicates the supremacy of constitutional values and the State's obligation to ensure they are enforced.³⁸⁶ The reference here to 'values' may pose problems bearing in mind what was alluded to in the above regarding the complexities that may come to the fore pertaining to what the meaning of these values should be due to different belief-laden or pre-suppositional points of departure. The third purpose provides the opportunity to examine public goods and individual private interests in light of established law, particularly in light of the values of the Constitution,³⁸⁷ which leads to the final purpose of the limitations clause: To establish a test that assists in determining the extent in which laws may be enacted which limit constitutionally guaranteed rights.³⁸⁸

As a point of departure, the various rights involved in the debate will be examined, and their nature as well as importance indicated. Initially, the right to life is discussed. The right to life is foundational in the euthanasia debate for obvious reasons. However, the right is examined from both the perspective of the patient and the State's obligation to ensure its promotion and protection. Additionally, the belief or conviction of the medical practitioner will be discussed, highlighting in particular the reasons why he harbours aversion to euthanasia based on the right

³⁸⁵ S. Woolman & H. Botha, "Limitations", in S. Woolman & M. Bishop (eds.), *Constitutional Law in South Africa*, 2nd Ed., (Cape Town: Juta, 2014), Original Service: 07-06, 34-1.

³⁸⁶ Woolman & Botha, "Limitations", 34-2.

³⁸⁷ Woolman & Botha, "Limitations", 34-2.

³⁸⁸ Woolman & Botha, "Limitations", 34-2.

to life. Subsequently, the right to human dignity will be discussed, highlighting the foundational role it plays as a right in and of itself as well as in relation to other rights; a right that constitutes one of the hallmarks of a democratic society. The right to human dignity is a right inextricably connected to the right to life and, as is the case with the right to life, it finds application to both the medical practitioner and the patient against the background of euthanasia and the practitioner's conscientious objection against the administering thereof. The patient claims that the effect of the illness and his ensuing helplessness are degrading and detrimental to his inherent human dignity, and therefore requests euthanasia, whereas the medical practitioner, upon receiving a request to terminate the life of the patient, refuses, basing his refusal on his religious belief and consequent convictions and which in turn, implicates the protection of the conscience. Although the relationship between human dignity and religion has been touched upon elsewhere, this section will reiterate the pivotal role played by human dignity in religious adherence, and that an infringement of religious interests may severely impinge human dignity.

The final right that will warrant a discussion is the right to privacy. The right to privacy appears somewhat underdeveloped in South African jurisprudence. Therefore, invaluable comparative knowledge will be examined, particularly in light of American jurisprudence, which assists in casting a clearer light on the meaning of privacy as it applies to both the deeply personal decision made by the patient to have his life terminated and the complexities as well as the relative and arbitrary nature that accompanies such a right. How this right connects to the interests of the medical practitioner is also brought to the fore. The relevance of the right to safety and security of the person will also be touched upon. Throughout the discussion of these rights, their interrelated nature and co-dependence will also become evident. As such, the right to life will be the first right examined.

4.2 The right to life

Preceding the qualification of the importance of human life by means of reference to human rights is the fact that 'life' is a primary good of persons, which encompasses our bodily and experiential as well as intellectual existence. This understanding of human life as a basic human good precedes the understanding that the right to life is an important universal right. Craig Paterson states that life is "a grounding good because it sustains all of our choices and actions and in this regard, it is of instrumental value. Added to this, life is also of intrinsic

importance.³⁸⁹ The right to life is the most important of all the rights contained in the *Universal Declaration of Human Rights*. The *Constitution of the Republic of South Africa* states, “Everyone has the right to life”.³⁹⁰ Across the world, particularly in the West, great emphasis is placed on the necessity of States to protect life. Article 3³⁹¹ of the *Declaration* creates an obligation on member States to protect life within their respective jurisdictions and the argument follows that the right to life is the source from which all other rights emerge.³⁹² It is in essence a moral principle that emphasises the inviolability of human life. No one person, should intentionally terminate the innocent life of another (even when requested to do so by the latter). No person has the authority to decide who lives and who dies; who is entitled to a certain life and who is not. Most jurisdictions across the world guarantee the right to life.³⁹³ The right to life is more than a mere statement or undertaking and its sanctity is projected on religious and philosophical grounds. In the words of Pope John Paul II:

Even in the midst of difficulties and uncertainties, every person sincerely open to truth and goodness can, by the light of reason and the hidden action of grace, come to recognize in the natural law written in the heart (cf. Rom. 2:14-15) the sacred value of human life from its very beginning until its end, and can affirm the right of every human being to have this primary good respected to the highest degree. Upon the recognition of this right, every human community and the political community itself are founded.³⁹⁴

As argued earlier, human life and human dignity are closely related. In the South African Constitutional Court case of *S v Makwanyane*, O’Reagan J commented:

The Constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society.

³⁸⁹ C. Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, (Burlington: Ashgate Publishing Company, 2008), 51. Paterson adds that, “Due respect for the primary good of human life minimally demands that we always refrain from actions intent on killing an innocent person”, *ibid.*, 104.

³⁹⁰ *Constitution of the Republic of South Africa*, section 11.

³⁹¹ “Everyone has the right to life, liberty and security of the person.”

³⁹² *S v Makwanyane and Another* 1995 (3) SA 391 (CC), par. 217. Langa J.

³⁹³ The right to life is generally a universally recognised right protected by various international instruments, such as *inter alia* the *Universal Declaration of Human Rights*, the *International Covenant on Civil and Political Rights* and the Protocol to the *African Charter on Human and Peoples’ Rights*.

³⁹⁴ Pope John Paul II *Evangelium Vitae* (To the Bishops, Priests and Deacons, Men and Women, religious lay Faithful and all People of Good Will on the Value and Inviolability of Human Life), 25 March 1995, par. 2. In this regard, also see *ibid.*, par. 65. Pope John Paul II adds, “As far as the right to life is concerned, every innocent human being is absolutely equal to all others. This equality is the basis of all authentic social relationships which, to be truly such, can only be founded on truth and justice, recognising and protecting every man and woman as a person and not as an object to be used”, *ibid.*, par. 57.

The right to life, thus understood, incorporates the right to dignity. So the right to human dignity and life are entwined. The right to life is more than existence; it is a right to be treated as a human being with dignity.³⁹⁵

Chaskalson J, whilst delivering the Third Bram Fischer Memorial Lecture, confirms the inextricable relationship between life and human dignity:

The affirmation of human dignity as one of the founding values of the Constitution is significant. The interim Constitution emphasised the values of democracy, freedom and equality. Although dignity is immanent in these values and in the rights entrenched in the interim Constitution's Bill of Rights, its role as a foundational value of the constitutional order was not acknowledged in specific terms until the adoption of the 1996 Constitution. Consistently with this, the 1996 Constitution now refers to the 'inherent dignity' of all people, thus asserting that respect for human dignity, and all that flows from it, as an attribute of life itself, and not a privilege granted by the state.³⁹⁶

As is critically elaborated upon below regarding the right to privacy, there are those (which include supporters of the legal administering of euthanasia), as pointed out by Robert George, who distinguish *mere biological human life* from the life of a *person*. Regarding an understanding of the latter, a person possesses developed capacities for “characteristically human mental activity, such as conceptual thinking, deliberation, and choice. According to this understanding, it is ‘personal life’ that has intrinsic value and dignity whilst ‘biological life’ does not.”³⁹⁷ Explained otherwise, this approach views a living human body “not as a person until it becomes associated with a mind and such a body ceases to be a person not only by dying but at any point at which it loses this association of mind and body.”³⁹⁸ This view comes into contrast with the view that bodily life denotes an intrinsic good and is therefore an end in itself; the human physical or biological entity (which includes the retarded and the comatose) is sufficient so as to qualify as human life, and therefore the right to life should aim at the protection thereof. In other words, the body has not got a merely instrumentalist attribute, rather the body constitutes primarily an intrinsic good. For example, a newly born baby, although

³⁹⁵ *S v Makwanyane and Another*, paras. 326-327.

³⁹⁶ A. Chaskalson, “Human dignity as a foundational value of our constitutional order”, *South African Journal of Human Rights*, Vol. 16, 2(2000), 193.

³⁹⁷ R. P. George, “Terminal Logic”, *Touchstone*, March 2006, 32.

³⁹⁸ R. P. George, *The Clash of Orthodoxies: Law, Religion, and Morality in Crisis*, (Wilmington: ISI Books, 2001), 34.

being substantively under-developed regarding its intellectual and experiential ability, remains irrespective, a human life that should enjoy full protection. John Finnis comments:

Sensing one's fingers hitting keys, for example, is rather a 'dimension' or 'manifestation' of what it is to be a living body, intelligent or not. Of course, in the human subject bodily life in all its manifestations is a dimension of the *one human life* by which a person composing onto a word processor *also* exercises and experiences intelligence and autonomy, and by which a sleeping person breathes, metabolizes air and food, dreams, and responds to stimuli³⁹⁹ ... one's living body is intrinsic to one's personal reality. One does not merely possess, inhabit, or use one's body, as one possesses and uses an instrument or inhabits a dwelling. Thus, human life, which is nothing other than the very actuality of one's body, is a good intrinsic to one. It is not merely an instrumental good of the person, or extrinsic to the person. Intrinsic to the original unity of the person, it shares in the dignity of the person ... even an impoverished instantiation of the good of life remains specifically human and proper to the person whose life it is. Human life is inherently good, and does not cease to be good when one can no longer enjoy a degree of cognitive affective function or attain other values. Human bodily life, even the life of one in a coma, has value. To choose to kill even such a person is to choose to harm that person. It is therefore inconsistent with a rational love of that person, and (however much motivated by feelings of affection and compassed about with thoughts and words of respect) is inconsistent with respect for and justice to the person.⁴⁰⁰

John Keown discusses this notion pertaining to the intrinsic importance of biological life, with reference to a British case heard in the House of Lords, *Airedale NHS Trust v Bland*.⁴⁰¹ In this judgement, Lord Mustill considered the notion that a person's life lessens in worth the more its quality is diminished through disease or some other incapacity; and added that such determination, if it were correct, would conclude the debate surrounding euthanasia, as it would serve as the basis of both active and passive euthanasia. Such, however, is not the case. Any determination upon the quality of life being of less worth because of some ailment is a "very dangerous road indeed", and apparently, one he was unwilling to take.⁴⁰² Such understanding

³⁹⁹ J. M. Finnis, *Human Rights and Common Good, Collected Essays: Vol. 3*, (Oxford: Oxford University Press, 2011), 239.

⁴⁰⁰ Finnis, *Human Rights and Common Good*, 247-248.

⁴⁰¹ J. Keown, "The legal revolution: From 'sanctity of life' to 'quality of life' and 'autonomy'", *Journal of Contemporary Health Law and Policy*, Vol. 14, 2(1998), 270; *Airedale NHS Trust v Bland*: HL 4 Feb 1993.

⁴⁰² *Airedale NHS Trust v Bland*, 984, cited in Keown, "The legal revolution: From 'sanctity of life' to 'quality of life' and 'autonomy'", 270.

has become the basis of the right to life; the right to life is narrowed down to it ‘axiomatic imperative’ that no one shall be deprived of his life.⁴⁰³ This includes the understanding that the biological life of a human being is exclusively sufficient to substantiate the fundamental importance and sanctity of life. Craig Paterson states:

No one doubts, for example, that a day-old-human infant or the very senile may lack the actual capacities of, for example, a day old foal. Human infants and the very senile, in terms of mobility, awareness of environment, feeding ability, etc. are not very impressive in the exercisable functioning stakes. But surely this sort of comparison does not convince us that foals somehow have greater fundamental worth than human infants or the very senile. If anencephalic infants or the very senile were, say, intentionally killed and sold for food, we would surely find such a practice deeply undignified and repugnant. This example may seem rather extreme to the reader, and yet, if the true worth of individual human beings, at the end of the day, were held to be ultimately and contingently dependent on having some ready prospect for individually exercising capacity X or capacities X ... rather than their having ‘radical dignity by virtue of their essential nature,’ there should – apart from obvious health concerns or feelings of squeamishness or dealing with the reaction of relatives – be no deep moral problem with intentionally killing such profoundly damaged human beings in order to make use of their harvested dead flesh for the manufacture of consumer edibles.⁴⁰⁴

This confirms the importance of human life, where human biological life remains substantively important and sacred, and together with the intellect (the mind and its experiences) form union, which constitutes human life.⁴⁰⁵ The right to life in South Africa is an ‘unqualified’ right, which

⁴⁰³ D. van Wyk, J. Dugard, B. de Villiers & D. Davis, *Rights and Constitutionalism*, (Kenwyn: Juta & Co., 1994), 215.

⁴⁰⁴ Paterson, *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*, 138-139. Paterson also states, “Bodies are not ‘prisons of the immortal soul’ nor are they ‘mere biological equipment.’ Bodies are intrinsically and not merely extrinsically valuable to us because they are seamlessly integral to the very reality of who and what we are as persons. A body is not something ‘sub-personal’ to ‘personal life’ as if X (consciousness life) can be radically juxtaposed with Y (bodily life) such that X can be held intrinsically valuable to us but not Y. Both X and Y are fully integral to our personal beingness”, *ibid.*, 51.

⁴⁰⁵ J. M. Finnis, “The ‘value of human life’ and ‘the right to death’: Some reflections on *Cruzan* and Ronald Dworkin”, Hiram H. Lesar Distinguished Lecture, 24 September 1992, *Southern Illinois University Law Journal*, Vol. 17, (1993), 568-569. On the *unity* of both the biological and mental (experiential, intellectual) attributes of life, John Finnis explains, “We experience this complex unity more intimately and thoroughly than any other unity in the world; indeed, it is for us the very paradigm of substantial unity and identity. As I write this, I am the unitary subject of my fingers hitting the keys, the sensations I feel in them, the thinking I am articulating, my commitment to write this paper, my use of the computer to express myself. As I speak it, I am the unitary subject of the muscular effort in projecting my voice, of the hearing that voice, of observing your bodily responses, of the thoughts I am articulating and the thoughts I am not articulating (as I wonder how it’s going across), and the emotions that colour all this. So the one reality that I am involves at once consciousness and bodily experience and behavior ... So,

differentiates it from many other Constitutions across the world, where the right to life is ‘qualified’. Unqualified means that no law or statute may limit its application, other than the limitations clause.⁴⁰⁶ Therefore, discussions surrounding limiting the right to life, assuming that such limitation is necessary for the democratic functioning of a free and equal society,⁴⁰⁷ would, according to Van Wyk *et al* necessitate the satisfaction of four requirements: (1) a legal basis is necessary for any deprivation of the right to life; (2) the deprivation must be proportionate to the circumstances at hand; (3) any deprivation of the right to life should be subject to independent judicial processes to assess its justification; and (4) any deprivation of life may only be justified in terms of defence for the right to life.⁴⁰⁸ Therefore, questions surrounding the admissibility of the right to life should be contrasted in light of these four requirements, which could perhaps open the possibility for further expanding the right to life into other problematic areas as well.

In conclusion, the right to life is often described as the most fundamental human right, particularly on account of its intrinsic worth, and emanating from this, its intimate relationship with human dignity. Because of its substantive importance, foreign law as well as international and regional human rights instruments undertake to protect the sanctity and value of human life. Disagreements exist within the ranks of philosophers and jurists regarding the nature of human life – some have argued that it is an absolutely inviolable right, regardless of any distinction created by biology or medical science, whereas others are of the view that the right to life should be expanded to include additional meanings other than the obvious. Be as it may, human life remains intrinsically of importance, which, in turn, enhances the argument in opposition to many forms of euthanasia due to a deep-seated respect towards the protection of innocent human life.

4.3 The right to human dignity

one’s living body is intrinsic to one’s personal reality. One does not merely possess, inhabit or use one’s body, as one possesses and uses an instrument or inhabits a dwelling.”

⁴⁰⁶ I. Currie & J. de Waal, *The Bill of Rights Handbook*. 5th Ed., (Claremont: Juta, 2005), 281. The qualified nature of the right to life in many other Constitutions means that some law may limit its application, such as provisions in national legislation prescribing the death penalty.

⁴⁰⁷ *Constitution of the Republic of South Africa*, section 36(1).

⁴⁰⁸ Van Wyk *et al*, *Rights and Constitutionalism*, 223.

Some view human dignity as both a constitutional principle and a fundamental value that serves as both the foundation and moral justification of fundamental rights.⁴⁰⁹ Others view dignity as a principle dependent on a particular context; it substantiates other rights but is not in itself enforceable.⁴¹⁰ From a South African perspective, it has been established that dignity⁴¹¹ is the most important right and serves as the pillar upon which all other rights rely. The South African Constitutional Court judgment of *S v Makwanyane* serves as a bastion of protection and acknowledgment of human dignity:

Respect for the dignity of all human beings is particularly important in South Africa ... The new Constitution rejects [the] past and affirms the equal worth of all South Africans. Thus recognition and protection of human dignity is the touchstone of the new political order and is fundamental to the new Constitution.⁴¹²

In addition to *Makwanyane*, the South African Constitutional Court held in *Dawood v Minister of Home Affairs*⁴¹³ that:

Human dignity therefore informs constitutional adjudication and interpretation at a range of levels. It is a value that informs interpretation of many, possibly all, other rights. This court has already acknowledged the importance of the constitutional value of dignity in interpreting rights such as the right to equality, the right not to be punished in a cruel, inhumane or degrading way, and the right to life.⁴¹⁴

For some rights, it is unnecessary to invoke the right to dignity, as it is commonly accepted that the right in question already encompasses respect for dignity, such as the right to life.⁴¹⁵ In other instances, there is no familiar benchmark and the right to dignity is invoked to establish a criterion of what is required or what needs to be protected.⁴¹⁶ In Germany for example, it has

⁴⁰⁹ L. R. Barroso, "Here, There and Everywhere: Human Dignity in Contemporary Law and in the Transnational Discourse", *Boston College International & Comparative Law Review*, Vol. 35, (2012), 354-355.

⁴¹⁰ C. McCrudden, "Human dignity and judicial interpretation of human rights", *The European Journal of International Law*, Vol. 19, 4(2008), 681.

⁴¹¹ As well as the right to life.

⁴¹² *S v Makwanyane and Another* 1995 (6) BCLR 665 (CC), par. 329.

⁴¹³ *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* 2000 (8) BCLR 837.

⁴¹⁴ *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others*, par. 35.

⁴¹⁵ *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others*, par. 36.

⁴¹⁶ J. Waldron, "Is dignity the foundation of human rights?", *New York University Public Law and Legal Theory Working Papers*, Paper 374(2013), 3.

been held that when it comes to the meaning of dignity, “the alleged violation of human dignity went along with alleged violations of other individual rights so that access to the Court never depended on the qualification of human dignity as an individual right.”⁴¹⁷ Thus, it can easily be said that dignity is merely a ‘placeholder’ for certain abstract ideas.⁴¹⁸ To illustrate, it is accepted in South African jurisprudence that dignity is the foundational value underpinning religious freedom and freedom of conscience.⁴¹⁹ However, the term ‘human dignity’ can be used by those that allege its infringement, to fit their particular worldview or values; “it is a linguistic-symbol that can represent different outlooks.”⁴²⁰

Oscar Schachter is of the view that one can easily do away with abstract definitions and attempts at making them, and accept the fact that dignity is a term that cannot be defined. But this would, says Schachter, be ineffective as reliance on dignity to justify certain conduct then falls away.⁴²¹ Rather, one should, according to Schachter, view dignity in the context of the Roman-Dutch concept of *dignitas*, which refers to a person’s ‘intrinsic worth’.⁴²² In terms of the common law, this refers to the self-esteem of a person, or his personality. It is inseparably connected to a person’s personhood – who that person is as a human being. It is a value that cannot be granted, nor can it be lost.⁴²³ Thus, references in the Constitutions of democratic States and international instruments to respect the ‘dignity’ or ‘inherent human dignity’ of a human being can be viewed as referring to the intrinsic *worth* of a human being.

Respect for dignity *affirms* the free will and consent of an individual. Not only is the freedom of a person’s will part of the idea behind respect for a person’s dignity, but it plays a role in ensuring respect for a person’s psychological integrity as well.⁴²⁴ Accordingly, the first ‘element’ in a proper definition of the right to human dignity would entail respect for both physical and psychological integrity.⁴²⁵ Schachter holds that “the use of coercion, physical or

⁴¹⁷ C. Walters, ‘Human dignity in German constitutional law’, 17 (as part of the UniDem Seminar in Montpellier, France, 2-6 July 1998. *European Commission for Democracy through Law*, Venice Commission: ‘The principle of respect for human dignity’).

⁴¹⁸ McCrudden, “Human dignity and judicial interpretation of human rights”, 722.

⁴¹⁹ *MEC for Education: KwaZulu-Natal and Others v Pillay* 2008 (1) SA 474, paras. 62-65.

⁴²⁰ D. Shultziner, “Human dignity- Functions and meanings”, *Global Jurist Topics*, Vol. 3, 3(2003), 5.

⁴²¹ O. Schachter, “Editorial comment”, *The American Journal of International Law*, Vol. 77, 4(1983), 849.

⁴²² Schachter, “Editorial comment”, 849.

⁴²³ Barroso, “Here, There and Everywhere: Human Dignity in Contemporary Law and in the Transnational Discourse”, 363.

⁴²⁴ Schachter, “Editorial comment”, 849.

⁴²⁵ Barroso, “Here, There and Everywhere: Human Dignity in Contemporary Law and in the Transnational Discourse”, 364.

psychological, to change personal beliefs is as striking an affront to the dignity of the person as physical abuse or mental torture.”⁴²⁶ Respect for dignity would mean the whims and wishes of one or few members of society cannot be used as a coercive tool against the free will of an individual; neither can governments impose and enforce beliefs that subject an individual or a group’s views to conformity of their own, thereby asserting their authority into an individual’s life that is personal and familial to that person.⁴²⁷

Human dignity entails another aspect. In addition to ensuring respect for a person’s inherent worth, recognition of an individual’s personal responsibility should be highlighted. This refers to the capacity of a person to make individual choices that give expression to his distinct identity.⁴²⁸ The inability of a person to provide for himself, or the inability to act in accordance with his convictions through prohibitions beyond his control has a profound impact on the dignity of any individual. It degrades a person by forcing the person to act against his personal convictions – ideas upon which his entire conception of his personhood and his life are based.

By virtue of the nature of the Constitution, dignity is therefore a far-reaching right, applicable to all, even in the sphere of religious and conscientious adherence. The infringement on the conscience of another is a violation of his inner sanctum, his human dignity. If a medical doctor is brought to the point where he has to decide whether a patient ‘has worth’, thus entitled to further medical care, or such person has lost all ‘worth’, and no longer eligible for medical treatment, such a decision will frequently be influenced by moral concerns that are inextricably related to religious beliefs. Addressing the relationship between human dignity and the importance of ensuring religious freedom, Langa CJ adds:

There is however more to the protection of religious... practices than saving believers from hard choices. ...[R]eligious... practices are protected because they are central to human identity and hence to human dignity which in turn is central to equality. Are voluntary practices any less part of a person’s identity or do they affect human dignity any less seriously because they are not mandatory?⁴²⁹

⁴²⁶ Schachter, “Editorial comment”, 849.

⁴²⁷ Schachter, “Editorial comment”, 850.

⁴²⁸ *MEC for Education: KwaZulu-Natal and Others v Pillay*, par. 63.

⁴²⁹ *MEC for Education: KwaZulu-Natal and Others v Pillay*, par. 62.

Using this argument concerning human dignity, Langa CJ proceeds to emphasise the value of freedom in South Africa's constitutional context and how it is the next 'element' vital to give full effect to dignity;⁴³⁰ each of which cannot exist individually, but exists in unison to enhance and reinforce each other.⁴³¹ Ackermann J expressed this relationship as follows:

Human dignity has little value without freedom; for without freedom personal development and fulfilment are not possible. Without freedom, human dignity is little more than an abstraction. Freedom and dignity are inseparably linked. To deny people their freedom is to deny them their dignity.⁴³²

As such, an individual's freedom must be interpreted as widely as possible, while maintaining the same standard of respect for another's freedom. An individual must be free to pursue their own goals, develop their own goals and fulfil their own ideas of what is a "good life".⁴³³ This means freedom is granted to ordinary citizens to pursue their ideals, dreams and pursuits. However, they are not simply granted the freedom to do so; they are allowed to do so in a way that corresponds with their convictions and personal affirmations, religious or non-religious. As such, freedom of conscience and freedom of religion, as well as the protection thereof, are vital in a society proclaiming itself to be open and democratic, as well as based on human dignity, equality and freedom. Pope John Paul II also emphasises the inextricable connection between human dignity and the right to conscientiously object to the administering of euthanasia in the following:

To refuse to take part in committing an injustice is not only a moral duty; it is also a basic human right. Were this not so, the human person would be forced to perform an action intrinsically incompatible with human dignity, and in this way human freedom itself, the authentic meaning and purpose of which are found in its orientation to the true and the good, would be radically compromised. What is at stake therefore is an essential right which, precisely as such, should be acknowledged and protected by civil law. In this sense, the opportunity to refuse to take part in the phases of consultation, preparation and execution of these acts against life should be guaranteed to physicians, health-care personnel, and directors of hospitals, clinics and convalescent facilities. Those who have

⁴³⁰ And equality.

⁴³¹ *MEC for Education: KwaZulu-Natal and Others v Pillay*, par. 63.

⁴³² *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others* (CCT5/95) [1995] ZACC 13; 1996 (1) SA 984 (CC), par. 49.

⁴³³ *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others*, par. 50.

recourse to conscientious objection must be protected not only from legal penalties but also from any negative effects on the legal, disciplinary, financial and professional plane.⁴³⁴

Considering the above insights related to human dignity, there should not be any legitimate prohibition on a medical practitioner to refuse a particular request made by one of his patients. Respect is due to the medical practitioner, not on account of the position he holds in society, but by virtue of him being a human being endowed with a free will and rationality as well as a bearer entitled to the protection of fundamental rights and freedoms. The personal autonomy and individual responsibility of the medical doctor should be *respected*. As has been alluded to earlier, believers often find meaning or purpose for their lives, and accordingly their identity and dignity, through religious practices. Iain Benson refers to the eminent theologian Emil Brunner's understanding (as presented in his *Justice and the Social Order*) that:

Insofar as man is a person in relationship, he is bound by the authority of the State, but insofar as he is a person before God, he is bound by no State. The State has never had rights over his soul; man never "belongs" to the State. Man never receives his human dignity through the State, but prior to the State and independently of it.⁴³⁵

In this regard, human dignity is to be understood as that which is in accordance with the foundational belief of the believer. In this regard, the believer, in his innermost being, connects with an importance, which surpasses the State, hereby finding himself in a relational experience with that which provides utmost meaning and purpose and to which such a believer committedly responds to under the direction of the conscience. Compelling a person to abandon his religious convictions, to assist another to do something that is in his eyes abhorrent, constitutes a grave infringement on the inherent dignity of such a person. Such a person should not be treated as a mere means to an end. By becoming a medical practitioner, he did not agree to set aside those aspects of his inherent dignity such as the ability to make informed decisions about himself, or the right to embrace certain convictions, religious or otherwise. If certain requirements are put in place forcing a medical practitioner to actively act in contradiction to his sincerely held values and beliefs, it would amount to a non-recognition of his inherent worth

⁴³⁴ Pope John Paul II, *Evangelium Vitae*, par. 74.

⁴³⁵ I. T. Benson, *An Associational Framework for the Reconciliation of Competing Rights Claims Involving the Freedom of Religion*, (Unpublished PhD thesis, University of the Witwatersrand, 2013), 22.

in society and a limitation is placed on his beingness; only to become subjected to the will and whims of others who wish to have their wishes respected at the cost of another. Also, it is precisely the medical practitioner's sense of the intrinsic worth of the innocent life of the patient who wants to be euthanised that feeds such a medical practitioner's conscientious objection against terminating the life of such a patient. In fact, it is the sense of human dignity radiating from the patient that forms part of the medical practitioner's sense of abhorrence towards administering euthanasia.

To conclude, jurisprudence on the right to human dignity has unequivocally established its undeniable worth and affirmed its purpose in South Africa's constitutional discourse. In South Africa's Bill of Rights, certain rights plead specific reliance on the right to dignity to ensure their effectual integration into society, whereas the concept of human dignity is so glaringly obvious, it warrants no particular mention.⁴³⁶ It therefore entrenches, throughout the various rights in which it finds application, the individual worth of a human being, as being an individual person with an individual personality that can never be utilised as a mere means to an end. It is a construct protecting both the physical and psychological integrity of a person, affirming an individual's ability to assume responsibility for his own well-being and personal flourishing. Human dignity is therefore of fundamental importance regarding the protection of a medical practitioner's conviction that assisting, whether directly or indirectly, in the intentional termination of an innocent life (even where a patient voluntarily requests such termination himself) is a substantively serious matter.

It has been argued that religion is not a protected right because of sentimental constraints. Rather, religion is protected because it is a human basic good central to the religious believer. From the believer's religious convictions, he finds his inherent worth and meaning, and therefore his inherent human dignity. Additionally, the constitutional principle of freedom plays a vital supportive role in assisting individuals realising their inherent human dignity. Freedom and human dignity are inseparable from one another; they exist in a harmonious relationship, each supporting the inherent value of the other. Without dignity, freedom is meaningless; arbitrarily deprive a person of his freedom and his dignity is destroyed. Human

⁴³⁶ A. Alen (ed.), *Treatise on Belgian Constitutional Law*, (Kluwer Law and Taxation Publishers, 1992), cited in Van Wyk *et al*, *Rights and Constitutionalism*, 218 indicate that the right to life, for example, was never included in the Belgian constitution because "this right was so self-evident that it was not deemed necessary to guarantee it explicitly in the text of the Constitution."

dignity, as properly understood therefore, allows ample room for individuals to decide on their own (and sometimes as part of associations sharing the same doctrinal convictions) which actions they prefer to partake in, or from which to recuse themselves. Therefore, on the basis of dignity and freedom alone, a medical practitioner should be allowed to refuse to act contrary to his own conviction when it comes to the exercise of the many forms of euthanasia described at the beginning of this study.

4.4 The right to privacy

The right to privacy is inextricably connected to the justification of euthanasia,⁴³⁷ and therefore an analysis of this right is of the utmost relevance and importance to this study. The right to privacy is a right guaranteed explicitly in the *Declaration* and the *International Covenant on Civil and Political Rights* by virtue of Article 17 and Article 8 respectively.⁴³⁸ In South Africa, the right to privacy is a guaranteed right in the Constitution. Section 14 holds that everyone has the right to privacy and it goes further by stating that this right “*includes* the right not to have their home or person searched, have their possessions unlawfully seized, their property searched or have the privacy of their communications infringed.”⁴³⁹ Thus, the right to privacy in South Africa is multifaceted. The right to privacy in Western democracies, has been the subject of profound scholarship and has been elaborated upon in a number of cases to elucidate more clearly its meaning, namely, extending the right to privacy to not only the ‘informational’ sense, meaning preventing the dissemination of personal knowledge or information, but also to substantive concepts relevant to every-day life of the person holding them⁴⁴⁰ such as marriage, contraception, education, child rearing and so forth.

Inextricably connected to the proliferation of rights (and their meanings) is the practice by scholars in support of the secular tradition that endeavours the exclusion of anything religious, as well as the courts in liberal paradigms, to ascribe a non-religious connoted meaning to a right that does not necessarily accord with meanings emanating from amongst others, the

⁴³⁷ S. Klein, “The right to die as an issue of privacy: A selective bibliography”, *Journal Articles*, 1150(1994), 138; S. J. Wolhandler, “Voluntary active euthanasia for the terminally ill and the constitutional right to privacy”, *Cornell Law Review*, Vol. 69, 2(1984), 375; D. Novak, *The Sanctity of Human Life*, (Washington, D.C.: Georgetown University Press, 2007), 147.

⁴³⁸ Strangely, it is not mentioned explicitly in the *African Charter on Human and Peoples’ Rights*. However, it is, as understood through jurisprudence and other international instruments, implied in the various provisions of the *African Charter*.

⁴³⁹ Author’s emphasis.

⁴⁴⁰ J. Rubinfeld, “The right of privacy”, *Harvard Law Review*, Vol. 102, 4(1989), 740.

religious. These meanings then undergo further development which do not necessarily remain intact due to new or opposing meanings replacing earlier ones. Included in this are also contrasting or opposing views within the non-religious rationale itself. The end result is a smorgasbord of subjective and varied meanings that in many instances come into opposition to religious meanings. In this regard, the right to privacy especially in the context of American jurisprudence serves as a good example of such a predicament. The right to privacy is not included in the American Constitution, however, this right was first referred to just over half a century ago in the US Supreme Court case of *Griswold v Connecticut*.⁴⁴¹ In the precedent-setting *Roe v Wade*⁴⁴² decision, the American Supreme Court created its own meaning pertaining to the right to privacy so as to oppose the protection of the unborn up until the attainment of viability (which begins at around six months into the pregnancy). Justice Blackmun asserted that the right to privacy, which, prior to *Roe*, related to marriage, procreation, contraception, education and child-rearing was now “broad enough to encompass a woman’s decision whether or not to terminate her pregnancy,” and that regulation limiting this right of personal privacy may only be justified by a compelling State interest.⁴⁴³ This textually unsupported assertion has been subjected to a plethora of criticism – some of it from the most respected legal minds.⁴⁴⁴

Looking further at the American jurisprudential context, one sees that American Supreme Court judge, Justice Blackmun,⁴⁴⁵ listing cases recognising some form of a ‘right of privacy’, acknowledged that “these decisions make it clear that only personal rights that can be deemed ‘fundamental’ or ‘implicit in the concept of ordered liberty’ ... are included in this guarantee of personal privacy”. To this, Horan and Balch comment that it remains vague as to what makes abortion ‘implicit’ in the very nature of ‘ordered liberty’.⁴⁴⁶ Although in subsequent American

⁴⁴¹ *Griswold v. Connecticut* 381 U.S. 479 (1965).

⁴⁴² *Roe v. Wade* 410 U.S. 113 (1973).

⁴⁴³ J. N. Haley, “Haunting shadows from the rubble of *Roe’s* right of privacy”, *Suffolk University Law Review*, Vol. 9(1974), 146-147.

⁴⁴⁴ D. J. Horan & T. J. Balch, “*Roe v. Wade*: No justification in history, law, or logic”, in D. J. Horan, E. R. Grant & P. C. Cunningham (eds.), *Abortion and the Constitution: Reversing Roe v. Wade Through the Courts*, (Washington D.C.: Georgetown University Press, 1987), 70; S. J. Frankowski, “United States of America,” in *Abortion and Protection of the Human Fetus*, S. J. Frankowski & G. F. Cole (eds.), (Dordrecht: Martinus Nijhoff Publishers, 1987), 24; R. H. Bork, *The Tempting of America. The Political Seduction of the Law*, (New York, Touchstone, Simon & Schuster Inc., 1990), 113-114; J. O’Meara, “Abortion: The court decides a non-case”, *The Supreme Court Review*, Vol. 1974(1974), 337-340; P. A. Smith, “The Right to Privacy: *Roe v. Wade* Revisited”, *The Jurist*, Vol. 43(1983), 316.

⁴⁴⁵ *Roe v. Wade*.

⁴⁴⁶ Horan & Balch, “*Roe v. Wade*: no justification in history, law, or logic”, 70.

case law, the ‘privacy’ rationale has been exceeded by the ‘undue burden standard’,⁴⁴⁷ fact remains that the *Roe*-decision, which opened the floodgates to abortion practices (both in America and beyond), relied on its own creation of an understanding related to privacy in order to argue in support of the legalisation of abortion. The prominent American legal scholar namely Ronald Dworkin also supports the right to privacy as a qualifier for the legalisation of abortion.⁴⁴⁸

The idea of ‘personhood’ also became inextricably connected to what was to be understood pertaining to the right to privacy. This ‘personhood’ is anchored in the Kantian grounded conception of “*individual* self-government. Its institutions are designed primarily to secure individual autonomy: The freedom of each to choose and pursue his own ends, limited only by the principle that others must be free to do likewise.”⁴⁴⁹ What is sought in this regard, is the protection of the freedom of individuals to define themselves in contradistinction to the values of the society in which they happen to live. Such a form of liberty is based on an individualist understanding of human self-definition: “A conception of self-definition as something that persons are, and should be, able to do apart from society.”⁴⁵⁰ In the words of Jed Rubenfeld, “Grounded in personhood's right to self-definition, privacy serves the classically liberal goals of preventing government from legislating morality and ensuring that individuals are free to make critical value-choices for themselves.”⁴⁵¹ However, as salutary as this may seem, a contradiction arises in that the judiciary itself takes a specific moral view on certain matters when ascribing to the protection of the right to privacy. A classic example in this regard, is the *Roe v Wade* judgment referred to earlier, which decided against the protection of the unborn with specific emphasis on the first two trimesters of pregnancy. This right to privacy has also been extended to justify euthanasia, for example, active euthanasia, where a person may, due to pain and suffering, choose to have a medical practitioner administer substances that would result in the termination of a human life.

This is indicative of the extent to which a right can exponentially be accorded new meanings, which, in this instance regarding the right to privacy, places it on a slippery slope towards a

⁴⁴⁷ *Planned Parenthood of Southeastern Pa. v. Casey* 505 U.S. 833 (1992).

⁴⁴⁸ R. Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia*, (London: Harper Collins, 1993), 106-107.

⁴⁴⁹ Rubenfeld, “The right of privacy”, 761.

⁴⁵⁰ Rubenfeld, “The right of privacy”, 761.

⁴⁵¹ Rubenfeld, “The right of privacy”, 762.

plethora of additional interpretations that can be applied so as to suit the views of whoever supports the protection of a specified moral view. What makes it even more of a concern is that, as briefly alluded to earlier, in many constitutional societies, it is the liberal (secular) views that enjoy domination; which in many instances, counter the interests of, for example, religious views. This proliferation of insights regarding specific human rights, which is accompanied by dominant meanings regarding rights (and concepts), is further elaborated upon by Steven Smith's *The Disenchantment of Secular Discourse*, which unveils and critiques the "smuggling" of secular frames of understanding by means of popular concepts pertaining to the normative. Such secular frames frequently oppose religious views on moral matters. Scholars in the secular mould frequently qualify their views by connecting them to popular concepts such as "harm", "freedom", "human dignity" and "equality". According to Smith, "It is the cage of secular discourse, within which public conversation and especially judicial and academic discourse occurs today."⁴⁵²

Such concepts act as a medium, which convey particular subjective meanings that, in many instances, do not ascribe to for example, religious meanings nor do they always assist in the furtherance of the protection of the right to freedom of religion. Smith's analysis pertaining to the above provides a renewed awareness of the dominance of secular interpretations of fundamental human rights. This in turn has implications for matters of fundamental importance such as for example, the determination of the parameters of religious education in public education, obscenity regulation, abortion, euthanasia and prohibitions on membership to religious associations based on specific forms of sexual conduct.

From the above it can be gleaned that the right to privacy has a very recent history and has been created as a right aimed at the protection of interests and understandings that do not necessarily ascribe to universalism pertaining to substantial moral matters such as abortion. This in turn results in it being questionable and weakened in credibility pertaining to the protection of the administering of euthanasia, which is, needless to say, a fundamental moral matter that touches at the heart of the parameters that should be drawn pertaining to the right to life (as is the case with abortion). More specifically, the shaky and varied foundations of the right to privacy weakens its ability to convincingly oppose conscientious objection against the

⁴⁵² S. Smith, *The Disenchantment of Secular Discourse*, (Cambridge and London: Harvard University Press, 2010), 23.

administering of euthanasia by a medical practitioner. Then there is also the argument that the right to privacy should protect the medical practitioner who conscientiously objects to administering euthanasia, in which his autonomy and freedom of choice also deserves protection?

The right to privacy as understood and applied by the judiciary and scholarship in liberalist societies (as described in the above) where the emphasis is placed on autonomy and freedom of the individual to decide for himself, also finds relevance to the debate regarding what life should mean in the context of the ‘mind’ versus ‘body’ argument (also discussed earlier). This has been discussed in the section on the sanctity of life above, however, this distinction also is of relevance to privacy and personhood. In this line of thinking that distinguishes human “biological life” from “experiential personal life”, a person possesses developed capacities for “characteristically human mental activity, such as conceptual thinking, deliberation, and choice” – it is “personal life” that has intrinsic value and dignity whilst “biological life” does not.⁴⁵³ Explained otherwise, Robert George refers to the secularist position on euthanasia, which understands a living human body “not as a person until it becomes associated with a mind and such a body ceases to be a person not only by dying but at any point at which it loses this association of mind and body.”⁴⁵⁴

John Finnis argues, “To deny that one’s living body is one’s person, is to accept some sort of dualistic theory of human persons, according to which human beings are inherently disembodied realities who only *have* their bodies, only inhabit them and use them.”⁴⁵⁵ According to George, the secularist’s point of view is that it is the “conscious, desiring, self-aware, and future-directed part of the human being that is truly the ‘person’ and in the process the living body is not part of the personal reality of the human being.”⁴⁵⁶ Therefore, this understanding places the question to be emphasised not on when human life begins or ends but rather on when a person qualifies or ceases to qualify “as a person” and therefore as a “creature with a serious right to life”.⁴⁵⁷ This approach is usually connoted to an outright belief in *autonomy* or *privacy* as a fundamental right. In this regard, says George, “the right of autonomy

⁴⁵³ George, “Terminal Logic”, 32.

⁴⁵⁴ George, *The Clash of Orthodoxies. Law, Religion, and Morality in Crisis*, 34.

⁴⁵⁵ Finnis, “The ‘value of human life’ and ‘the right to death’: Some reflections on *Cruzan* and Ronald Dworkin”, 568.

⁴⁵⁶ George, *The Clash of Orthodoxies. Law, Religion, and Morality in Crisis*, 35.

⁴⁵⁷ George, “Terminal Logic”, 32.

immunizes individual choice in matters having to do with how one leads one's own life against interference by others, including the State, especially when the choices do not directly damage the interests or violate the rights of others."⁴⁵⁸ This understanding is also inextricably connected to John Finnis' confirmation that one of the essential grounds for the validity of euthanasia is that of autonomy rights.⁴⁵⁹

In what George comments in the above, the secularist argument for the administering of euthanasia based on the popular claim to "autonomy" or "privacy" fails to provide a convincing rationale so as to argue for the validity of a generous approach towards euthanasia, especially when competing with the view that subscribes to the inherent importance (sanctity) of human life, even if it is only biological. In other words, the pre-suppositional point that this secularist view holds, does not constitute a superiority over the view that holds that life has a 'bodily' or 'biological' sense of fundamental importance as well. In fact, one can even argue that biological human life is worthy of protection by means of the dictates of universal reason, which is evident in many of the arguments presented in this study. This in turn provides the medical practitioner, who conscientiously objects against the administering of euthanasia and who strongly believes that for example, the comatose patient lying there constitutes life itself, with a convincing argument for the protection of his conscience in not being forced or pressurised (whether directly or indirectly) to administer euthanasia to such a patient. As George comments, "The law should honor the principle of the sanctity of human life and not privilege the belief in autonomy over it."⁴⁶⁰

Therefore, it is not only the right to privacy versus the right of the medical practitioner to conscientiously object, but also the fundamental importance (sanctity) of *biological life* versus the *privacy* or *personhood*. In this we find that the importance (sanctity) of human life strengthens the medical practitioner's right to conscientiously object to administering euthanasia. Added to this, Finnis reminds us that the argument in support of euthanasia namely that "a life not worthy of living any longer qualifies for termination of such a life" is partly assessed by means of the opinion of a court or medical practitioners. The result is that "what you are proposing is not a private act, but precisely an act in which you seek assistance from

⁴⁵⁸ George, "Terminal Logic", 32.

⁴⁵⁹ J. M. Finnis, "Euthanasia, Morality, and Law", (Fritz B. Bums Lecture, Loyola Law School, Los Angeles), 22 November 1996, *Loyola of Los Angeles Law Review*, Vol. 31, (1998), 1123.

⁴⁶⁰ George, "Terminal Logic", 33.

someone else, or which you are asking someone else to carry out, sharing your intent to destroy your personal life. It is no more a private act than a duel or an agreement to sell myself into slavery.”⁴⁶¹

What was gleaned from insights, complexities and problems related to the right to privacy may also be inexorably connected to what Robert George speaks of “orthodox secularism’s moral stance as being pre-occupied with ‘appetite’ or ‘passion’, a stance that rests on the ‘desires’ of the individual, and to which, in the spirit of David Hume, has reason as being subservient to such desires. This brings to the fore the instrumental axiom.”⁴⁶² This is, according to George, in contrast to for example, the Christian approach that “parallel to that of the pre-Christian Greek philosophers such as Plato and Aristotle, calls for the prioritisation of reason over desire.”⁴⁶³ It is this reason says George, “that teaches the inherent sacredness of human life, whether one is speaking of a healthy teenager or a comatose person of old age.”⁴⁶⁴ The right to privacy has surely been, in many instances, understood and applied in the context related to the bolstering of the individual’s ‘desires’, ‘appetites’ or ‘passions’. This in turn, in the context of this study, is of relevance to the view that supports the separation of biological life from life in the sense of the mind and its choices, experiences, passions and perceptions’. Viewing the latter as the only framework for ‘life’ places the meaning of life in the category of what is ‘desired’ and this can change in meaning from person to person. In this regard, what should be meant by ‘life’ becomes exposed to a plethora of meanings and therefore highly relativistic. This in turn leads to a diminishing of meaning pertaining to life *per se*, which includes the biological attribute. The end result is a substantive devaluation of life by a democratic and constitutional society that paradoxically preaches the importance of life.

In South Africa, the right to privacy was traditionally recognised well before the existence of the Constitution through the concept of *dignitas*. Ackermann J held that “the right to privacy is recognized as an independent personality right which the courts have included within the

⁴⁶¹ Finnis, “Euthanasia, Morality, and Law”, 1131-1132. One finds a similar argument in the abortion debate, where the right to privacy (or autonomy over the body) of the pregnant woman is questioned in that, in many instances, a medical doctor has to be convinced that the woman who wants an abortion fulfils certain criteria that may be set as qualification for an abortion such as for example, whether the unborn poses a substantive threat to the socio-economic status of the woman who wants an abortion.

⁴⁶² George, *The Clash of Orthodoxies. Law, Religion, and Morality in Crisis*, 15.

⁴⁶³ George, *The Clash of Orthodoxies. Law, Religion, and Morality in Crisis*, 16.

⁴⁶⁴ George, *The Clash of Orthodoxies. Law, Religion, and Morality in Crisis*, 34.

concept of *dignitas*.⁴⁶⁵ An infringement of *dignitas* amounts to a delict however, since the Constitution was enacted, the interpretation of the right to privacy⁴⁶⁶ acquired a constitutional dimension, and thus a different means of interpretation was required.⁴⁶⁷ As confirmed earlier, this right to privacy, includes a general privacy provision and four subsections pertaining to an individual's person and home, his property, possessions and communications.⁴⁶⁸

It is now understood that the term 'personhood' includes ideas referring to a person's individuality, his privacy, his autonomy⁴⁶⁹ or who the person is according to his own mind and spirit. It refers to the *quality* of being an individual, with dignity and worth, worthy in itself of protection. In essence, it grants the right to be left to one's own devices. It refers to a rebuttable presumption that a citizen ought to be free to live his life in the manner of his choosing without the government interfering or telling him how it should be lived.⁴⁷⁰ Although the idea of personhood is understood to a certain extent, it remains a topic difficult to define in *precise* terms. Freund encapsulates this predicament aptly:

The theme of personhood is ... emerging. It has been groping ... for a rubric. Sometimes it is called privacy, inaptly it would seem to me; autonomy perhaps, though that seems too dangerously broad. But the idea is that of personhood in the sense of those attributes of an individual which are irreducible in his selfhood. We all know the agonizing judgements that have had to be made and that will have to be made in such diverse areas as abortion and the death penalty, which it seems to me are aspects of this issue of personhood. In the future, this issue is likely to loom ever larger as we see advances in the biomedical sciences that will lead to ... precise behaviour control that will test our conceptions of individual responsibility and individuality.⁴⁷¹

⁴⁶⁵ *Bernstein v Bester No 1996 (2) SA 751 (CC)*, par. 68. Ackermann J cited from *O'Keeffe v Argus Printing and Publishing Co Ltd*. 1954 3 SA 244 (C). *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 1977 (4) SA 376 (T), 377: "Personal injury of the kind which is suffered in the infringement of the ... *dignitas* is not something which in the nature of things can be experienced by the *universitas* in its impersonality. Defloration, assault, adultery – to mention but a few – are causes of action which are exclusively associated with the human being. Infringement of the right of privacy belongs to this class."

⁴⁶⁶ *Constitution of the Republic of South Africa*, section 14: "Everyone has the right to privacy, which shall include the right not to have – (a) their person or home searched; (b) their property searched; (c) their possessions seized; or (d) the privacy of their communications infringed".

⁴⁶⁷ *Bernstein v Bester*, par. 71.

⁴⁶⁸ *Constitution of the Republic of South Africa*, section 14.

⁴⁶⁹ J. B. Craven, "Personhood: The right to be let alone", *Duke Law Review*, Vol. 1976(1976), 702.

⁴⁷⁰ Craven, "Personhood: The right to be let alone", 706.

⁴⁷¹ Professor Freund, delivering a dinner address at the 52nd Annual Meeting of the American Law Institute, cited in Rubinfeld, "The right of privacy", 752.

In *Olmstead v. United States*,⁴⁷² Brandeis J had addressed this dilemma in his *dictum*:

[The drafters of the right to privacy] recognized the significance of man's spiritual nature, of his feelings, and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect ... beliefs ... thoughts ... emotions and ... sensations. They conferred, as against the Government, the right to be let alone -- the most comprehensive of rights, and the right most valued by civilized men. To protect that right, every unjustifiable intrusion by the Government upon the privacy of the individual, whatever the means employed, must be deemed a violation of the Fourth Amendment.⁴⁷³

Thus, it can be said that the reason why an individual is entitled to privacy is because of his freedom to think and form ideas according to his judgement, his own emotional responses to situations or whichever conception he applies his mind to, by virtue of being an individual endowed with personhood – the right to self-determination. According to Craven, it would be impossible to delineate each and every right that falls within the domain of privacy perfectly,⁴⁷⁴ and afford each its rightful recognition. Rather, it would be easier to acknowledge that, on account of a person's inherent dignity, worth and the capacity to make rational, individual decisions, he be allowed to do as he pleases, provided he causes no harm to another. In the words of the *Declaration of the Rights of Man and the Citizen*, one should be free to do “anything that does not injure others.”⁴⁷⁵

Apart from the recognition of one's moral personhood, being able to do as one pleases, there are some who hold that the content of the right to privacy at its core entails more than personal inviolability. Some hold that privacy has to do with accessibility of a person by virtue of “information-gathering, attention and physical access”⁴⁷⁶ while others view the right to privacy

⁴⁷² *Olmstead v United States* 277 US 438, 478, 72 Led 944 956, 48 SCt 564, 66 ALR 376.

⁴⁷³ “The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized,” *ibid* at 277 U. S. 476.

⁴⁷⁴ Craven, “Personhood: The right to be let alone”, 706.

⁴⁷⁵ Art. 4. The *Declaration of the Rights of Man and of Citizens* was a document enacted during the early days of the French Revolution. It addressed fundamental rights, such as freedom of expression, *habeas corpus*, private property rights and adequate due process. For a full discussion on the document see V. Johnson, “The French Declaration of the Rights of Man and of Citizens of 1789, the Reign of Terror, and the Revolutionary Tribunal of Paris”, *Boston College International & Comparative Law Review*, Vol. 13, 1(1990), 1-45.

⁴⁷⁶ R. Gavinson, “Privacy and the limits of the law”, *Yale Law Journal*, Vol. 89, 3(1980), 437.

in light of the law of torts, or in the South African context, the law of delict.⁴⁷⁷ Individuals exist in a state of constant interaction with others; such is human nature. These interactions help individuals survive, develop themselves and to have themselves thrive as human beings. There should be a balance between these interactions of individuals and their privacy.⁴⁷⁸ Privacy should be the freedom of an individual's choice about what he chooses to communicate to others around him, about himself, and in turn, this freedom to do so should be viewed in light of greater, more encompassing freedoms guaranteed within a properly functioning society.⁴⁷⁹

The personal autonomy of an individual is inviolable in all spheres: intellectual, physical and spiritual,⁴⁸⁰ and serves as a negative right against government, protecting citizens from intrusion. Various meanings can be connoted to this idea of autonomy or inviolability. Often, it conjures in the mind a picture of a sanctuary.⁴⁸¹ For many this concept of 'sanctuary' in turn refers to different conceptions; some see this sanctuary as a personal enclave absolutely free from the influence or opinions of others, subject to the sole will of the individual,⁴⁸² as "a refuge for persons and their intimate relationships against invasion and intrusion",⁴⁸³ whereas others view one's body, both physical or psychological, as an object of inherent worth, because of moral or religious convictions in which they find or identify their personhood.⁴⁸⁴ In light of a person's sanctuary – his innermost wants and desires that cannot be dictated to by the whims of others, one of the basest forms of stating one's desire to privacy is through doing exactly that. One satisfies a want by getting into your possession that which would state the desire. Accordingly, by virtue of personhood, an individual can desire something and by virtue of his privacy be entitled to fulfil such a wish. This argument functions on the basis that one's choices should be respected. The respect of another's choices are the foundations of a healthy and plural society. And herein lies the dilemma.

⁴⁷⁷ W. Prosser, "Privacy", *California Law Review*, Vol. 48, 3(1960), 389. Prosser indicated four particular instances in which the right to privacy is infringed namely: intrusion upon seclusion or solitude, or one's private affairs; public disclosure of embarrassing private facts of an individual; publicity placing another publicly in a false light; or appropriation of another person's name or likeness with the intent of garnering benefit from it.

⁴⁷⁸ Gavinson, "Privacy and the limits of the law", 440.

⁴⁷⁹ M. S. McDougal, H. D. Laswell & L. Ghen, "The protection of respect and human rights: Freedom of choice and world public order", *The American University Law Review*, Vol. 24(1975), 936.

⁴⁸⁰ L. McClain, "Inviolability and privacy: The castle, the sanctuary, and the body", *Yale Journal of Law & the Humanities*, Vol. 7, 1(1995), 195.

⁴⁸¹ McClain, "Inviolability and privacy: The castle, the sanctuary, and the body", 203.

⁴⁸² For example, the frequent abortionist mantra: "My body, my choice."

⁴⁸³ McClain, "Inviolability and privacy: The castle, the sanctuary, and the body", 203.

⁴⁸⁴ McClain, "Inviolability and privacy: The castle, the sanctuary, and the body", 205. Such as the Christian notion that one's body is the temple of God, see 1 Corinthians 6:10. Religion is but one factor. Vegans refuse to eat foods others consider normal, and therein find their identity and personhood. Individuals athletically inclined eat healthy and abstain from alcohol or smoking, and often refer to their bodies as temples. Therein lies their personhood.

A patient is in a perceived intolerable position, and requests a medical practitioner to assist him in ending his life. He raises, *inter alia*, the right to privacy as a basis for his request. Regardless of his suffering and continued pain being an affront to his human dignity, he is entitled to make, so goes the argument, such a request by virtue of his fundamental right to privacy. Privacy, as has been established in the above, is the ability to make decisions for oneself, free from interference, constraints or limitations of another entity, such as the State, and therefore it is presumed to extend to the request for assisted dying.⁴⁸⁵ In the United States, the Supreme Court held in *Cruzan v Director, Missouri Department of Health*⁴⁸⁶ that the right to privacy, and by implication, the right to self-determination, would allow patients the right to discontinue medical treatment.⁴⁸⁷ The right to privacy affirmed in *Cruzan* is emphasised by Cardozo J: “Every human being... has a right to determine what shall be done with his own body...”⁴⁸⁸ Further, the court in *Cruzan* declared: “[N]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others...”⁴⁸⁹ Therefore, on account of the right to privacy, the court determined that a patient can legally refuse further medical treatment. However, the court declined to extend this position to requests to assisted dying.⁴⁹⁰ It would appear that granting patients the right to refuse medical treatment, or the furtherance thereof, by invoking the right to privacy, but denying the same patients the right to die through assistance, is arbitrary, and accordingly unconstitutional.⁴⁹¹ The argument is presented that no distinction should be made between the cessation of medical treatment and a request for assisted dying, as both are subject to the right to privacy and should accordingly be respected.⁴⁹² This adds to the ambiguities related to the application of protection against the background of the right to privacy.

Does refusal to honour a patient’s request to euthanasia amount to an infringement of his right to privacy? In light of the above discussion it has been established that an individual is entitled to his free will, to make his own choices and to develop himself in accordance with his own

⁴⁸⁵ K. Chamberlain, “Looking for a ‘good death’”, *The Elder Law Journal*, Vol. 17(2009), 75.

⁴⁸⁶ *Cruzan v. Director, Missouri Department of Health* 497 U.S. 261 (1990).

⁴⁸⁷ *Cruzan v. Director, Missouri Department of Health*, 269, 273 and 278.

⁴⁸⁸ *Schloendorff v Society of New York Hospital*, 211 N.Y. 125, 129-130, 150 N.E. 92, 93.

⁴⁸⁹ *Cruzan v. Director, Missouri Department of Health*, 269.

⁴⁹⁰ *Vacco v Quill* 521 U.S. 793; *Washington v Glucksberg* 521 U.S.

⁴⁹¹ Chamberlain, “Looking for a ‘good death’”, 75.

⁴⁹² Chamberlain, “Looking for a ‘good death’”, 76.

ideologies and convictions. Within the ability to make choices an individual expresses his identity.⁴⁹³ As the right to privacy was developed to its current stature by developing and applying the law on a case to case basis, so too would the right to die had to be determined, at least with regard to the right to privacy as its foundation. The court saw the opportunity fit in the case of Karen Quinlan.⁴⁹⁴ This was a matter brought on appeal to allow the guardians, Karen's parents, the right to terminate extraordinary medical care, that being the only means Karen remained physically alive. At the time, the medical personnel refused to consent to the request fearing charges of murder or malpractice.⁴⁹⁵ Robert Muir J held in the court *a quo*, "There is a duty to continue life-assisting apparatus. There is no constitutional 'right-to-die' that can be asserted by a parent for his incompetent adult child."⁴⁹⁶ However, upon appeal, it was declared, on grounds of the right to die, that the Constitution does imply a right to die, as the right to privacy, by virtue of cases such as *Griswold* and *Roe*, is broad enough to allow the family of the comatose to disconnect machines providing life support.⁴⁹⁷

Following *Quinlan*, the courts expanded, and quite pertinently stated in *Bouvia v. Superior Courts (Glenchur)*,⁴⁹⁸ that patients have the right to terminate their own lives. After a series of bouts with the courts, each unsuccessful, it was eventually conceded and held that the right to privacy can be extended to include the right to terminate one's own life. The applicant wanted to starve herself, but in a hospital. This created the understandable dilemma for hospital staff; they cannot 'allow' a patient to succumb before their very eyes. The staff intervened and caused her to receive the required nutrition by means of a feeding tube.⁴⁹⁹ The Court determined their actions wrongful by holding (quoting from *Bartling v Superior Court (Glendale Adventist Medical Center) (1984)* that:⁵⁰⁰

⁴⁹³ *Bowers v. Hardwick* 478 U.S. 186 (1986), 204: "We protect those rights not because they contribute, in some direct and material way, to the general public welfare, but because they form so central a part of an individual's life."

⁴⁹⁴ *In Re Quinlan* 70 N.J. 10, 355 A.2d 647 (1976).

⁴⁹⁵ H. Ball, *The Supreme Court in the Intimate Lives of Americans: Birth, Sex, Marriage, Childbearing, and Death*, (New York: New York University Press, 2002), 172.

⁴⁹⁶ Ball, *The Supreme Court in the Intimate Lives of Americans: Birth, Sex, Marriage, Childbearing, and Death*, 173.

⁴⁹⁷ J. A. Jackson, "The Ethics and Legality of Euthanasia and Physician Assisted Suicide", *University of Tennessee Honors Thesis Projects*, 5-2003, 8.

⁴⁹⁸ *Bouvia v. Superior Court (Glenchur)* [No. B019134. Court of Appeals of California, Second Appellate District, Division Two. 16 April 1986].

⁴⁹⁹ Jackson, "The Ethics and Legality of Euthanasia and Physician Assisted Suicide", 9; Ball, *The Supreme Court in the Intimate Lives of Americans: Birth, Sex, Marriage, Childbearing, and Death*, 169.

⁵⁰⁰ *Bartling v. Superior Court (Glendale Adventist Medical Center) (1984)* [Civ. No. B007907, Court of Appeals of California, Second Appellate District, Division Five. 27 December 1984].

We do not doubt the sincerity of real parties' moral and ethical beliefs, or their sincere belief in the position they have taken in this case. However, if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors. The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged... Such a course of conduct invades the patient's constitutional right of privacy, removes his freedom of choice and invades his right to self-determination.⁵⁰¹

Thus, the right to privacy was extended to refuse sustenance with the intent of starvation.⁵⁰² However, in 1990 the United States had to deal outright with the right to die. In *Cruzan*⁵⁰³ (referred to briefly in the above) the court was confronted by a young woman that had been involved in a motor vehicle accident and subsequently entered a persistent vegetative state.⁵⁰⁴ Basing their request on the right to privacy, her parents requested the hospital staff to remove her feeding tube, but they refused to do so unless the order came from the Federal Court. The court granted the order, but upon appeal to the Missouri Supreme Court⁵⁰⁵ was reversed.⁵⁰⁶ The rights of the patient were weighed against compelling State interests. The Court's basis for reversing the order made by the court *a quo* was because it determined the evidence presented as insufficient,⁵⁰⁷ and that the State had a duty to ensure the principle of the sanctity of life remains protected.⁵⁰⁸ The matter proceeded on further appeal to the United States Supreme

⁵⁰¹ *Bartling v. Superior Court*, [1c] Footnotes omitted; *Satz v Perlmutter* 362 So.2d, 164.

⁵⁰² *Bouvia v Superior Court (Glenchur)*, 12. "Here Elizabeth Bouvia's decision to forego medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is hers alone."

⁵⁰³ *Cruzan v. Director, Missouri Department of Health*.

⁵⁰⁴ C. Supenor, "Ignoring an incompetent person's constitutional right to forgo life-sustaining treatment", *Florida State University Law Review*, Vol. 19, 1(1991), 212. Nancy Cruzan was "...completely and permanently disabled. She remained unconscious and was completely oblivious to her environment except for primitive [vegetative] reflexes. While she would never recover, she was not terminally ill."

⁵⁰⁵ *Cruzan v. Harmon* 760 S.W.2d 408 (1988).

⁵⁰⁶ Ball, *The Supreme Court in the Intimate Lives of Americans: Birth, Sex, Marriage, Childbearing, and Death*, 176. The Court initially granted the order based on witness testimony of friends and family, and held, "A person in Nancy's condition had a fundamental right under the State and Federal Constitutions to refuse or direct the withdrawal of 'death prolonging' procedures."

⁵⁰⁷ *Cruzan v. Harmon*, IV: "In sum, we hold that the co-guardians do not have authority to order the withdrawal of hydration and nutrition to Nancy. We further hold that the evidence offered at trial as to Nancy's wishes is inherently unreliable and thus insufficient to support the co-guardians claim to exercise substituted judgment on Nancy's behalf. The burden of continuing the provision of food and water, while emotionally substantial for Nancy's loved ones, is not substantial for Nancy. The State's interest is in the preservation of life, not only Nancy's life, but also the lives of persons similarly situated yet without the support of a loving family. This interest outweighs any rights invoked on Nancy's behalf to terminate treatment in the face of the uncertainty of Nancy's wishes and her own right to life."

⁵⁰⁸ *Cruzan v. Harmon*, 419 C, *The State's Interests*: "The state's concern with the sanctity of life rests on the principle that life is precious and worthy of preservation without regard to its quality. This latter concern is

Court, which upheld the order made by the Missouri Supreme Court by a very narrow margin of 5-4. Thus, the right to privacy was not extended to individuals to include the right to demand an unfettered right to die. As a matter of fact, Justice Scalia, concurring, added:

...the federal courts have no business in this field; that American law has always accorded the State the power to prevent, by force if necessary, suicide -- including suicide by refusing to take appropriate measures necessary to preserve one's life; that the point at which life becomes "worthless," and the point at which the means necessary to preserve it become "extraordinary" or "inappropriate," are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory; and hence, that even when it is demonstrated by clear and convincing evidence that a patient no longer wishes certain measures to be taken to preserve her life, it is up to the citizens of Missouri to decide, through their elected representatives, whether that wish will be honored. It is quite impossible (because the Constitution says nothing about the matter) that those citizens will decide upon a line less lawful than the one we would choose; and it is unlikely (because we know no more about "life-and-death" than they do) that they will decide upon a line less reasonable.⁵⁰⁹

This is indicative of the grey area related to the meaning of life which in turn strengthens the argument in support of the protection of the medical practitioner's objection against administering euthanasia. Justice O'Connor, although concurring with the majority, was of the view that there was indeed a liberty interest⁵¹⁰ involved upon determination of withdrawing life-support as "[a] seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any State coercion."⁵¹¹ In dissent, Justice Brennan rejected the views of the majority and held that a patient subjected to feeding by artificial nutrition and hydration does have a fundamental right

especially important when considering a person who has lost the ability to direct her medical treatment. In such a circumstance, we must tread carefully, with due regard for those incompetent persons whose wishes are unknowable but who would, if able, choose to continue life-sustaining treatment. Any substantive principle of law which we adopt must also provide shelter for those who would choose to live, if able to choose, despite the inconvenience that choice might cause others."

⁵⁰⁹ *Cruzan v. Director, Missouri Health Department* Justice Scalia, concurring.

⁵¹⁰ By implication therefore, also privacy.

⁵¹¹ *Cruzan v. Director, Missouri Health Department*, 288. Justice O'Connor, concurring: "Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause."

to decide whether to utilise such a right or to waive it; the interests of the State should not play any role in its determination.⁵¹² Regardless, the court accordingly refrained from extending the right to privacy for requests to die and placed the task in the hands of individual States to act as surrogate decision-makers.⁵¹³

Considering what has been discussed thus far it is not too difficult to come to the realisation that the right to privacy has been developed to include a vast array of concepts, each having as its central foundation personhood, self-identification, liberty and personal autonomy.⁵¹⁴ According to this line of thinking, one ought to have free and unfettered control over one's mind; absolute personal autonomy. But more relevant to a medical context, it involves the right to choose whether, in line with one's own values and beliefs, one would submit to a particular recommended course of treatment.⁵¹⁵ Naturally, opponents of those advocating the right to absolute personal autonomy hold that it is indeed a valuable right, and ought to be cherished, but its importance is often exaggerated.⁵¹⁶

John Keown, in his opposition to euthanasia in general, proposes an understanding of personal autonomy that is aligned with moral prescriptions. The value of personal autonomy lies not only in the ability to make a choice, but also in the nature of the choice made; by making choices, humans flourish. Making choices, says Keown, entails a human responsibility to ensure choices are made that promote human flourishing, rather than undermine it.⁵¹⁷ These choices ensure a better society, and are in the best human interests; therefore, they ought to be respected. Such is the common line of thought, choices made in line with one's personhood

⁵¹² "...the Court, while tentatively accepting that there is some degree of constitutionally protected liberty interest in avoiding unwanted medical treatment, including life-sustaining medical treatment such as artificial nutrition and hydration, affirms the decision of the Missouri Supreme Court. The majority opinion, as I read it, would affirm that decision on the ground that a State may require 'clear and convincing' evidence of Nancy Cruzan's prior decision to forgo life-sustaining treatment under circumstances such as hers in order to ensure that her actual wishes are honored. *See ante* at 282-283, 286-287. Because I believe that Nancy Cruzan has a fundamental right to be free of unwanted artificial nutrition and hydration, which right is not outweighed by any interests of the State, and because I find that the improperly biased procedural obstacles imposed by the Missouri Supreme Court impermissibly burden that right, I respectfully dissent. Nancy Cruzan is entitled to choose to die with dignity." *Cruzan v. Director, Missouri Health Department*, 302. Justice Brennan, dissenting.

⁵¹³ Jackson, "The Ethics and Legality of Euthanasia and Physician Assisted Suicide", 12.

⁵¹⁴ These terms are often used interchangeably as each amount to the personal inviolability of the individual involved.

⁵¹⁵ D. Giesen, "Dilemmas at life's end: a comparative legal perspective", in J. Keown, *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, (Cambridge: Cambridge University Press, 1995), 201.

⁵¹⁶ J. Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, (Cambridge: Cambridge University Press, 2002), 53.

⁵¹⁷ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 53.

merit respect only if they are made in accordance with sound moral values.⁵¹⁸ Keown provides some examples illustrating this point: A person can act in accordance with his personhood and chooses to murder someone else. However, society ought to (and ordinarily will) condemn his action as his actions breach a grave moral norm.⁵¹⁹ A simpler example involves a person driving without his seatbelt. He may do so, but for his own safety it is a requirement by law, the penalty of which he would have to be prepared to face.

A second point against the absolutism of autonomy is the blind assertion that choices made by an individual ought to be respected merely because they are his and his alone.⁵²⁰ This begs the question: If one makes choices simply because one has the right to do so, surely a point is reached where one first has to ask whether it is indeed the *appropriate* thing to do?⁵²¹ For example, one can choose many things in life, but is it the right thing to choose rape or paedophilia or bestiality? These are all choices open to an individual, but do they merit moral respect?

In summation therefore, the right to privacy plays a pertinent role in the discussion surrounding euthanasia. It is a right guaranteed on both the local, foreign as well as international jurisprudential level, and has been the subject of extensive academic discussion. Although the explicit inclusion of the right to privacy is lacking in the American Constitution, much of privacy's development is found in American courts. Cases ranging from reproductive rights to domestic circumstances eventually signalled the courts to make a determination to what extent the right to privacy can be developed. However, enter *Roe*, where the right to privacy was seemingly extended from thin air to support the right to abortion. This extended understanding of the right to privacy gave rise to the concomitant idea of personhood: The basis of who an *individual* is in society, and the right he has to act in accordance with what he determines for *himself* to be the best course of action. In this regard, the understanding is that government should not be in the business of legislating certain codes of required moral conduct; an individual should be able to make value-based choices himself. The development of privacy has experienced a plethora of meanings, which in many instances, such as matters related to abortion and euthanasia, has placed religion at a disadvantage. This is in line with the liberal

⁵¹⁸ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 53.

⁵¹⁹ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 53.

⁵²⁰ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 54.

⁵²¹ Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*, 54.

project that distinguishes between an individual's *life*, in the sense that he is able to enjoy the qualities of being human, and *biological life*, which refers to the physical characteristics of a human body. This discussion leads the debate to include not only discussions between the right to privacy versus the right to conscientious objection, but also between the right to privacy and the right to the sanctity of biological life. As was indicated, there are scholars who hold that the law should preserve human life instead of privileging the belief of absolute autonomy over it. A clearer picture is therefore cast on the debate surrounding euthanasia and the manner in which it is influenced by the right to privacy.

What also comes to the fore in this regard is that the right to privacy has become a right that has been adapted towards meanings that are not only varied from jurisdiction to jurisdiction, but that this is also a right that has been created so as to suit certain non-religious views on what the parameters of human life should be. This consequently results in a loss of credibility and objectivity pertaining to the strength of privacy in being viewed as superior over the rights of the medical practitioner who conscientiously objects against the administering of euthanasia. Stated otherwise, this confirms the weakness in using the right to privacy as understood from the perspective of the patient wanting to die to trump the religious interests of the medical practitioner who conscientiously objects against the administration of euthanasia.

Added to this, the question can be asked as to whether the privacy interests of medical practitioners are infringed if they are compelled to perform in terms of the patient's request? It is obvious that the objecting medical practitioner would be acting contrary to his own convictions if he is compelled to euthanise a patient. Above, the words of the court in *Bartling v. Superior Court* held, "The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right, which must not be abridged ... such a course of action invades the patient's constitutional right of privacy, removes his freedom of choice and invades his right to self-determination"⁵²² What relevance may this be regarding a similar right that the medical practitioner may have who refuses to participate in administering euthanasia? In other words, it is convincing to also deduce, "The right of a competent medical practitioner to refuse to act in contradiction to his sincerely held religious beliefs is a constitutionally guaranteed right which must not be abridged.... Such a course of action invades the medical practitioner's constitutional right of privacy, removes his freedom of choice and invades his right to self-

⁵²² *Bartling v. Superior Court* [1c].

determination.” Would *compelling* a medical practitioner to grievously transgress his own religious convictions, and to his mind, commit an act so heinous that it has historically been abhorred by any civilised society, not amount to an invasion of privacy and self-determination of a far greater magnitude than that of the patient? It is *unequivocally* submitted in the affirmative.

Such a contrast of positions indicates the necessity of the so-called limitations clause test. This test is based on the limitation clause of the *Constitution of the Republic of South Africa*,⁵²³ and aims to assist in determining disputes, which arise when two differing rights, touted as being equally important in light of the Constitution, conflict. Therefore, courts would have to determine the nature of each conflicting right in question and contrast them with one another by viewing the nature and importance of each right. Subsequently, the importance of the limitation is necessary, and the question should be asked: For what purpose should the right in question be limited? What would the extent and nature of such a limitation be, and what would the effect of such a limitation be in the long run? Lastly, the courts should be satisfied that there is an existent, rational connection between the limitation and the need for such limitation, and that there is no other alternative available other than limiting a fundamental right. In the following section, a deeper discussion of the limitation of rights follows.

4.5 The general limitations clause test

4.5.1 Introduction

A constitutional society functions on the basis of rights individuals claim as important, and which are entrenched in the *Constitution of the Republic of South Africa*. The said Constitution’s Bill of Rights assists the State and guides conduct to promote and fulfil fundamental guaranteed rights. If one of these rights are infringed, or if conduct runs contrary to them, such infringement or conduct is unconstitutional and therefore invalid.⁵²⁴ However, because of the complex nature of human rights, and the inherent complexity of human relationships, infringements abound. In the event that an infringement occurs, a determination is necessary whether the infringement can (or should) possibly be justified, in terms of what is

⁵²³ *Constitution of the Republic of South Africa*, section 36.

⁵²⁴ Currie & de Waal, *The Bill of Rights Handbook*, 23.

known as a ‘proportionality analysis’.⁵²⁵ This is of special relevance to arguments in support of the protection of religious rights and freedoms, especially in the public sphere where the dominance of secularism (understood as anti-religious) has placed religion on the backfoot in many instances. The application of a proportionality analysis has played a significant role in the development of constitutional law in South Africa, and plays a vital role in ensuring an equal and just constitutional society.

By way of a general introduction as to the more specific aspects related to the limitation test it is apt to take cognisance of the comments by Alec Sweet and Jud Mathews namely that a proportionality analysis generally entails four steps.⁵²⁶ As a point of departure, the ‘legitimacy’ of the infringement in question is examined: Does the infringement bear constitutional approval?⁵²⁷ In other words, does it serve a goal envisioned by the Constitution? If so, the second step, ‘suitability’ would require that the infringement be supported by certain stated policy objectives.⁵²⁸ In light of the legitimate policy objectives pursued, the third step, ‘necessity’, requires determining whether a less restrictive means exists that would achieve the same end; therefore, if an infringement cannot be constitutionally sanctioned, it is *per se* disproportionate.⁵²⁹ Lastly, if it has been established that a constitutionally valid infringement has indeed occurred, but in the least disruptive means possible, the final decisive determination has to be made in light of the differing constitutional values in question, giving full regard to the respective importance of each.⁵³⁰

The South African application of the proportionality analysis was a product of the transition from apartheid to a constitutional democracy. The resultant Constitution was vested with a limitation clause to firstly balance the various newly guaranteed rights set forth in the Bill of

⁵²⁵ A. S. Sweet & J. Mathews, “Proportionality balancing and global constitutionalism”, *Columbia Journal of Transnational Law*, Vol. 47, Paper 14(2008), 73. Sweet and Mathews determine this analysis as “an overarching principle of constitutional adjudication, the preferred procedure for managing disputes involving an alleged conflict between two rights claims, or between a rights provision and a legitimate state or public interest”.

⁵²⁶ Sweet & Mathews, “Proportionality balancing and global constitutionalism”, 75.

⁵²⁷ Sweet & Mathews, “Proportionality balancing and global constitutionalism”, 75. The legitimacy test requires the judge in question to determine the constitutional authority of the infringement or limitation. Does the limitation serve a legitimate purpose?

⁵²⁸ Sweet & Mathews, “Proportionality balancing and global constitutionalism”, 75. Suitability refers to judicial verification. Do the steps taken by the state necessitate the infringement?

⁵²⁹ Sweet & Mathews, “Proportionality balancing and global constitutionalism”, 75. Necessity entails the ‘least-restrictive means’ test. This test entails examining whether the infringement is the least restrictive means possible to achieve the purpose aimed for, or are there other, less disruptive avenues available?

⁵³⁰ Sweet & Mathews, “Proportionality balancing and global constitutionalism”, 75. The final step requires that the infringement in question pass the first three steps. Should this be the case, the final determination is made by weighing the benefits of the infringement against the costs of the infringement, in light of the facts.

Rights,⁵³¹ and secondly to effectively ensure judicial review,⁵³² as the rights in the Bill of Rights are by no means absolute.⁵³³ Rights may be limited,⁵³⁴ but only in the event that the limitations would serve to further South Africa's constitutional commitments,⁵³⁵ which became strikingly evident in the manner through which the court dealt with *Makwanyane*.⁵³⁶

Having discussed the various rights related to the matter pertaining to a medical practitioner who objects against the administering of euthanasia, the application of the limitations clause is now appropriate. A proportionality analysis will be conducted to determine whether compelling a medical practitioner to comply with the demands posed by a patient's request to terminate the life of the latter will result in an infringement of such a practitioner's guaranteed rights. The aim of analysing the matter at hand is to remind proponents of patient rights that no right exists, which grant them authority to outright insist that medical practitioners act in opposition to their conscience pertaining to the administering of euthanasia. It is submitted that an unreasonable and unjustifiable infringement of the medical practitioner's rights indeed occurs when forced to administer euthanasia in opposition to his conscience. This is substantiated by reasons set out in the following analysis surrounding the limitation clause.

4.5.2 The nature of the right

The issue that is to be addressed firstly is to determine the nature of the infringed right (or right that is threatened to be violated) namely, the exercise of religious freedom, and its protective ambit,⁵³⁷ in order to justify its limitation. Is the right to freedom of religion and by implication,

⁵³¹ *Interim Constitution of the Republic of South Africa*, section 33. *Constitution of the Republic of South Africa*, section 36.

⁵³² *Constitution of the Republic of South Africa*, section 36: "(1) The rights in the Bill of Rights may be limited only in terms of the law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including – (a) the nature of the right; (b) the importance and purpose of the limitation; (c) the nature and extent of the limitation; (d) the relation between the limitation and its purpose; and (e) less restrictive means to achieve the purpose. (2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights."

⁵³³ Woolman & Botha, "Limitations", 34-1; *De Reuck v Director of Public Prosecutions (Witwatersrand Local Division) and Others* 2002 (12) BCLR 1285 (W), par. 89. This case pertained to child pornography. Epstein J specifically indicates: "I reiterate that the rights in the Bill of Rights are not absolute. Rights have to be exercised with due regard and respect for the rights of others. Organised society can only operate on the basis of rights being exercised harmoniously with the rights of others."

⁵³⁴ Should they satisfy the criteria set forth in section 36 of the *Constitution of the Republic of South Africa*.

⁵³⁵ Woolman & Botha, "Limitations", 34-1.

⁵³⁶ (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665.

⁵³⁷ I. M. Rautenbach, "Proportionality and the limitations clauses of the South African Bill of Rights", *Potchefstroomse Elektroniese Regsblad*, Vol. 17, 6(2014), 2254.

freedom of conscience, necessary so as to ensure the constitutional commitments of South Africa, or do these freedoms run counter to these commitments?⁵³⁸ Also, determining the nature of the right does not only entail viewing the right as a concept, as particular traits within the right itself should be examined, as well as the nature of the individual bearer of the right.⁵³⁹ Woolman and Botha conclude that, frankly, the nature of the right should be determined so as to be able to clearly discern which right is more important than the other.⁵⁴⁰

The right to freedom of belief, conscience and religion⁵⁴¹ is, by nature, inherently intertwined with several other rights that influence the importance of religious freedom.⁵⁴² It has been indicated that through religion, in its various modes of expression,⁵⁴³ individuals discover and embrace their dignity and humanity.⁵⁴⁴ The nature of the right to religious freedom is ardently described through the words of Sir Winston Churchill and President Roosevelt who were of the view that the right to freedom of religion is to allow individuals to “worship God in one’s own way anywhere in the world.”⁵⁴⁵ The South African Constitutional Court in *Christian Education* shares this view by highlighting the extent to which religious believers act in total submissiveness to their God in every aspect of their daily activities, while at the same time finding, through such conduct, profound dignity and meaning in their existence.⁵⁴⁶ Statistical data of South Africa’s diverse demography indicates that the vast majority of South Africans are religious, the majority being adherents of Christianity. Bearing this in mind, courts have previously recognised that it is impossible to read the Constitution without giving due regard to the importance and value of religion in South African society, and that the Constitution, therefore, specifically “seeks to protect, in several ways, the rights of South Africans to freedom of religion.”⁵⁴⁷ In addition to South Africa’s constitutional recognition of, and

⁵³⁸ Currie & de Waal, *The Bill of Rights Handbook*, 178; R. Malherbe, “The constitutionality of government policy relating to the conduct of religious observances in public schools”, *Journal of South African Law*, Vol. 3(2002), 409; Rautenbach, “Proportionality and the limitations clauses of the South African Bill of Rights”, 2254.

⁵³⁹ Rautenbach, “Proportionality and the limitations clauses of the South African Bill of Rights”, 2254-2255.

⁵⁴⁰ Woolman & Botha, “Limitations”, 34-73.

⁵⁴¹ Which was dealt with in detail in Chapter Three.

⁵⁴² Rautenbach, “Proportionality and the limitations clauses of the South African Bill of Rights”, 2254. The various interrelated rights been discussed elsewhere but Rautenbach holds that: “The abstract importance of the affected right *relative to other rights* must be distinguished from that importance *relative to the importance of the purpose of the limitation*, which may include the exercise, protection or promotion of another individual right...”

⁵⁴³ *Eweida and Others v. The United Kingdom*; *MEC for Education: KwaZulu-Natal and Others v Pillay*.

⁵⁴⁴ *MEC for Education: KwaZulu-Natal and Others v Pillay*, par. 62; *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC), par. 36.

⁵⁴⁵ M. Kirby, “Law, human rights and religion – Of genocide, sexuality and apostasy”, *Macquarie Law Review*, Vol. 9(2009), 1.

⁵⁴⁶ *Christian Education South Africa v Minister of Education*, par. 36.

⁵⁴⁷ *S v Lawrence*; *S v Negal*; *S v Solberg* (CCT38/96, CCT40/96, CCT40/96) 1997 (10) BCLR 1348, par. 116 (CCT38/96, CCT40/96, CCT40/96).

apparent commitment to, religious freedom,⁵⁴⁸ the relevance of the *Charter of Religious Rights and Freedoms* has been discussed, specifically in light of the protections affirmed, which fall within the domain of religious freedom.⁵⁴⁹ Further still, South Africa is party to various international instruments which echo similar sentiments. Therefore, South Africa can rightly join in the global chorus of nations echoing the words of the European Court of Human Rights in *Kokkinakis v Greece*.⁵⁵⁰

[Freedom of thought, conscience and religion] is ... one of the most vital elements that go to make up the identity of believers and their conception of life, but it is also a precious asset for atheists, agnostics, sceptics and the unconcerned. The pluralism indissociable from a democratic society... depends on it.⁵⁵¹

Christian Education indicated a similar sentiment when it agreed there is a particular “constitutional value [in] acknowledging diversity and pluralism.”⁵⁵² It is a special value in our society that should be cherished as it “affirms[s] the right of people to be who they are without being forced to subordinate themselves to the... norms of others.”⁵⁵³ It is therefore *indisputable* that South Africa has a duty of care towards its citizens from both a local and international perspective to safeguard the free and reasonably unfettered exercise of religious beliefs in South Africa.

Earlier on, it was clearly indicated that the medical practitioner’s right to human dignity is actively part of his religious expression.⁵⁵⁴ From this relationship between his religious observance and his human dignity, the medical practitioner finds the meaning of his existence.

⁵⁴⁸ *MEC for Education: KwaZulu-Natal and Others v Pillay; Fourie v Minister of Home Affairs* 2005 (3) BCLR 241 (SCA); *Christian Education South Africa v Minister of Education; Prince v President, Cape Law Society* 2002 (2) SA 794 (CC); and *S v Lawrence*.

⁵⁴⁹ The CRL Commission, which drafted the document is a constitutionally mandated commission in terms of the *Constitution of the Republic of South Africa*, section 181, working towards the furtherance and continued protection of religious rights and freedoms.

⁵⁵⁰ *Kokkinakis v. Greece* (25 May, §31, Series A no. 260-A).

⁵⁵¹ *Kokkinakis v. Greece*, par. 31. *Prince v President, Cape Law Society*, par. 25. Ngcobo J confirmed South Africa’s concurrence: “The constitutional right to practice one’s religion asserted by the appellant here is of fundamental importance in open and democratic society. It is one of the hallmarks of a *free* society.” (Author’s emphasis).

⁵⁵² *Christian Education South Africa v Minister of Education*, par. 24.

⁵⁵³ *Christian Education South Africa v Minister of Education*, par. 24.

⁵⁵⁴ Dworkin, *Life’s Dominion: An Argument about Abortion and Euthanasia*, 239. Such expression might also take the form of the vows taken through the Hippocratic Oath. Dworkin holds that: “Because we cherish dignity, we insist on freedom, and we place the right of conscience at its center, so that a government that denies that right is totalitarian no matter how free it leaves us in choices that matter less.”

In essence, the nature of the right to freedom of religion, belief and opinion consists of making choices in line with one's own personal convictions, regardless of whether they are secular or religious.⁵⁵⁵ Justice McKenzie recognised this principle in *Chamberlain v Surrey School Board*⁵⁵⁶ by writing:

In my opinion, ... moral positions are to be accorded standing in the public square irrespective of whether the position flows out of a conscience that is religiously informed or not... No society can be said to be truly free where only those whose morals are uninfluenced by religion are entitled to participate in deliberations related to moral issues...⁵⁵⁷

Then there is also the medical practitioner's right to freedom and security of his person that should be called upon so as to protect the interests of the medical practitioner. Therefore, in context, what would prevent the medical practitioner from relying on the rights that are normally afforded to the patient in this regard? The medical practitioner can rely on the same provisions affording him the right to exercise his discretionary powers in accordance with his own psychological integrity, which would only compliment his right to be secure in his own body. If a religious medical practitioner is compelled to act contrary to his own convictions, he would not only be forced to compromise his own psychological integrity but he would for all intents and purposes be 'molested' by either the State or an individual.⁵⁵⁸ The effects of compromising sincere religious convictions is discussed elsewhere but it is sufficient to conclude that such an infringement would be unjustifiable, not on account of any physical pain, but due to the extreme anxiety medical practitioners could possibly endure.⁵⁵⁹ Surely this also qualifies as some or other form of harm and requires sensitivity and protection. This also links up to the medical practitioner's right to privacy, autonomy and personhood to not want to live a life of experiential pain and suffering from a psychological point of view.

⁵⁵⁵ Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia*, 240. Dworkin points to the importance of individual convictions: "They are honourable convictions, and those who have them must live and die in their light. But it is unforgivable to ignore the high importance of these [convictions] altogether, to... leave the fate of [a] ... friend to strangers in white coats on the ground that what happens to him no longer matters".

⁵⁵⁶ *Chamberlain v Surrey School Board* [2002] 4 S.C.R. 710.

⁵⁵⁷ *Chamberlain v Surrey School Board*, par. 138.

⁵⁵⁸ *Blencoe v. British Columbia (Human Rights Commission)* 2000 SCC 44, [2000] 2 S.C.R. 307, par. 55: "...state interference with bodily integrity and serious state-imposed psychological stress constitute a breach of an individual's security of the person.... Security of the person has been held to protect both the physical and psychological integrity of the individual." (Author's emphasis); *Carter v Canada (Attorney General)* SCC 5, [2015] 1 S.C.R. 331, par. 64.

⁵⁵⁹ The effects of compulsion to contravene sincere beliefs are discussed subsequently.

However, it is not only the medical practitioner's right to dignity, freedom of conscience, privacy as well as freedom and security of his person, which is of relevance, but also how these relate to the sanctity and inviolability of the right to life. It was evident from *Makwanyane* that the *sanctity of life* is foundational to South Africa's constitutional commitment. It has been said that the greatest insult one can hurl at 'sanctity of life' is to be indifferent in light of its complexity.⁵⁶⁰ As such, regardless of views the law takes regarding preserving or taking human life, religion inherently observes the foundational inviolability and sacredness of innocent human life.⁵⁶¹ Pope John Paul II explains this inherent respect by describing the purpose of life to ultimately amount to a vocation:

Man is called to a fullness of life which far exceeds the dimensions of his earthly existence, because it consists in sharing the very life of God. The loftiness of this supernatural vocation reveals the greatness and the inestimable value of human life even in its temporal phase. ... After all, life on earth is not an "ultimate" but a "penultimate" reality; even so, it remains a sacred reality entrusted to us, to be preserved with a sense of responsibility and brought to perfection in love and in the gift of ourselves to God and to our brothers and sisters.⁵⁶²

Because of a religious individual's obedience to divine precepts, intentionally killing an innocent individual, regardless of whether consent is granted, amounts to a heinous transgression.⁵⁶³ Thus, the objection of the medical practitioner is not only qualified by the

⁵⁶⁰ Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia*, 240.

⁵⁶¹ Christians and Jews rely on especially the historic content of the first book of the Bible namely, Genesis. Genesis 1:27 states that: "... God created man in his own image, in the image of God he created him; male and female he created them," ESV (English Standard Version), (Wheaton: Crossway, 2001). Human life is therefore to be lived in accordance with the representation of its origin. Secondly, Genesis 2:7 indicates the difference between human life and any other: "... then the Lord God... breathed into his nostrils the breath of life, and the man became a living creature," *ibid*. Humans are accordingly creatures with divine attributes derived directly from God. It is not within the power or authority of a person to intentionally take the life of an innocent at whim. Ultimately Christ himself gave the commandment to "... love the Lord your God with all your heart and with all your soul and with all your mind. This is the greatest and first commandment. And the second is like it: You shall love your neighbour as yourself," Matthew 22: 37-39, *ibid*. After all, Christ proclaimed: "I came that they may have life and have it abundantly," John 10:10, *ibid*. Similar sentiments are indicated in Islam. According to Islamic teaching, the Quran holds at Chapter 17:33: "Nor take life which God has made sacred, except for a just cause," *ibid*. Thus, the crux of religious respect for the sanctity of life as at its core, the belief that life, particularly human life, is directly derived and sanctioned by God. Because it is derived from God, only God has the authority to determine its termination.

⁵⁶² Pope John Paul II, *Evangelium Vitae*, par. 2.

⁵⁶³ Pope John Paul II, *Evangelium Vitae*, 8: "Like the first fratricide, every murder is a violation of the 'spiritual' kinship uniting mankind in one great family, in which all share the same fundamental good: equal personal dignity. Not infrequently the kinship 'of flesh and blood' is also violated; for example, when threats to life arise within

fundamental importance of especially the right to freedom of religion and human dignity (and consequently conscience) but also supports a moral precept in support of life *per se* (which includes both the mind and the body). This sanctity related to life as well as its inextricable relationship to the other rights of relevance, strengthens the credibility of the medical practitioner's case against participating in the administering of euthanasia.

Therefore, the first aspect of the limitations clause is to determine the nature of the right in question, which would assist in establishing the relative importance of any opposing rights. The right in question is the right to freedom of belief, conscience and religion, which, as has been made clear up to this point, is closely related to other important rights, such as dignity, and privacy. With this understanding of its nature, it becomes easier to determine whether a rational relationship exists, which would justify a limitation. Both local, foreign and international jurisprudence favourably indicate the relevance of religious freedom and also its strong connection to human dignity. It also indicates from a particular South African perspective, its foundational value in society. This is not only evident from jurisprudence, but also from the *Charter of Religious Rights and Freedoms*, which would effectively serve to cement the religious rights and freedoms of religious individuals in South Africa. It therefore becomes clear that the right to freedom of belief, opinion and religion is an immensely important right in South Africa as it assists the Constitution to attain important principles, values and rights, such as fostering a society based on mutual respect, human dignity and pluralism.

4.5.3 The importance of the purpose of the limitation

Determining the importance of the limitation's purpose entails two assessments, namely identifying the purpose of the limitation as well as determining its importance.⁵⁶⁴ When determining the purpose one has to bear in mind that the values of the Constitution seek to build an open and democratic society built on the principles of human dignity, freedom and equality.⁵⁶⁵ In this regard, the question that needs to be posed is whether the limitation's purpose builds further on this foundation, or breaks it further down? Determining the importance of the purpose entails asking, "Why ought a right (or rights) to be limited?" To

the relationship between parents and children, such as happens in abortion or when, in the wider context of family or kinship, euthanasia is encouraged or practiced."

⁵⁶⁴ Woolman & Botha, "Limitations", 34-73.

⁵⁶⁵ Woolman & Botha, "Limitations", 34-74.

determine the importance of the limitation, the contextual position of the infringed rights have to be discussed.

As discussed in Chapter Two, one of the main arguments in support of euthanasia is the termination of pain and suffering (which may not only be viewed as physical pain and suffering but also psychological pain and suffering). Added to this is the view that distinguishes between human experience and choice (that which pertains to the mind) on the one hand and the human biological make-up (the body) on the other. In this regard, there are those who argue that when the patient is of the view that the experiential part of existence is not worth continuing with (normally due to serious physical and/or mental suffering), that this qualifies the patient to, out of his own free will, choose to be relieved from all of this through the administering of euthanasia. It was argued in Chapter Two and above that the qualification of the termination of human life in accordance with the view that experiential life may no more be enjoyed, ignores the sanctity of human life, which also is comprised of a biological dimension. In this regard, the *importance* of the purpose of the limitation (as resulting from euthanasia) as argued by those who distinguish between life as experience (mind) and biological human life (body), becomes questionable. It was also argued in Chapter Two, that those who oppose euthanasia practices in general, are of the view that there is sufficient palliative care and medication to limit the physical and mental suffering that a patient may experience, which also has a negating effect on the *importance* of the purpose of the limitation. Extending upon this argument is the argument presented in Chapter Two regarding the credibility of “a caring approach” related to the protection of even biological human life.

Privacy, as discussed earlier on, is a right often broadly interpreted to cover a host of situations involving the ‘personhood’ of the individual involved, such personhood referring to his individuality, autonomy or personal identity.⁵⁶⁶ Thus, the purpose of the limitation aims to give unfettered effect to the right to privacy of the patient, and to effectively curb medical personnel from relying on their personal beliefs (religious or otherwise) as a means of denying the patient his request. However, as seen in the case of *Roe*, the right to privacy can be contentious (and arbitrary) in its application. For example, the court had applied the principles of the right to privacy to abortion, but without a proper basis, resulting in a constitutional provision seemingly being moulded at will to apply to a given situation. This is indicative of the fact that the right

⁵⁶⁶ The right to dignity is closely related in this regard.

to privacy has the capacity to be fashioned to fit any given situation depending on the whims or opinions of the one making the determination. However, from a local perspective, *Bernstein v Bester* provides a little more substance: When a contentious matter involving privacy arises, a person is entitled to a *legitimate* expectation of privacy,⁵⁶⁷ but, “In the context of the right to privacy this would mean that it is only the inner sanctum of a person, such as his/her family life, sexual preference and home environment, which is shielded from erosion by conflicting rights...”⁵⁶⁸ Thus, “... once an individual enters into relationships with persons outside this closest intimate sphere; the individual’s activities then acquire a social dimension *and the right of privacy... becomes subject to limitation.*”⁵⁶⁹

However, one should take specific cognisance of the patient’s right to privacy (as discussed above) as well as the patient’s right to freedom and security of his person⁵⁷⁰ as outlined in the Constitution with specific regard to security in and control over his body.⁵⁷¹ It has been discussed that patients often suffer from extreme pain and discomfort, both physically and emotionally, which substantiates the inclusion of the right to freedom and security of the person in the Constitution. Iain Currie and Johan de Waal indicate this right must be read in two components.⁵⁷² To be secure in one’s body refers to the right to be left alone, to be unmolested by other individuals or the State, whereas the right to control over one’s body refers to an individual being free to live his life in a manner he chooses.⁵⁷³ In certain circumstances, this right to bodily integrity is subject to infringement, resulting in the court having to determine whether the infringement is warranted or unjustifiable.⁵⁷⁴ It is submitted that an infringement can only be justified if it is necessary, proportional and if it does not inflict needless ‘physical pain or anxiety.’⁵⁷⁵ To bring the matter into perspective, the patient can rightly rely on his right to bodily integrity as well as psychological integrity.⁵⁷⁶ According to this line of thinking, any

⁵⁶⁷ *Bernstein v Bester*, par. 75.

⁵⁶⁸ *Bernstein v Bester*, par. 67.

⁵⁶⁹ *Bernstein v Bester*, par. 77 (Author’s emphasis). *Bernstein v Bester*, par. 67; *Affordable Medicines Trust and Others v Minister of Health and Others* 2006 (3) SA 247 (CC), par. 60: “... we live in a modern and industrial world of human interdependence and mutual responsibility. Indeed, we are caught in an inescapable network of mutuality.”

⁵⁷⁰ *Constitution of the Republic of South Africa*, section 12,

⁵⁷¹ *Constitution of the Republic of South Africa*, section 12(2)(b).

⁵⁷² Currie & de Waal, *The Bill of Rights Handbook*, 309.

⁵⁷³ Bastarache J discussed this principle in *Blencoe v. British Columbia (Human Rights Commission)*, par. 54: “Although an individual has the right to make fundamental personal choices free from state interference, such personal autonomy is not synonymous with unconstrained freedom.”

⁵⁷⁴ Currie & de Waal, *The Bill of Rights Handbook*, 309.

⁵⁷⁵ Currie & de Waal, *The Bill of Rights Handbook*, 309.

⁵⁷⁶ *Constitution of the Republic of South Africa*, section 12(2).

person should be able to decide for himself what is best, according to his own discretion and determination. After all, in terms of psychological integrity, *integrity* refers to concepts dealing with self-determination, personhood and personal autonomy.⁵⁷⁷ The argument in this regard is therefore that although the environment may be established, which gives effect to the wishes of the patient (obviously within the limits of certain criteria as reflected in euthanasia legislation) it is not for the medical practitioner who conscientiously objects to administering euthanasia to bear the brunt of having to give effect to the patient who wishes to die. Also, as is proposed below, hospitals should be responsible for managing the provision of those health care practitioners who would be willing to participate in the administering of euthanasia hereby allowing patients who choose to die to have their lives terminated (obviously within the parameters of carefully formulated and rigid legislative prescriptions). Having said this, it is important to take note of the other criteria prescribed by section 36 for purposes of the aim of this study.

4.5.4 The nature and extent of the limitation

As a point of departure, one should naturally view the medical practitioner's aversion to euthanasia from his contextual perspective. The belief in the absolute sanctity of innocent life and the respect thereof, is a recognised precept in many religious doctrines and serves as the moral measure for many non-religious persons as well. Ordinarily, intentionally killing innocent human life is outright prohibited.⁵⁷⁸ In context, the medical practitioner's conduct is based on religious convictions included in these doctrines. Compelling the medical practitioner to comply with the request of the patient amounts to what is considered as one of the greatest sins namely murder.⁵⁷⁹ The severe effects such compulsion would exert on the practitioner's human dignity cannot be overstated as he would be considered (not only by himself and his

⁵⁷⁷ Currie & de Waal, *The Bill of Rights Handbook*, 310.

⁵⁷⁸ In Judaism and Christianity, the Ten Commandments specifically address and prohibit murder, see Exodus 20. The Quran in chapter 5:32 determines the killing of one person akin to the killing of the whole of mankind. Hindus, Jains and Buddhists abhor violence. For example, Hindu and Jain followers of Swaminarayan have the explicit commandment "Thou shalt not kill", which Swaminarayan considered true to original ancient Vedic teaching. R. B. Williams, *An Introduction to Swaminarayan Hinduism*, (Cambridge: Cambridge University Press, 2001), 159.

⁵⁷⁹ Islam considers murder as the fifth greater sin, and its penalty is found in Surah An-Nisa 4:9: "And whoever kills a believer intentionally, his punishment is Hell; he shall abide in it, and Allah will send his wrath on him and curse him and prepare for him a painful chastisement." In the Christian and Jewish faith, regarding the first murder committed, as recorded in Genesis 4:10-11: "And the Lord said, 'What have you done? The voice of your brother's blood is crying to me from the ground. And now you are cursed from the ground which has opened its mouth to receive your brother's blood from your hand.'"

fellow believers but more importantly, by God) a murderer, subject to divine wrath.⁵⁸⁰ Keeping these factors in mind, it is important to remember the words of Sachs J in the South African Constitutional Court judgement namely, *Prince v President* regarding the reasonable accommodation of competing interests of the State and religious communities. The importance of factors serving public interests should be considered in light of an individual's right to practise his religion and moral convictions in a dignified manner befitting an open and democratic society.⁵⁸¹

The importance of the purpose behind limiting religious freedom should, as has been indicated previously, be contextualised to the individual person, but should also be contrasted in light of the values of South Africa's constitutional project.⁵⁸² Enforcing a limitation of this nature would hardly attain such an end.⁵⁸³ The protection of individual privacy is indeed a worthy goal, and would serve to further cement democracy, but in context, granting supremacy to the patient's individual autonomy at the cost of the medical practitioner's sincerely held religious or conscientious beliefs falls drastically short of the goals sought by a plural society, particularly in light of South Africa's history. Compelling a religious individual to contravene his religious convictions will certainly assist in attaining the end sought by the patient, but at what cost?⁵⁸⁴ As has been said, the aversion by a religious medical practitioner is not solely

⁵⁸⁰ Regardless of how bizarre the belief may be, to the non-religious, that you may be exposed to the wrath of God, cognisance needs to be taken of the fact that such a belief is actual to the believer. Regarding this study, may it be said that to not want to induce the death of someone who requests it is not bizarre at all even though such objection may be driven by religious motivations. In *MEC for Education: KwaZulu-Natal and Others v Pillay*, par. 146 the court held: "A religious belief is personal, and need not be rational." Additional discussion is provided in *R. v. Big M Drug Mart Ltd.* [1985] 1 S.C.R. 295, 1985 CanLII 69 (SCC) [Online], paras. 94-95: "The essence of the concept of freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and *without fear of hindrance or reprisal* But the concept means more than that. Freedom can primarily be characterized by the absence of coercion or constraint. If a person is compelled by the state *or the will of another* to a course of action or inaction which he would not otherwise have chosen, he is not acting of his own volition and he cannot be said to be truly free" (Author's emphasis). Sachs J elaborated on this line of thought by adding: "It... brings out the fact that that freedom of religion may be impaired by measures that coerce persons into acting or refraining from acting in a manner contrary to their beliefs. Just as it is difficult to postulate a firm divide between religious thought and action based on religious belief, so it is not easy to separate the individual religious conscience from the collective setting in which it is frequently expressed", *Christian Education South Africa v Minister of Education*, par. 19.

⁵⁸¹ *Prince v President, Cape Law Society*, par. 146.

⁵⁸² Woolman & Botha, "Limitations", 34-74.

⁵⁸³ The goals the *Constitution of the Republic of South Africa* aims to enshrine are set out in the various chapters of the Constitution, but notably in Chapter One (section 1(a)) where the founding values are explicitly mentioned as *Inter alia* 'human dignity, the achievement of equality and the advancement of human rights and freedoms' and in Chapter Two, which sets out the Bill of Rights.

⁵⁸⁴ Dworkin indicates with regard to conflicts originating between laws and religious adherence running contrary to one another, that all individuals have duties to one another, but some have duties other than duties to the State: "A man must honour his duties to his God and to his conscience, and if these conflict with his duty to the State, then he is entitled, in the end, to do what he judges to be right. If he decides that he must break the law, however, then he must submit to the judgement and punishment that the State imposes, in recognition of the fact that his

influenced by his obedience to religious documents; a deeper understanding of the religious psyche is necessary, especially in matters such as euthanasia, that deal with the intentional termination of an innocent human life, which is staunchly regarded by many as inviolable and sacred. Religious persons stand in a perceived position of ultimate accountability towards an almighty and omnipotent God (or gods).⁵⁸⁵ As referred to in Chapter Three pertaining to the conscience, the religious believer's view of the importance of his relationship with God constitutes an important facet of the said believer's conscience. Religious adherents obtain individual purpose and moral guidance from their relationship with their God and forcing actions contrary to these moral guidelines is what Litz, Stein and Delaney term 'moral injury'. Moral injury is defined as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations."⁵⁸⁶

Moral injury often leads to harmful and intensely emotional repercussions; the consequences of compelling an individual to wilfully transgress against God cannot be overstated.⁵⁸⁷ Apart

duty to his fellow citizens was overwhelmed but not extinguished by his religious or moral obligation," Ronald Dworkin, *Taking Rights Seriously*, (Massachusetts: Harvard University Press, 1977), 186-187.

⁵⁸⁵ M. Polanyi, *Personal Knowledge: Towards a Post-Critical Philosophy*, (London: Routledge, 1958), 302. Polanyi indicates, "We owe our mental existence predominantly to the works of art, morality, *religious worship*, scientific theory and other articulate systems which we accept as our dwelling place and as the soil of our mental development," (Author's emphasis).

⁵⁸⁶ B. Litz, N. Stein & E. Delaney, "Moral injury and moral repair in war veterans: A preliminary model and intervention strategy", *Clinical Psychology Review*, Vol. 29, 8(2009), 700.

⁵⁸⁷ J. Budziszewski *Brief of amicus curiae J. Budziszewski in support of plaintiff/appellant in the case of Sandra Cano v. Thurbert E. Baker*, No. 05-11641-HH, 9. Budziszewski contends that conscience operates from a 'cautionary' mode and an 'accusatory' mode. The cautionary mode informs the individual that his actions are morally wrong, and generates an inhibition against it, whereas the accusatory mode brings about 'Inflexible, inexorable, and relentless,' feelings of remorse, guilt and profound psychological needs. An example from Christianity aptly explains the emotional dilemma experienced. The crux of Christian teaching is that Man was created to exist in perfect harmony with God. Sin cut humanity off from this once natural relationship with God, and the only manner in which this relationship could ultimately be restored to its former glory was through the requisite perfect sacrifice, embodied in Christ, whose example Christians are to follow, see Titus 2:11-14; 1 John 1:7 "...the blood of Jesus... cleanses us from all sin." On account of this perfect sacrifice Christians are commanded, in Romans 12:2 (ESV) to "... present their bodies as a living sacrifice, holy and acceptable to God, *which is your spiritual worship*." (Author's emphasis). Thus, the manner in which a Christian conducts himself in any given situation serves as a testament of his devotion and worship to God, and honours this ultimate sacrifice of Christ. However, if a person deliberately sins dire consequences await, as Hebrews 10:26-27 holds, "For if we go on sinning deliberately after receiving the knowledge of the truth, there no longer remains a sacrifice for sins, but a fearful expectation of judgement, and a fury of fire that will consume the adversaries." And at 29-30: "How much worse punishment, do you think, will be deserved by the one who has trampled underfoot the Son of God, and has profaned the blood of the covenant by which he was sanctified, and has outraged the Spirit of grace? For we know him who said, 'Vengeance is mine; I will repay.' ... It is a fearful thing to fall into the hands of the living God." To the non-religious, such a discussion could possibly seem as mere drivel, but to the believer, such consequences are of immeasurable sorrow. Constant and unbearable psychological suffering exerts its toll, which can possibly end, like the infamous Judas Iscariot, in suicide. (For a discussion on the effects of sin on an individual's psychology, see M. McMinn, J. Ruiz & D. Marx, *Professional psychology and the doctrines of sin and grace: Christian leaders' perspective*, Graduate School of Clinical Psychology, Faculty Publications, Paper 170(2006); Budziszewski *Brief of amicus curiae J. Budziszewski in support of plaintiff/appellant* No. 05-11641-HH, 9. Budziszewski adds to this argument: "How the avenging mode works is not difficult to understand. The

from the religious implications, Stephen Genuis and Chris Lipp indicate that although hardly any substantial research exists dealing with the consequences of medical conscientious objection, there is *anecdotal evidence*, which indicates that infringement on such deeply held moral (religious) beliefs cause psychological and emotional strain on individuals, which detrimentally affect their personhood.⁵⁸⁸ Surely, exerting extreme, and sometimes lasting, psychological sorrow and guilt on a medical practitioner for acting contrary to his sincerely held religious beliefs, as well as the ethical prescripts of his profession,⁵⁸⁹ cannot be what was envisioned by our constitutional order when it paved the way for a democratic, free society. As indicated by Iain Benson, a constitutional society functions on the basis of citizens' rights and duties. One citizen, such as the patient, cannot force another, being the physician, to give up his own sincerely held beliefs.⁵⁹⁰ In other words, it is the patient's duty to not cause a fundamental violation of the rights of the medical practitioner who conscientiously objects against the administering of euthanasia. Sachs J describes the preferred position pertaining to the protection of religious rights and freedoms pertaining to plurality and tolerance:

Given our dictatorial past in which those in power sought incessantly to command the behaviour, beliefs and taste of all in society, it is no accident that the right to be different has emerged as one of the most treasured aspects of our new constitutional order. Some problems might by their very nature contain intractable elements. Thus no amount of formal constitutional analysis can in itself resolve the problem of balancing matters of faith against matters of public interest. Yet faith and public interest overlap and intertwine in the need to protect tolerance as a constitutional virtue and respect for diversity and openness as a constitutional principle. Religious tolerance is accordingly not only

normal outlet of remorse is to flee from wrong; of the need for confession, to admit what one has done; of atonement, to pay the debt; of reconciliation, to restore the bonds one has broken; and of justification, to get back in the right. But a prerequisite for these outlets is acknowledging that one has done wrong... When surface moral belief is at war with deep conscience – when it goes on insisting that the deed was blameless – then such acknowledgment of wrong is impossible, and the normal outlets... are blocked [and] ... exact payment in ... driving the life of the one who has committed the deed yet further out of kilter". For an Islamic perspective on sin, its consequences and its psychology, see A. Khan "The concept and psychological effects of sin in Islam", *Asian Journal of Social Sciences & Humanities*, Vol. 4, 1(2012), 186-191.

⁵⁸⁸ S. Genuis & C. Lipp, "Ethical diversity and the role of conscience in clinical medicine", *International Journal of Family Medicine*, Vol. 2013(2013), 8.

⁵⁸⁹ Genuis & Lipp, "Ethical diversity and the role of conscience in clinical medicine", 8. Genuis & Lipp indicate that medical practitioners, having been observed over long-term studies indicated emotional dysregulation directly related to moral injury. Other matters that manifested included *inter alia* burnout, feelings of inadequacy and a marked change in the manner in which the physician took care of his patients.

⁵⁹⁰ I. T. Benson, "Physicians, Patients, Human Rights, and Referrals: A Principled Approach to Respecting the Rights of Physicians and Patients in Ontario", *Cardus*, 12 September 2008. www.cardus.ca/organization/news/625/physicians-patients-human-rights-and-referrals-a-principled-approach-to-respecting-the-rights-of-physicians-and-patients-in-ontario/ (Accessed on 15 October 2017).

important to those individuals who are saved from having to make excruciating choices between their beliefs and the law. It is deeply meaningful to all of us because religion and belief matter, and because living in an open society matters.⁵⁹¹

International instruments to which South Africa is party also provide physicians with valuable protection. The *Declaration on the Elimination of all Forms of Intolerance and of Discrimination Based on Religion or Belief* guarantees that no person can be coerced into anything that would impair his religious freedom, and in the event that a person's religious freedom should be limited it can only be done in such terms as prescribed by laws necessary to protect public order, safety, health, morals and the fundamental rights of others.⁵⁹² Similarly, the *Banjul Charter*⁵⁹³ and the *International Covenant on Civil and Political Rights*⁵⁹⁴ confirm this position.

In conclusion, one has to add that, as already addressed earlier, nothing prohibits the medical practitioner from claiming the same rights claimed by the patient.⁵⁹⁵ The medical practitioner has an equal right to privacy and individual autonomy with regard to his personal choices, which not only supplements his right to dignity, but most importantly his right to freedom of religion, belief and opinion. Even if considerations of morality or religion were not the deciding

⁵⁹¹ *Prince v President, Cape Law Society*, par. 170.

⁵⁹² *United Nations Declaration on the Elimination of all Forms of Intolerance and of Discrimination Based on Religion or Belief*, Arts. 1.2 – 1.3.

⁵⁹³ African Charter on Human and Peoples' Rights, Art. 8 specifically guarantee freedom of conscience, the profession and religion.

⁵⁹⁴ *International Covenant on Civil and Political Rights*, Art. 18. See in particular Art. 18.2 dealing with coercion impairing freedom of religion.

⁵⁹⁵ Time and again it has been reiterated by medical societies that euthanasia does not fall within the bounds of a medical professional's duties. The World Medical Association Statement on Physician-Assisted Suicide as reaffirmed by the 200th WMA Council Session in Oslo Norway in April 2015: "Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient". <https://www.wma.net/policies-post/wma-statement-on-physician-assisted-suicide/> (Accessed on 15 October 2017). This position is affirmed by the Cancer Association of South Africa (CANSA), see Cancer Association of South Africa Fact Sheet and Position Statement on Assisted Suicide. The HPCSA (Health Professionals Council of South Africa) also prohibits euthanasia. See the HPCSA, "Introduction", *Guidelines For the Withholding and Withdrawing of Treatment*, Booklet 7. The HPCSA also expects healthcare practitioners to observe the provisions of the *World Medical Association Declaration on Terminal Illness* (as revised by the World Medical Association General Assembly at Pilanesberg, South Africa, 2006) <https://www.wma.net/policies-post/wma-declaration-of-venice-on-terminal-illness/> (Accessed on 15 October 2017): "Preface, When addressing the ethical issues associated with end-of-life care, questions regarding euthanasia and physician-assisted suicide inevitably arise. The World Medical Association condemns as unethical both euthanasia and physician-assisted suicide. It should be understood that WMA policy on these issues is fully applicable in the context of this Statement on Terminal Illness."

factors serving as the basis of the medical practitioner's refusal, but simply his loyalty towards the moral purpose (and precepts) of the medical profession, such loyalty could still amount to a guaranteed right.⁵⁹⁶

There are two important, often interrelated concerns that have to be considered in light of the limitation, which particularly affects *South African society*. Firstly, it is no secret that the public health care system in South Africa is under extreme stress.⁵⁹⁷ Enforcing medical personnel to participate in actions contrary to their beliefs could possibly have drastic repercussions for many hospitals, care centres, pharmacies, clinics and hospices across the country as personnel might decide to apply their craft either in the private sector, or in countries with non-coercive legislation. Secondly, religious organisations, such as missions, churches and mosques,⁵⁹⁸ which are often actively involved in many of these institutions, could possibly cease their activities,⁵⁹⁹ as forcing their personnel to participate in actions contrary to their respective religious doctrine could cause such organisations to feel marginalised by the State, as it would appear that the State has grown apathetic toward the religious community, particularly towards religious members of the medical field. Similarly, the State owes a debt of gratitude to these religious organisations without which additional strain would be placed on the State's already limited resources.⁶⁰⁰

⁵⁹⁶ *Affordable Medicines Trust and Others v Minister of Health and Others*, par. 59: "What is at stake is more than one's right to earn a living, important though that is. Freedom to choose a vocation is intrinsic to the nature of a society based on human dignity as contemplated by the Constitution. One's work is part of one's identity and is constitutive of one's dignity. Every individual has a right to take up any activity which he or she believes himself or herself prepared to undertake as a profession and to make that activity the very basis of his or her life. And there is a relationship between work and the human personality as a whole. It is a relationship that shapes and completes the individual over a lifetime of devoted activity; it is the foundation of a person's existence."

⁵⁹⁷ "SA's shortage of medical doctors – A bleak picture", *Medical Brief* 19 October 2016. <https://www.medicalbrief.co.za/archives/sas-shortage-medical-doctors-bleak-picture/> (Accessed on 17 October 2017). According to an Econex study conducted on behalf of the Hospital Association of South Africa, up to 17% of newly trained medical doctors emigrate whilst up to 80% end up in the private sector. In comparison with other developing countries, South Africa has only 25 medical doctors for every 100 000 persons. The global average is 152 per 100 000. 19 October 2016, SA's shortage of medical doctors – a bleak picture; *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC): For a practical example indicating the severe strain of public health services.

⁵⁹⁸ See for example, the Catholic Health Care Association of South Africa at <http://cathca-sa.co.za/>; Emseni Care Centre in the heart of KwaZulu-Natal at <http://www.ksb.org.za/projects-2/emseni-care-centre/>; the Islamic Medical Association at <http://ima-sa.co.za/>. Numerous other institutions provide much needed services in areas the state often cannot provide necessary services. Ceasing such services would amount to disastrous consequences.

⁵⁹⁹ C. Niles, "Colombian bishops threaten to shut down hospitals" *Church Militant*. 29 April 2015. <https://www.churchmilitant.com/news/article/Colombian-Bishops-Threaten-to-Shut-Down-Hospitals> (Accessed on 19 July 2017). Colombian bishops issued a similar warning to the Colombian government: "We will proceed to close all our hospitals if they insist on forcing us to kill".

⁶⁰⁰ See <http://www.charitysa.co.za/alphabetical-list-of-organisations> for a full list of charities operating in South Africa. Many of these charities carry a strong religious ethos.

The Constitutional Court in *Christian Education* highlighted this vital role played by religion in South Africa, especially with regard to providing "... support and nurture and a framework for individual and social stability."⁶⁰¹ Many of these charities are operated by religious groups, which could take offence by the State's flippant attitude towards religious freedom and compelling individuals to act against their sincerely held beliefs. Risking the possibility that such organisations might cease their activities is one the State is ill prepared to face. Consequently, it is clear that South Africa is not in a position to bargain with medical practitioners. Out of the nature of their profession, medical professionals are highly sought-after commodities across the world, and lucrative options are available. The extent of a limitation could have severe implications for South Africans.

4.5.5 The relationship between the limitation and its purpose

The South African Constitutional Court indicated in *S v Steyn*⁶⁰² that a rational relationship ought to be found between a limitation and its purpose.⁶⁰³ The question therefore to be asked is whether the limitation would ensure the purpose is achieved?⁶⁰⁴ The purpose in the case at hand comprises the view that the patient should be allowed to die with dignity, by requesting a medical practitioner to administer or prescribe a substance, which would terminate his life. In context therefore, is honouring the request made by a patient of such vital constitutional importance that it would rationally warrant compelling a medical practitioner to deny his own sincerely held convictions by limiting the free religious exercise of a medical practitioner?

As had already been argued earlier, the patient relies on the protection of his right to personal autonomy by way of his right to privacy (which in turn implies the patient's right to protection of human dignity as well as safety and security over the body). Allowing a person to act autonomously in all affairs regarding his person is at the core of a democratic society.⁶⁰⁵ The extent of this has been clearly indicated: personal inviolability involves not only being physically in control of one's body, but psychological integrity as well. It has been argued that the patient's will to live has subjectively diminished to the point where death becomes the

⁶⁰¹ *Christian Education South Africa v Minister of Education*, par. 36.

⁶⁰² *S v Steyn* 2001 (1) BCLR 52 (CC).

⁶⁰³ *S v Steyn*, paras. 30-31.

⁶⁰⁴ Rautenbach, "Proportionality and the limitations clauses of the South African Bill of Rights", 2256.

⁶⁰⁵ The author refers back to the founding provisions of the *Constitution of the Republic of South Africa*, section 7(1): "This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom."

preferred option. This is often on account of constant pain and suffering experienced by the patient. This pain and suffering supplements the purpose of the limitation, as ‘maintaining’ the suffering of a person is cruel and the effects of the suffering often cause embarrassment to the patient and infringe his dignity.⁶⁰⁶ Even though the suffering can be sufficiently alleviated sufficiently, as is often countered by opponents of euthanasia (and as touched upon in Chapter Two); patients feel that the use of such pain medication offers no viable relief⁶⁰⁷ as they still remain locked in an inescapable situation; death remains the only solution. Death being the point of contention, it would seem that the purpose can be justified in terms of our law, as ‘killing’ is already allowed in certain circumstances, albeit in terms of passive euthanasia. What difference would the means make if the end result remains the same? This has been alluded to in Chapter Two of this study. Thus, in light of the purpose of the limitation, the free will of the patient ought to be respected and his wish to be euthanised complied with, also bearing in mind that the medical practitioner is providing a professional service. In this regard, the view is that personal religious convictions should not influence his professional life.⁶⁰⁸

Bearing the above in mind, the issue this study addresses is the right of the medical doctor to refuse to comply with the patient’s demands to administer euthanasia on the grounds that such a request runs contrary to his sincerely held religious belief. The verdict is still out on whether the practice of euthanasia will be legalised. Should it be, then the patient is indeed afforded the ability to request euthanasia, and in so doing, have his privacy and human dignity respected, as there are undoubtedly medical practitioners who would not object, regardless of their religious or non-religious affiliation. However, forcing medical practitioners, across the board, to partake in actions some object to on highly contentious moral grounds, is substantively draconian, injurious and arbitrary.⁶⁰⁹ This would result in the practitioner being forced to

⁶⁰⁶ *Stransham-Ford v Minister of Justice and Correctional Services and Others* (27401/15) [2015] ZAGPPHC 230: 2015 (4) SA 50 (GP), paras. 9.3-9.5: “As time progresses the Applicant’s condition will become progressively worse and will later on require an even stronger doses of opioid drugs such as morphine and to possibly be hospitalized. He is becoming weaker by the day and needs constant assistance in normal daily activities such as getting up from bed, bathing, brushing his teeth and eating. As the Applicant’s disease progresses and until his last breath, he will become confused and afraid. His last breath might even be with the aid of a machine. Applicant says that he is not afraid of dying, he is afraid of dying while suffering.”

⁶⁰⁷ *Stransham-Ford v Minister of Justice and Correctional Services and Others*, paras. 7.4-7.5: “Cannot sleep without morphine or other painkillers; Uses pain medication, which makes him somnolent.”

⁶⁰⁸ The Hippocratic Oath taken by medical students graduating from the University of the Witwatersrand Medical School entails vowing to “... not permit consideration of religion... to intervene between [the medical doctor’s] duty and [his] patient.”

⁶⁰⁹ Additionally, if a medical practitioner acts in a coerced manner, it cannot be said he is acting with integrity. For example, the Canadian Medical Association *Code of Ethics* prescribes in Art. 7, that a medical practitioner should at all times act in accordance with integrity, ‘resist[ing] any influences or interference’ that could cause the practitioner to act otherwise. Genuis and Lipp indicate that once a practitioner acts contrary to what he deems

compromise his own personhood to such an extent that he is to act mechanically without any regard for his own personal involvement. This consequently leaves the medical practitioner with only two options: either allow infringement of his human dignity, privacy and religious convictions or refuse to concede to the patient's request and hereby keep intact the protection of his rights, which, as argued above, are to be regarded of high importance. Surely, this cannot be a society founded on the principles, rights and values of freedom, equality and human dignity, as envisioned by the Constitution where a medical practitioner is forced to administer euthanasia against his conscience? Sachs J warned in particular against such ultimatums; equal consideration has to be afforded to all rights in question, particularly when taking into consideration the "basic notion of tolerance and respect for diversity that our Constitution demands for and from all in our society."⁶¹⁰ Genuis and Lipp conclude by arguing along similar lines. Respect for diversity, ethical uncertainty, policy and legal precedents as well as the impact of coercion on both society and the individuality of medical practitioners does not warrant such "intolerant, illegitimate, and immoral" punishment on health providers "who act on deeply-held conscience perspectives..."⁶¹¹

To conclude therefore, it is accepted that a relationship ought to exist between the limitation and its purpose. The purpose of the limitation at hand is to enforce the supposed right of a patient to die with dignity, by ensuring that medical practitioners do not rely on the protections afforded by their religious beliefs. Therefore, the question, as asked above, is posed again: Are the interests of the patient of such vital constitutional importance to warrant the limitation of sincerely held religious beliefs, and thereby create substantial inroads into the free exercise of religion in South Africa? These religious beliefs are not only central to the identity of the practitioner, but they assist the State in promoting antecedent constitutional rights. The concerns of the medical practitioner cannot simply be discarded merely because they are subjective. The positions of both the patient and the medical practitioner have been made abundantly clear, and it has been indicated that the rights to privacy, dignity and equality apply to each in equal measure. This leads to a point that should be emphasised namely that in the event that euthanasia is to be legalised, the request of the patient would only be limited in so far as his request is being denied by a *religious* medical practitioner whose *personal religious*

to be sound or ethical medical care, his position as an ethical medical practitioner is compromised, Genuis & Lipp, "Ethical diversity and the role of conscience in clinical medicine", 9.

⁶¹⁰ *Prince v President, Cape Law Society*, par. 147.

⁶¹¹ Genuis & Lipp, "Ethical diversity and the role of conscience in clinical medicine", 9.

beliefs conflict with the patient's request. The patient remains free to request another medical practitioner to assist him, thereby ensuring his rights to privacy and dignity remain respected. However, if an objecting practitioner is in thrall of the patient's request through compulsion of the law, against his own views, it amounts to an inexcusable affront to his dignity, autonomy and religious freedom. Compulsion against sincerely held views ascribing to constitutional principles can never be considered constitutional in a democratic society founded on the principles of human dignity, freedom and equality, especially pertaining to the intentional termination of the life of an innocent person.

4.5.6 Less restrictive measures to achieve the purpose

If it is established that the limitation in question serves a purpose and there is indeed a rational objective between the purpose and the limitation, the final determination in the analysis entails determining whether there are other, less restrictive measures available that would achieve the same results.⁶¹² Therefore, should a party suggest a limitation, it should be proven that alternative measures, if any, had been considered, but no option could be found that would achieve the desired result, leaving only the limiting option. The court in *S v Manamela*⁶¹³ was of the view that determining whether a less restrictive means is available requires a careful examination of the purpose of the limited provision itself.⁶¹⁴ The purpose of religious freedom has been extensively discussed and its relevance firmly established, while the constitutional position of the medical practitioner has also been made clear. The relevance of affiliated rights in the context of religious rights has also been clearly addressed. Subsequently, it is evident that the implications, particularly psychological implications, of a restriction are substantial and severe.⁶¹⁵ This leads to the question whether any less restrictive measures exist.

In determining a less restrictive means, the court has made it clear that the standard to be attained should be realistic and reasonable.⁶¹⁶ The writer hereof is of the opinion that a less

⁶¹² Woolman & Botha, "Limitations", 34-85.

⁶¹³ *S v Manamela and Another (Director-General of Justice Intervening)* 2000 (5) BCLR 491 (CC).

⁶¹⁴ *S v Manamela and Another*, par. 96.

⁶¹⁵ As was informatively argued in especially Chapter Three.

⁶¹⁶ *S v Mamabolo* 2001 (5) BCLR 449 (CC), par. 49; Genuis & Lipp, "Ethical diversity and the role of conscience in clinical medicine", 9. Genuis & Lipp aptly indicate the realistic sphere surrounding the debate: medical practitioners are not merely 'service providers or therapy vendors'. Rather, they are professional *human individuals* using wisdom and judgement to make decisions expected of them in light of their capability to act as required. For this very reason the medical profession is required to govern itself and remain out of the grasp of societal or State dictates.

invasive option indeed exists. In this regard, it is proposed that a ‘roll’ be compiled, termed along the lines of the ‘roll of non-objecting physicians’. Such a roll would remove the proverbial middleman and allow a patient to approach any medical practitioner or physician on the roll directly, who would accordingly be authorised to acquiesce to the patient’s request.⁶¹⁷ Should a practitioner, however, deny a patient’s request, such a patient should, instead of infringing on the constitutional rights of a medical practitioner by compelling him to act in accordance with the patient’s wishes, be referred to what Iain Benson terms a ‘physician’s referral service’.⁶¹⁸ This service should be open to the public, and receive any inquiry or request, to which they respond and provide the necessary assistance, such as assisting the patient to contact a medical practitioner on the above-mentioned ‘roll’. Additionally, nothing would prohibit a practitioner from clearly indicating in his practice, or in the case of a pharmacist, in his dispensary, the range of services provided, and explicitly indicating the range of service he does *not* provide. Such non-provision of services, could include refusing to refer a practitioner to another practitioner.⁶¹⁹

It has been emphasised earlier that according to South African Constitutional Court jurisprudence, the State has an obligation to ensure believers are not subjected to agonising and painful choices when it comes to choosing to obey the law and complying with their own moral or religious convictions.⁶²⁰ It is also true that governments conversely have the obligation to ensure that religious laws are not flaunted by believers to escape their duties.⁶²¹ The court confirmed as much in *Prince v President* that the right to religious freedom does not qualify an individual to disregard a “valid and neutral law...” against actions prohibited by his religion.⁶²² Thus, religion may not be used to circumvent laws necessary to ensure public order and welfare. However, it is difficult to conclude that refusal to comply with a law to intentionally terminate innocent life on request from the basis of respect for sanctity of life and sincere

⁶¹⁷ Such a roll should contain all the relevant details of the practitioner, including details regarding the area in which he performs his duties and contact details to facilitate quick and efficient assistance.

⁶¹⁸ I. T. Benson, “Physicians, patients, human rights, and referrals: A principled approach to respecting the rights of physicians and patients in Ontario”.

⁶¹⁹ I. T. Benson, “Physicians, patients, human rights, and referrals: A principled approach to respecting the rights of physicians and patients in Ontario”.

⁶²⁰ *Christian Education South Africa v Minister of Education*, par. 35: “... the state should... seek to avoid putting believers to extremely painful and intensely burdensome choices of either being true to their faith or else respectful of the law.”

⁶²¹ *Christian Education South Africa v Minister of Education*, par. 35: “...a society can cohere only if all its participants accept that certain basic norms and standards are binding. Accordingly, believers cannot claim an automatic right to be exempted by their beliefs from the laws of the land.”

⁶²² *Prince v President, Cape Law Society*, par. 120. The court cited from a case, which appeared before the United States Supreme Court, *Employment Division, Department of Human Resources of Oregon v. Smith* 494 U.S. 872.

religious adherence (which runs parallel to the State's obligations), amounts to a violation of the principles, values and rights of human dignity, equality and freedom.⁶²³ This is also of relevance for the promotion of higher levels of plurality in South Africa's democratic dispensation (and the same applies to other democracies around the world) and here the following understanding by Sachs J rings loud:

In my view... insufficient weight [is given] to the impact the measure will have, not only on the fundamental rights of the appellant and his religious community, but on the basic notion of tolerance and respect for diversity that our Constitution demands for and from all in our society.⁶²⁴

As was indicated, the submission had been made that a less restrictive means exists that would ensure the protection of the rights of all parties concerned. It is proposed that a roll be compiled akin to the Roll of Attorneys, which would allow for the registration of medical practitioners who do not object to the administration of euthanasia. The patient will be at liberty to peruse the roll for an available medical practitioner, while the practitioner he chooses will be voluntarily enrolled. Objecting practitioners are under no obligation to enrol themselves. This would ensure that both parties are afforded the respect due to their dignity, privacy and personal autonomy.

4.5.7 Conclusion

The positions of both patients and medical practitioners have been set out clearly pertaining to the nature and importance of each respective right, also against the background of the nature and purpose of the limitation of the relevant rights. The purpose for limiting the practitioner's right to freedom of religion, belief and opinion is to ensure the patient's rights are adequately addressed. The patient's right to privacy (and consequently his human dignity) is indeed infringed if a medical practitioner refuses to comply with his request to end his life, but similarly is the right to dignity of the medical practitioner infringed if he is compelled to comply with the request of the patient to assist in terminating the life of the latter. There is no doubt that the limitation seeks to attain an admirable goal, but is the limitation reasonable and

⁶²³ *Constitution of the Republic of South Africa*, section 36; *Prince v President, Cape Law Society*, par. 147: "Exemption from general laws always impose some cost on the State, yet practical inconvenience and disturbance of established majoritarian mind-sets are the price that constitutionalism exacts from government."

⁶²⁴ *Prince v President, Cape Law Society*, par. 147.

justifiable in an open and democratic South Africa based on human dignity, freedom and equality? Compelling a person to act against his beliefs, knowing full well the toll, which contravening his religious precepts entail, is far from logical, humane, justifiable and fair. As the court previously indicated, the ‘purpose, effects and importance’ of the infringement is contrasted with the nature and effect of the reason for such infringement. The greater the inroad into the protected right, the more substantial the justification ought to be.⁶²⁵ Against this backdrop, forcing an individual to act contrary to his will, knowing full well that such a decision will cause him anguish and suffering, is cruel, and cannot be expected to be justifiable in a society envisioned by the Constitution. The consequences of imposing such a limitation in light of South Africa’s ailing public health service were also highlighted and the incredibly dire position this would place the authorities in. Regardless of the State’s duty to protect human life, the State can indeed effect a less invasive approach, which would amount to the inclusion of a ‘conscientious objection clause’ in possible future euthanasia legislation. Such a clause would cater effectively to the guaranteed rights of the medical practitioner, whilst providing the patient with the possibility of requesting another medical practitioner to assist in terminating his life.

In conclusion therefore, the limitation of the medical practitioner’s right to exercise his religious or conscientious rights freely is not reasonable nor justifiable in an open and democratic society. The purpose of the limitation, simply cannot justify its extent, if the nature and purpose of what free religious exercise entails as well as the moral importance (sanctity) of life is taken fully into consideration. This also has implications for the medical practitioner’s human dignity and freedom of autonomy, privacy or personhood. Considering the harmful implications of ending a person’s life from the perspective of a medical practitioner’s religious convictions, it would become clear that it is too severe to justify the purpose sought. In addition thereto, requiring a medical practitioner to simply switch off when he leaves for work, and set his religious convictions aside for the period of time he appears in the public eye, is quite frankly an impossible task as far as the exercise of religion is concerned.⁶²⁶ An individual carries his religious convictions with him, as they are ingrained in every aspect of his daily

⁶²⁵ *S v Bhulwana; S v Gwadiiso* 1995 (2) SACR 748 (CC), par. 18.

⁶²⁶ *Christian Education South Africa v Minister of Education*, par. 33: “... many major religions regard it as part of their spiritual vocation to be active in the broader society”; *R. v. Big M Drug Mart, Ltd.*, par. 95. The court indicated its support for religious freedom by describing how religious freedom is a right open to free manifestation.

life.⁶²⁷ As has been indicated, this is the pre-suppositional point from where he finds his dignity and meaning in life. As Ronald Dworkin posits:

... if people retain the self-consciousness and self-respect that is the greatest achievement of our species, they will let neither science nor nature simply take its course, but will struggle to express, in the laws they make as citizens and the choices they make as people, the best understanding they can reach of why human life is sacred, and the proper place of freedom in its dominion.⁶²⁸

Only by means of an approach whereby the views of all parties concerned are recognised, cherished and protected can true accommodation and diversity find its rightful application and true definition.⁶²⁹ The author accordingly submits that compelling a medical practitioner to participate in procedures or treatments to which he sincerely objects with specific reference to the administering of euthanasia, to be cruel and inhumane, and certainly not conduct justifiable in an open and democratic society founded on the principles of *human dignity, equality and freedom*. Also, such an act will constitute a substantive violation of his right to freedom of religion, which on its own is of sufficient importance so as to merit such protection.

Here it is also apt to refer to equality jurisprudence (and by implication the possibility of unfair discriminatory practices). Section 9 of the Constitution is clear on religion constituting one of the listed grounds regarding unfair discrimination. In this regard, it is argued that for the medical practitioner who is instructed (or pressurised in any manner) to participate in the administering of euthanasia, even though it is against such a practitioner's religious convictions, results in discrimination and may result in unfair discrimination. Elaborating upon this, section 1 of the *Promotion of Equality and Prevention of Unfair Discrimination Act*⁶³⁰ defines "discrimination" as: "any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly – (a) imposes burdens, obligations or

⁶²⁷ *Prince v. Massachusetts* 321 U.S. 158 (1944), 165: "Heart and mind are not identical. Intuitive faith and reasoned judgment are not the same. Spirit is not always thought. But, in the everyday business of living, secular or otherwise, these variant aspects of personality find inseparable expression in a thousand ways. They cannot be altogether parted in law more than in life." *Christian Education South Africa v Minister of Education*, par. 33: "Religion is not just a question of belief or doctrine. It is part of life, of a people's temper and culture."

⁶²⁸ Dworkin, *Taking Rights Seriously*, 241.

⁶²⁹ I. T. Benson, "Seeing through the secular illusion", *Nederduitse Gereformeerde Teologiese Tydskrif*, Vol. 54, 4(2013), 23.

⁶³⁰ The *Promotion of Equality and Prevention of Unfair Discrimination Act* 4 of 2000 (PEPUDA), commonly referred to as the *Equality Act*.

disadvantage on; or (b) withholds benefits, opportunities or advantages from, any person on one or more of the prohibited grounds”. Bearing this in mind, discrimination based on religious conviction is included where a medical practitioner is instructed or pressurised in any manner to participate (directly or indirectly) in the administering of euthanasia. Added to this, the *Equality Act* requires disadvantage at this stage (so as to confirm discrimination) but this does not necessarily imply that it is unfair, although there will be a presumption of unfairness. Also, the *Equality Act* lists the following criteria so as to assist in the determination as to whether certain actions may constitute *unfair* discriminatory practices:⁶³¹

Section 14 (2)-(3) reads as follows: (2) In determining whether the respondent has proved that the discrimination is fair, the following must be taken into account: (a) The context; (b) the factors referred to in subsection (3); (c) whether the discrimination reasonably and justifiably differentiates between persons according to objectively determinable criteria, intrinsic to the activity concerned. (3) The factors referred to in subsection (2) (b) include the following: (a) Whether the discrimination impairs or is likely to impair human dignity; (b) the impact or likely impact of the discrimination on the complainant; (c) the position of the complainant in society and whether he or she suffers from patterns of disadvantage or belongs to a group that suffers from such patterns of disadvantage; (d) the nature and extent of the discrimination; (e) whether the discrimination is systemic in nature; (f) whether the discrimination has a legitimate purpose; (g) whether and to what extent the discrimination achieves its purpose; (h) whether there are less restrictive and less disadvantageous means to achieve the purpose; (i) whether and to what extent the respondent has taken such steps as being reasonable in the circumstances to – (i) address the disadvantage which arises from or is related to one or more of the prohibited grounds; or (ii) accommodate diversity.

The fact that such a medical practitioner finds himself in the workplace, the *Employment Equity Act* (EEA⁶³²) also comes into play, and in this regard, the emphasis is placed on whether such a medical practitioner should be ‘reasonably accommodated’. In this regard, J. L. Pretorius *et al* state that: “The duty of reasonable accommodation comprises of positive measures that ought to be taken to meet ... the different needs of those who, by reason of a protected characteristic such as ... *religious affiliation* cannot be adequately served by arrangements that

⁶³¹ The relevance of these criteria (emanating from the *Equality Act*) for the workplace (which falls under the direct authority of the *Employment Equity Act* (see below) was confirmed in *Du Preez v Minister of Justice and Constitutional Development and Others* (368/04, ECJ24/2006) [2006] ZAECHC 17, par. 25.

⁶³² One of the main objectives of this Act is to forbid unfair discrimination (based amongst others on the listed grounds which includes religion) in the workplace.

are suitable for people who do not share such a characteristic.”⁶³³ Pretorius *et al* comment that “read with the prohibition on unfair discrimination contained in sections 6(1) and (2),⁶³⁴ as well as the constitutional guarantee of religious freedom, reasonable accommodation of religious practices and beliefs have to be adhered to by employers. Failure to reasonably accommodate may constitute direct or indirect discrimination based on religious belief.”⁶³⁵ Pretorius *et al* refer to the requirements for a successful claim regarding workplace based religious discrimination as set out by the Labour Appeal Court in *SA Clothing and Textile Workers Union and Others v Berg River Textiles – A Division of Seardel Group Trading (Pty) Ltd*⁶³⁶ these being, amongst others (and of relevance to this study) that: “it is incumbent on the [employees] to show that the employer by means of the workplace rule or policy interfered with their participation in or practice of their religion”; and “the principle involved must be a central tenet of that religion.”⁶³⁷ In Chapters 3 and 4 of this study it had been clearly and convincingly argued that the belief that a medical practitioner may have to not intentionally terminate innocent human life constitutes a central tenet of the Christian faith (amongst others). It also needs to be noted that “reasonable accommodation” is foremost a non-discriminatory principle.⁶³⁸

Applying the above to the scenario where a medical practitioner who refuses to participate in the administering of euthanasia due to his religious convictions but who is instructed or pressurised to participate in euthanasia, surely this would constitute a successful claim regarding unfair discrimination based on religion (and by implication, conscience).⁶³⁹ Added to this, a hospital that has employed such a medical practitioner is necessitated to reasonably accommodate such a medical practitioner. It is therefore clear that to instruct (or pressurise in any manner whatsoever) a medical practitioner to administer euthanasia where such an action is opposed to the practitioner’s religious convictions (and consequently his conscience), will

⁶³³ J. L. Pretorius, M. E. Klinck and C. G. Ngwena, *Employment Equity Law*, (Durban: LexisNexis South Africa, 2012), Chapter 7 – “Reasonable Accommodation”, 2 (Author’s emphasis).

⁶³⁴ Of the *Employment Equity Act* (55 of 1998). Section 6 (1) reads as follows: “No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including ... religion ... conscience ... belief ... culture ...”

⁶³⁵ Pretorius *et al*, *Employment Equity Law*, 54.

⁶³⁶ (2012) 33 ILJ 972 (LC).

⁶³⁷ Pretorius *et al*, *Employment Equity Law*, 55.

⁶³⁸ Pretorius *et al*, *Employment Equity Law*, 2.

⁶³⁹ This is especially supported by Chapter Three’s elaboration of the importance of religion and the convictions of the medical practitioner who objects against the administering of euthanasia due to his religious belief and the centrality of such a belief to his religion.

constitute unfair discrimination.⁶⁴⁰ One must however distinguish here between a ‘general’ healthcare institution on the one hand and on the other hand a healthcare institution such as a ‘euthanasia clinic’ that has as its central functional mission the administering of euthanasia (on the condition needless to say, that euthanasia has been legalised). A medical practitioner who therefore works in such a euthanasia clinic may therefore not seek protection from being instructed or pressurised into participating in euthanasia practices because this may be justified if administering euthanasia is an inherent job requirement or operational requirement in terms of the EEA or intrinsic to the activity concerned in terms of section 14(2)(c) of the *Equality Act* (PEPUDA) – and this is most certainly the case regarding a euthanasia clinic. One needs to also bear in mind that whatever the finding may be regarding the determination for unfair discrimination in accordance with the EEA and PEPUDA, a reasonable and justifiable limitation of the medical practitioner’s right to mainly human dignity and freedom of religion (in accordance with section 36 of the Constitution) would certainly not succeed.⁶⁴¹

4.6 Conclusion

Upon examination of the various fundamental rights at play pertaining to the validity or not of euthanasia, as well as the protection of the medical practitioner’s rights to object against the administering of euthanasia due to his religious convictions, it becomes clear that from the perspective of either party involved, a clash of wills and interpretations is inevitable. As indicated in the discussion on the right to life, the concept is far from straightforward. Its relationship with dignity enables it to garner specific support, which has traditionally been understood to refer to the absolute protection of the sanctity of life. However, efforts have recently been made to broaden the scope of the right to life to include contentious issues, such

⁶⁴⁰ Chapters Three and Four add to this argument where the importance of the relevant rights (especially that pertaining to the right to freedom of religion and human dignity) were discussed in detail. Here cognisance also needs to be taken of the relevance of the *Labour Relations Act* (66 of 1995) (LRA) against the background possibilities of ‘unfair dismissals.’ In other words, a doctor who has been dismissed by the hospital management for refusing to participate in any act of euthanasia, may argue that he has been unfairly dismissed. In this regard, J. V. du Plessis and M. A. Fouche state that, “In terms of section 187 of the LRA some dismissals are automatically unfair. In the main a dismissal is automatically unfair if an employer discriminates against an employee or if an employee is dismissed because he exercised his rights in terms of the Act”, J. V. du Plessis and M. A. Fouche, *A Practical Guide to Labour Law* (Eighth Ed. (2014), LexisNexis (Pty) Ltd, 2015), 320. More specifically, and amongst others, a dismissal because of the employer’s unfair discrimination qualifies such a dismissal as an automatically unfair dismissal, *ibid.* 320-321. It was argued above that instructing or pressurising (in any manner whatsoever) a medical practitioner to administer euthanasia against his religious convictions constitutes unfair discrimination and therefore to dismiss a medical practitioner due to such a practitioner not wanting to violate his own religious beliefs and convictions through the administration of euthanasia, constitutes an automatic unfair dismissal.

⁶⁴¹ See the arguments presented in Chapter Four.

as euthanasia and a right to die, under its banner. Therefore, from a South African perspective, if such a development was to occur, it would amount to a limitation of the right to life, which could carry substantial repercussions, as it conveys the message that even one of the most inviolable and sacred rights can in fact be limited regarding innocent human beings.

Additionally, human dignity, the right to life's ever-present companion, exerts considerable influence in the discussion. Its influence has been both recognised and utilised by the judiciary, on a local and international level, particularly in support of both the right to life and the rights revolving around religious freedom. It plays a substantial role in establishing a person's identity as an individual, responsible, free human being, capable of making individual choices and directing the course of his life. It enables an individual to flourish and partake in human goods, which finds particular relevance in the current discussion, as this flourishing includes concepts such as religion and its corresponding beliefs. This ability to make free and informed choices to one's own benefit leads to the third important right in the debate: the right to privacy, which is also a right closely related to the right to dignity. In essence, the right to privacy emphasises, similar to human dignity, the free will of an individual and ensures the capability of an individual to enforce his own beliefs and convictions, such as his choice of sexual partners, reproduction, domestic circumstances or decisions regarding medical treatment.

In the euthanasia debate pertaining to conscientious objection within health care, the rights referred to above, conflict with one another on much the same basis from the perspectives of the different role-players. This, as indicated, requires the application of a limitations test to determine the nature of the conflicting rights in question, the reasons why a limitation is sought and the importance of the limitation – what does it aim to achieve? This is aimed at answering the further question namely whether such a limitation is reasonable and justifiable. What has become evident through examining the rights through the criteria set forth in the limitations clause is that both sides of the argument, the patient and the medical practitioner, raise important concerns with regard to the various rights. The right to life as it applies to the patient would require developing (thereby limiting) the right to life to include the right to die. If this were to occur, such development would be strongly supported by the privacy concerns of the patient, as substantiated by the right to dignity. What bolsters this approach is the view that the body and mind are to be distinguished from one another. If life, as that which is experiential (mental), is not in line with the wishes of the patient then such a patient may freely choose to have his life ended, irrespective of the presence of biological human life. However, if this were

to come to pass, the anticipated conflict with objecting medical practitioners would arise. Thus, the question would have to be asked whether the interests of the requesting patient are of such a sufficiently important nature that it would justify the limitation of the practitioner's religious rights. It is common cause that the medical practitioner staunchly upholds the right to life from the basis of his religious convictions (and also from his rational sense of what is moral or immoral), and these convictions have at their foundation the rights to privacy and, as with the patient, the right to dignity. It was indicated that the practitioner, through his sincere convictions, would have to make the painful choice of either denying his faith (or himself) or take the risk of either disciplinary or criminal sanctions.

The *Constitution of the Republic of South Africa* envisages a society where different individuals would be able to express their unique traits and interests in a tolerant society based on the values of equality, freedom and human dignity. Under the previous dispensation, the conduct of individuals in society were regulated relentlessly; certain conduct once prohibited are now afforded protection under rights considered fundamental. Can a society truly be seen as free if it seeks to foster a plural and tolerant society, but when an opportunity to apply tolerance and pluralism arises, relegates them to the background and instead enforce values diametrically opposed to the values it seeks to enforce? Therefore, it is submitted that should the rights of the patient limit the rights of the objecting medical practitioner pertaining to the administering of euthanasia, such limitation would amount to an unjustified limitation as the medical practitioner would be left with no recourse. The only avenue would be the avenue of compliance, which can certainly not be in line with the values of the Constitution. Therefore, such limitation would necessitate the inclusion of the proposed conscientious objection clause in right to die legislation. This would provide the required balance between the rights of the patient and those of the medical practitioner. Also, regarding equality jurisprudence it has convincingly been argued that even under the test for unfair discrimination, the right of the medical practitioner to be allowed to conscientiously object against the administering of euthanasia in a general hospital (whether public or private) should enjoy protection.

Chapter 5

Conclusion

From antiquity to the present, moral and legal questions pertaining to euthanasia, whether active or passive, (also regarding physician-assisted suicide) have consistently resulted in contentiousness. Even in jurisdictions where it is legally practised it remains dogged by controversy.⁶⁴² The matter is only further complicated by the various and relevant fundamental human rights and their accompanying interpretations at play. At the inception of this study, it was indicated that the decision reached by the Canadian judiciary in *Carter* served as the catalyst for this study. A particularly heartening statement by the court was the observance of not only patient rights, but also those of medical practitioners. The court indicated the necessity of reconciling both patient and physician rights in forthcoming legislation,⁶⁴³ and allayed the author's initial fear. However, when legislation was drafted, Bill C-14 made no mention of any form of conscientious objection, and as such, the author's concerns were realised when the Ontario Divisional Court determined medical practitioner rights, regardless of *Carter*, subservient to those of patients,⁶⁴⁴ and may accordingly not refuse patients' requests, even if it comes at the cost of their professions.⁶⁴⁵ In light hereof, South Africa could very well be heading the same way. Prior to South Africa's constitutional democracy, the question surrounding euthanasia was effectively dealt with by the courts in a number of situations, by

⁶⁴² R. Cohen-Almagor, "First do no harm: Shortening lives of patients without their explicit request in Belgium", *Journal of Medical Ethics*, Vol. 41, 8(2015); E. Nyst, "Een wilsverklaring kan een mondeling verzoek niet vervangen – Ethicus stapt uit de toetsingscommissie euthanasie", *Medisch Contact*. 10 January 2018. <https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/een-wilsverklaring-kan-een-mondeling-verzoek-niet-vervangen.htm> (Accessed on 10 January 2018). The personal conflict experienced by an ethicist on one of the Dutch regional assessment committees regarding euthanasia legislation pertaining to non-consenting demented patients; E. Kreulen, "Euthanasie bij wilsonbekwame dementiepatiënten is niet te verdedigen", *Trouw*, 13 January 2018. <https://www.trouw.nl/samenleving/-euthanasie-bij-wilsonbekwame-dementiepatiënten-is-niet-te-verdedigen-~a70bdd45/> (Accessed on 15 January 2018).

⁶⁴³ *Carter v Canada (Attorney General)*, par. 11.

⁶⁴⁴ N. a. "Medically assisted dying in Ontario: Limited conscientious objection for doctors" *Généthique*, 9 February 2018. <http://www.genethique.org/en/medically-assisted-dying-ontario-limited-conscientious-objection-doctors-69162.html#.WonA56iWaUk> (Accessed on 10 February 2018).

⁶⁴⁵ J. Savulescu & U. Schuklenk, "Doctors have no right to refuse medical assistance in dying, abortion or contraception", *Bioethics*, Vol. 31, 3(2017), 164 (Footnote omitted): "Doctors must put patients' interests ahead of their own integrity. They must ensure that legal, beneficial, desired services are provided, if not by them, then by others. If this leads to feelings of guilty remorse or them dropping out of the profession, so be it. As professionals, doctors have to take responsibility for their feelings. There is an oversupply of people wishing to be doctors. The place to debate issues of contraception, abortion and euthanasia is at the societal level, not the bedside, once these procedures are legal and a part of medical practice"; N. a. "Nurse who refuses to administer euthanasia to her patients is forced to resign", *Généthique*, 7 July 2017. <http://www.genethique.org/en/nurse-who-refuses-administer-euthanasia-her-patients-forced-resign-67917.html#.WonLK6iWaUk> (Accessed on 10 February 2018).

making it clear that active euthanasia can never be anything other than murder. However, the courts remained compassionate to the ‘murderer’, through the imposition of light sentences, or no sentence at all.⁶⁴⁶ Under the present *Constitution of the Republic of South Africa*, euthanasia remains unlawful although the High Court in the *Stransham-Ford* case has intimated that an evident void exists in South African law pertaining to the legalisation of euthanasia.

As has been clarified throughout, the purpose of this study is not primarily to provide an argument on whether euthanasia (both active, passive and physician-assisted suicide) should be legalised or not; rather, this study is to serve as a contribution to the protection of religious rights and freedoms of those medical practitioners who conscientiously object against the administering of euthanasia. This is achieved by sketching a scenario evidencing the typical conflict between patient and practitioner rights; and in this scenario it is accepted that euthanasia (in the said forms referred to above) has indeed been legalised. In light of such a scenario, this study mainly postulates insights related to the South African context, however it also presents important insights to other democratic jurisdictions, as it appears that it is becoming more and more prevalent for medical practitioners to avail their rights associated with their autonomy to escape unwarranted demands by patients, which many consider to be beyond the confines of standard, or even extraordinary medical care. Bearing this in mind, as well as the lack of substantial scholarly literature regarding the need of conscientious objection and euthanasia, this study contributes towards the development of jurisprudence in this regard as it highlights and addresses an evident void in an area of South Africa’s jurisprudence in need of direction. As has been indicated previously, the idea of conscientious objection is not a foreign concept; it has long been recognised in other disciplines, such as that which pertains to military conscription, abortion practices and marriage commissioners. However, its application to euthanasia requires attention. Based on such line of thought, this study indicates the need for the accommodation of difference and therefore of tolerance (which is akin to any society that prides itself on diversity) by protecting those medical practitioners who conscientiously object against the administering of euthanasia.

The term euthanasia, as has been indicated, is a term divided into differing categories, namely active and passive euthanasia. These terms respectively refer to the active steps deliberately taken by an individual to end the life of a patient by administering to such a patient a toxin,

⁶⁴⁶ *S v Marengo* 1991 (2) SACR 43 (W); *S v De Bellocq* 1975 (3) SA 538 (T).

which would end the patient's life, and on the other hand, the ending of a patient's life on account of cessation of treatment, or the complete lack of treatment being provided at all. Included in this, for purposes of this study, is also physician-assisted euthanasia. Accordingly, the argument is presented that such a conflict of rights may originate from the medical practitioner's irreconcilable religious (or ethical) beliefs. It therefore follows that should the practitioner be confronted by such a conflict, an unwarranted and often severely painful choice is placed before him to either obey his religious precepts or to break the law. It is common cause, therefore, that there are medical practitioners who harbour *inherent* objections to the intentional taking of an innocent human life. It goes further than simply entertaining a dislike to a particular emerging societal practice. Such inherent objection is foundational to the objector's religious convictions and worldview, as it is inextricably connected to the importance and sanctity of human life, which emphasises a qualified and convincing pre-argumentative aversion to euthanasia, and therefore, necessitates protection from its inception. In other words, to object against the intentional taking of an innocent life, even when asked to do so by the person whose life is to be taken, is morally qualified, mainly due to the importance (and sanctity) of human life *per se* and this may inextricably be connected to the religious convictions of the medical practitioner.

Preceding the qualification of the importance of human life by means of reference to human rights is the fact that 'life' is an inherent primary good of persons, which encompasses both the individual's experiential and bodily existence. This understanding of life as a basic human good precedes the understanding that the right to life is a fundamental universal right. No person, generally speaking, should intentionally take the life of another innocent human being. Emanating from this understanding is the view that bodily life denotes an intrinsic good and is therefore an end in itself (and therefore not a mere instrument towards the attainment of something more important); the human physical or biological entity (which includes the retarded and the comatose) is sufficient so as to qualify as human life, and therefore the right to life should aim at the protection thereof. Therefore, the right to life is often described as the most fundamental human right, particularly on account of its intrinsic worth. Because of its substantive importance, foreign law as well as international and regional human rights instruments undertake to protect the sanctity and value of human life, which is, in turn, inextricably connected to human dignity. It is precisely the medical practitioner's sense of the intrinsic worth of the innocent life of the patient who wants to be euthanised that feeds such a medical practitioner's conscientious objection against terminating the life of such a patient. In

fact, it is the sense of human dignity radiating from the patient that forms part of the medical practitioner's sense of abhorrence towards administering euthanasia. Bearing the above in mind, human life remains intrinsically of importance, which, in turn, enhances the argument in opposition to many forms of euthanasia due to a deep-seated respect towards the protection of innocent human life.

In South Africa, and as indicated, in many parts across the world, religious objections are raised against the development of euthanasia legislation, particularly in light of the often-perceived flippant attitudes of States and non-objecting medical practitioners in nations practising euthanasia. The freedom of religious practices in many democratic and plural societies are often negated due to a secular detestation of anything religious in the public sphere. However, it has been confirmed that religion performs invaluable functions in society; it provides an avenue for individuals to establish, in accordance with their frame of reference, fundamental values necessary for not only their full development, but also for their *flourishing* in social settings, which also bodes well for the good of the community in general. In fact, all foundational beliefs, not only those that are religious, play a fundamental role in the human-inclined quest towards finding meaning and freedom in life. Religion provides the platform for religious believers to express their conception and meaning of life, and urges personal development, as the adherent is encouraged to reach the conclusion as to why he, as an individual, matters in the greater (cosmological) picture; and any idea not part and parcel of this greater picture is foreign to the religious adherent and therefore incompatible with his particular worldview. This gains in added meaning when taking cognisance of the matter at hand, namely the intentional termination of innocent life. As alluded to earlier, this greater picture is not only limited to the traditional understanding of the right to religious freedom, because it has been argued earlier that this right does not only refer to religion *per se*, but also includes foundational non-religious beliefs and opinions. The right to freedom of religion is fundamental in nature precisely because it guarantees the freedom to harbour any convictions vital to an individual's personal understanding of his place and purpose in life, and to concurrently manifest those views publicly and privately, either individually or in association with others. However, this does not mean that religious individuals are given free rein to conduct themselves as they please due to the fact that the maintenance and protection of the public order remains important. Emanating from religious convictions is the believer's conscience which directs him to partake in activities (whether by commission or omission) that

are morally qualified, hereby satisfying the loyal sense of obligation that the believer has in his relationship with the Divine.

A prevalent aspect examined was the concept of personal autonomy, which emphasised the understanding that the individual's free will and ability to make independent, responsible choices to the individual's benefit, is of importance and consequently deserving of protection. The principle behind personal autonomy is the inviolability of the individual; no one, least of all the State, may dictate the choices made by an individual, which is why, as the argument goes, a choice to terminate life (in the event of a terminal disease, pain and suffering as well as loss of enjoyment and purpose) should be honoured. These arguments teach that any individual should be allowed to make decisions that would be, from his perspective, in his best interest, particularly if deeply layered, *socially contentious* moral dilemmas are involved – thereby emphasising, together with the aforementioned argument, the importance of true autonomous conduct. This is inextricably related to a view that distinguishes between the mind and the body; between the intellect and experience and the biological composition of the person. As argued in this study, this approach is indicative of a diminished respect toward innocent human life. For the medical practitioner, the person is a human being based on the inherent sanctity of human biological life, irrespective of the state of the mind or its wants. Therefore, for example, the senile, the elderly, the person with Down's syndrome, the comatose and those born with a defective brain (no matter to what degree) ought to be regarded as human life, which should qualify for protection, especially when innocent.

This in turn, necessitates an analysis of the right to freedom of religion and the implications of this for matters related to conscientious objection. Freedom of religion, as well as the protection thereof, are vital in a society proclaiming itself to be open and democratic, as well as based on human dignity, equality and freedom. In this regard, human dignity is to be understood as that which is in accordance with the foundational belief of the believer. In this regard, the believer, in his innermost being, connects with an importance, which surpasses the State, hereby finding himself in a relational experience with that which provides utmost meaning and purpose and to which such a believer committedly responds to under the direction of the conscience. Compelling a person to abandon his religious convictions, to assist another to do something, which is in his eyes abhorrent, constitutes a grave infringement on the inherent dignity of such a person. Such a person should not be treated as a mere means to an end. By becoming a medical practitioner, he did not agree to set aside those aspects of his inherent dignity such as

the ability to make informed decisions about himself, or the right to embrace certain convictions, religious or otherwise. From the believer's religious convictions, he finds his inherent worth and meaning, and therefore his inherent human dignity. An individual's right to freedom of religion is a fundamental human right. It is a dignitary trait, characteristic of a truly free human being – an understanding that was recognised by the South African judiciary in *Christian Education* when it emphasised that religion affords an individual the opportunity to be who he wants to be, without subjecting himself to the cultural or religious pressures of others.⁶⁴⁷ In other words, this means that an individual is offered the opportunity to determine for himself whether he harbours particular religious concerns, and then be offered the freedom to act in accordance with his choice. In this lies the beauty of the right to freedom of religion: what the believer ends up believing is his own concern, provided that it possesses a substantive level of sincerity and concern on the part of the believer.

According to *Eweida* when relying on the right to freedom of religion, a certain standard of 'minimum requirements' should objectively be met: It should not be a mere trivial dilemma and it should be a serious matter based on a fundamental problem.⁶⁴⁸ A fundamentally important aspect accompanying a claim for the protection of religious belief in this regard is the sincerity test. For example, the question before the court in *Eweida* revolved around a small, seemingly insignificant piece of jewellery. However, as simple or absurd as the jewellery could have appeared to others, to its wearer it constituted significant religious significance. Although the crucifix was not a prescribed religious tenet, it provided her with a means of sincerely expressing her religious devotion. The same could be said in *Pillay*. Although the wearing of a nose ring was neither a religious or culturally prescribed custom, it nevertheless provided sincere significance to its wearer. This sincere religious understanding is vitally significant as it serves as a precursor to understanding other interrelated rights, such as human dignity and personal autonomy.⁶⁴⁹ Human dignity is considered by some to serve as the foundation upon which all other rights are built, while others consider the right to dignity as a concept substantiating a particular given set of circumstances, the outcome of which will be dependent

⁶⁴⁷ *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC), par. 24.

⁶⁴⁸ *Eweida and Others v. The United Kingdom* [2013] ECHR 37.

⁶⁴⁹ *MEC for Education: KwaZulu-Natal and Others v Pillay* 2008 (1) SA 474 (CC), par. 17: "It highlighted... the demeaning effect of denying Sunali's religion — and hence her identity — and the systemic nature of the discrimination."

on the context at hand.⁶⁵⁰ South African jurisprudence recognises the right to dignity as one of the *Constitution of the Republic of South Africa's* fundamental values as it gives substance to "... many, possibly all, other rights."⁶⁵¹ But human dignity goes even further by emphasising human dignity as the value underpinning the inherent worth of any human being. It highlights the human being as an end in itself, not a mere means to an end. Therefore, where rights such as religion, privacy and personal autonomy affords certain freedoms, human dignity is invoked to substantiate *why* these freedoms matter, and these freedoms, in the present instance, uniquely matter to the medical practitioner because they are informed by his sincere convictions on a substantive topic namely the intentional termination of innocent life.

Any choice made by the medical practitioner pertaining to the non-administering of euthanasia will, according to such a practitioner's personal understanding, have some or other eternal consequence – as alluded to earlier, he harbours this understanding as a fundamental part of his existence; every choice made is made by bearing in mind these eternal consequences. Therefore, his human dignity and his worldview is inseparably linked through his religious views. It becomes a relational experience culminating to the basis upon which his individuality, personhood and identity is built; it is who he has developed into as a human being, and as a human being, he carries the conception that as an earthly human being, he is bound by the laws of the State, but as a dignified creature in terms of his religious views, he is bound by no State, but by God, and it is not from the State from which his dignity emanates, but from God.⁶⁵² This is why sincerity is of such importance. Indeed, religious adherents are well aware that they ought to "render unto Caesar the things that are Caesar's"⁶⁵³ but they do so knowing full well that such a Divine command in itself is subject to God's law.⁶⁵⁴

Christianity, for example, provides many examples where the laws of the State are accorded its rightful place in society, but the only exception is clearly indicated: obedience to the State

⁶⁵⁰ Davis J contends that the courts have rendered dignity as "a piece of jurisprudential Legoland – to be used in whatever form and shape is required by the demands of the judicial designer." D. M. Davis, "Equality: The majesty of Legoland jurisprudence", *South African Law Journal*, Vol. 116(1999), 413.

⁶⁵¹ *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others*, par. 35.

⁶⁵² I. T. Benson, *An associational framework for the reconciliation of competing rights claims involving freedom of religion*, (Unpublished PhD thesis, University of the Witwatersrand, 2013).

⁶⁵³ Mark 12: 17; Romans 13: 1-7, ESV (English Standard Version), (Wheaton: Crossway, 2001).

⁶⁵⁴ Mark 12: 17 continues by stating that: "... and to God the things that are God's", ESV.

cannot come at the price of obedience to God.⁶⁵⁵ By choosing to obey his religious precepts as opposed to those the adherents determines as being contrary to God's command, the medical practitioner makes a morally based judgement, which is coincidentally informed by his religious views. The question that is posed, therefore, is whether a medical practitioner may object to administering euthanasia if his refusal is based on religious grounds? At hand, the patient makes a voluntary request to be euthanised. This request is arguably in line with the principles of privacy, personal autonomy and ultimately, as argued by many, the patient's human dignity, and therefore, the expectation is that, as a service provider, the medical staff at a hospital (whether public or private) should grant such a request. Under ordinary circumstances, it is generally expected of a service provider to provide his services without discriminating on any grounds. However, even as the patient claims his rights to personal autonomy, privacy and human dignity, so too does the medical practitioner, which forms the basis of his refusal to administer euthanasia.

The medical practitioner's personal convictions (also pertaining to a sincere understanding of health care), as religiously informed, brings him to a crossroads where he has to make a moral judgement call, which compels him to object, thereby highlighting the importance of his conscience. Conscience-based medical care is vitally important for any society, and if medical practitioners are not afforded the opportunity to raise concerns regarding conscientious objection, and have these concerns respected, society would be in the truly challenging position of having medical practitioners who practise without conscience.⁶⁵⁶ This position reflects an understanding of concerns that has received much support by intellectuals writing on the subject as well as concerns emanating from societies as a whole. In essence, both patients and health care providers should be able to rely on conscience, to subjectively determine which decision would best ensure their moral welfare.⁶⁵⁷

Therefore, the religious believer is in much the same position as the patient. The practitioner objects to euthanasia, basing his refusal on a fundamentally important component to free religious exercise: his conscience (and related rights). In other words, the objecting medical

⁶⁵⁵ Acts 4: 19-20: "But Peter and John answered them, 'Whether it is right in the sight of God to listen to you rather than to God, you must judge, for we cannot but speak of what we have seen and heard'; Acts 5: 19: "But Peter... answered, 'We must obey God rather than men'"; 1 Samuel 15: 22-23.

⁶⁵⁶ C. Lamb, "Conscientious objection: Understanding the right of conscientious objection in health and healthcare practice", *The New Bioethics*, Vol. 22, 1(2016), 39.

⁶⁵⁷ Lamb, "Conscientious objection: Understanding the right of conscientious objection in health and healthcare practice", 40.

practitioner refuses to participate in a deed toward which he inherently harbours dissent on account of conflicting religious and moral prescriptions. It has been clearly discussed that these prescriptions are anchored in his religious beliefs or ethical convictions, which warrant specific protection because it is from these religious norms that he finds his identity as a unique, rational human being. As an individual, the practitioner consciously undertook to obey his religious precepts, and to construct every aspect of his life in line with such precepts. These precepts govern his daily conduct and any social interactions, and through such conduct, establish within the practitioner a sense of spiritual fulfilment and sense of purpose. In light of this unique character or identity and sense of purpose, compelling him to commit an act he is inherently opposed to, shatters his self-worth. Without any prejudice, the choice before him is exceptionally dire. Persecution and religion often go hand in hand, and it would appear that even in the medical field, persecution could become a reality. Added to this is the understanding that the intentional termination of innocent life is not a trivial matter whether you are religious or non-religious. Human life, as argued, constitutes an inherent good and therefore the intentional termination of innocent life (even when requested to do so by the person who wants to die himself) is in opposition to not only the dictates of many religions but also to the dictates of universal morality.

It was confirmed at the outset of this study that the premise of this study is founded on the possibility that active euthanasia and physician-assisted suicide will become legalised in South Africa (note that passive euthanasia is legal in South Africa). In the event of legislation being promulgated pertaining to the legalisation of euthanasia, such legislation will have to include a conscientious objection clause, which protects the interests of the medical practitioner who may want to be excluded from the administering of the forms of euthanasia that were clarified in Chapter Two of this study. This clause should provide the medical practitioner, whether such practitioner is a medical doctor, a nurse, a pharmacist or any other person involved in the process of administering of euthanasia (whether directly or indirectly) upon request, the option to refuse participation, if such refusal is based on sincerely held beliefs, including beliefs founded on religious grounds. As discussed earlier, the rights to life and dignity are deeply involved in the scenario sketched. These rights influence the medical practitioner in the choices he has to make. On the other hand, the patient who wishes to die, also may call upon the protection of certain rights, such as the right to dignity and even privacy. Therefore, in order to ascertain whether the proposition set forth that medical practitioners have the right to conscientiously object to administering euthanasia in light of their religious convictions, the

limitation clause was thoroughly examined so as to assist in the determination whether the rights of the medical practitioner (in this case) may be reasonably and justifiably limited. The limitation of the practitioner's religious freedom would severely affect a host of rights associated therewith, namely his right to freedom of religion, conscience, dignity and privacy. The limitation would afford patients the ability to have their lives ended, and thereby bring about the perceived peace sought. But at what cost to others? The violated conscience of the practitioner will never be at peace, which would render the limitation on his conscience cruel and unbecoming of a model democracy. In addition thereto, and on a secondary level, the ever-ailing public health care system is not in a position to dictate to medical practitioners the manner in which they are to conduct their conscientious affairs with specific relevance to the intentional termination of innocent human life. In addition, the exodus of qualified personnel from South Africa will only increase if the State presumes to dictate on matters related to substantive matters regarding the conscience.

In conclusion, this study argues in support of the medical practitioner who objects against the administering of euthanasia based on religious conviction; to the true believer such a choice is the expression of a deeply intimate relationship between himself and his Deity. He commits the entirety of his being to that which he worships, meaning that he subjects his freedom, his privacy, his dignity and most importantly, his life, to the precepts of his religious belief. The promise of reward is always unmatched by earthly ideal, and refusal is out of the question. If this is understood it would make sense why so many across the world are often willing to destroy their own bodies, or to suffer severe humiliation and scorn because of their religious beliefs. This emphasises why it would be an exceptionally unwise decision of the State to blatantly require all medical practitioners to administer euthanasia upon request. Sincere medical practitioners would not hesitate to violate the law and refuse such a request; they would rather choose to face the consequences of their refusal than to act against their religious conscience. If a practitioner were to be required to set aside his own personal and sincere convictions that influence every aspect of his existence, with the end of enabling a patient to end his own life, can this amount to an envisioned free and democratic society? Is a society truly free and democratic if foreseeable, agonising choices that influence priceless eternal sentiment of not only practitioners, but also of individuals of all walks of life, are posed in such a way that submission to the will of the State will be enforced through legislation with no room of escape? Of course, as was discussed, many other instances exist where the free will of individuals are suppressed by State authority. It would suffice to indicate that the religious

practitioner in this regard is not obstructing the order of society, but in fact, promotes the importance and sanctity of human life. From the religious perspective, Melody Rose neatly summarises the practitioner's perspective, which has been made abundantly clear up until this stage:

It is never lawful, even for the gravest reasons, to do evil that good may come of it – in other words, to intend directly something which of its very nature contradicts the moral order, and which must therefore be judged unworthy of man, even though the intention is to protect or promote the welfare of an individual... or of society in general.⁶⁵⁸

It is therefore submitted, in no unclear terms, that the exclusion of the rights of medical practitioners in the euthanasia debate would be draconian, undemocratic as well as anti-pluralist, and cannot have any place in a society founded on the principles of freedom, human dignity and equality. Therefore, should active euthanasia (and physician-assisted suicide) be legalised in South Africa,⁶⁵⁹ a clause ought to be submitted in the corresponding legislation that would cater to the needs of medical practitioners who may be troubled by their conscience, even as the needs of the patients are being addressed. This would best give effect to the values enshrined by the *Constitution of the Republic of South Africa*, as it had been indicated that both the practitioners and the patients rely on many of the same fundamental rights. Also, this study argues for the protection of the medical practitioner who conscientiously objects against the administering of euthanasia in a passive sense as well.

To effect the rights of the practitioner in its totality efficiently, such a conscientious objection clause should be included in proposed legislation, but such a clause should not only afford the practitioners the opportunity to refuse to act in accordance with the patient's request, but also include the unique possibility that a practitioner, unlike the practitioners in other jurisdictions, may refuse to direct the patient to another medical practitioner. Referring a patient to another non-objecting medical practitioner often also conflicts with his views, even to such an extent that he considers himself complicit to the ensuing death. This is why the proposed 'Roll of Non-Objecting Physicians' would be such a useful addition to the debate, as this roll would allow practitioners to voluntarily indicate their preference. Not only would the practitioner's

⁶⁵⁸ M. Rose, *Abortion: A Documentary and Reference Guide*, (Westport: Greenwood Press, 2008), 59.

⁶⁵⁹ Note that passive euthanasia is legal in South Africa.

position be made clear, but it would also allow the patient to access an alternative option easily if the attending physician rejected his request. The roll could be subject to the scrutiny and knowledge of the Minister of Health, who could include additional requirements, such as requiring non-objecting medical practitioners to undergo a certification course authorising them to administer euthanasia as qualified practitioners. It is recommended that this roll be displayed at *all* hospitals and clinics across South Africa, with the relevant contact information of the non-objecting medical practitioners, as this would be an efficient way to ensure that the fundamental rights of patients are equally catered to.

Having argued for the protection of the medical practitioner's right, based on his religious conviction, to object against the administering of euthanasia (and to partake in any related referral action), it is proposed that a clause in support of the medical practitioner's right to conscientiously object against the administering of euthanasia (or to make a related referral) be included in legislation that supports the administering of euthanasia against the background of the legislative approaches taken in for example, the Netherlands and Belgium.⁶⁶⁰ In this regard, the following wording is proposed, having taken Britain's *Assisted Dying for the Terminally Ill Bill*⁶⁶¹ and the *Assisted Dying Bill*⁶⁶² (which was drafted after *the Assisted Dying for the Terminally Ill Bill*) as a guide:

No person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any diagnosis, treatment, omission of treatment or other action authorised by this Act⁶⁶³ to which he has a conscientious objection. If an attending physician whose patient makes a request to be assisted to die in accordance with this Act or to receive pain relief in terms of this Act has a conscientious objection as referred to earlier, he shall not be responsible for ensuring that the patient is referred to an attending physician who does not have such a conscientious objection.

This study has confirmed that a convincing argument exists in support of the accommodation of the exemption of medical practitioners (both in the public and private health care milieu) from administering (whether directly or indirectly) euthanasia in instances where such

⁶⁶⁰ See Chapter Two for more on these approaches.

⁶⁶¹ *Assisted Dying for the Terminally Ill Bill* HL Bill 17.

⁶⁶² *Assisted Dying Bill* HL Bill 24.

⁶⁶³ By "Act" is assumed euthanasia legislation of the type reflected in the Netherlands and Belgium, bearing in mind the possible differences there may be between such legislation and, if South Africa were to go this route, legislation legalising euthanasia in South Africa.

practitioners express a conscientious objection based on a sincere and substantive religious conviction. This is of specific relevance to the South African context although not exclusively, as it is expected from any democratic society that prides itself on the protection and furtherance of human dignity, freedom and diversity to be tolerant towards those who vehemently oppose the intentional termination of innocent human life, even where the person whose life may be terminated, requested such termination. A number of States around the world have legalised euthanasia practices within the health care paradigm, and there are also developments in other States slanting towards the legalisation of euthanasia. It is most certainly not a far-fetched probability that the legalisation of euthanasia may well become a reality in South Africa. These developments and possibilities call for the accommodation of the right of a medical practitioner to conscientiously object against the administering of euthanasia. As argued in this study, the nature of, and inextricable relationship between, the rights to: life, human dignity, religion and conscience as well as the autonomy of the person, undoubtedly qualify the protection of the medical practitioner's choice to not participate (in any manner whatsoever) in the administering of euthanasia. This in turn contributes to the furthering of the protection afforded by the right to freedom of religion, which in turn adds to the progression towards higher levels of plurality within democratic societies.

Bibliography

AHDAR R & LEIGH I

2013. *Religious Freedom in the Liberal State*, Oxford: Oxford University Press.

ALLEN WL & BRUSHWOOD DB

1996. "Pharmaceutically assisted death and the pharmacist's right of conscience", *Journal of Pharmacy & Law*, Vol. 5(1): 1-18.

ARAUJO RJ

2007. "Conscience, totalitarianism, and the positivist mind", *Mississippi Law Journal*, Vol. 77: 571-621.

ARTHURS H

2001. "The re-constitution of the public domain" in D. Drache (ed.) *The Market or the Public Domain? Global Governance and the Asymmetry of Power*, London: Routledge.

BAKLINSKI T

2015. "Dutch pediatricians: Allow euthanasia for children under 12", *LifeSiteNews*, 22 June 2015. www.lifesitenews.com/news/dutch-paediatricians-allow-euthanasia-for-children-under-12 (Accessed on 30 September 2017).

BALBONI A, BALBONI M & ENZINGER A

2013. "Provision of spiritual support to patients with advanced cancer and religious communities and associations with medical care at the end of life", *JAMA Intern Med.*, 173(12): 1109-1117.

BALL H

2002. *The Supreme Court in the Intimate Lives of Americans: Birth, Sex, Marriage, Childbearing, and Death*. New York: New York University Press.

BECKWITH FJ & GEISLER N

1991. *Matters of Life and Death. Calm Answers to Tough Questions about Abortion and Euthanasia*. Grand Rapids: Baker House Books.

BENSON IT

2013. *An associational framework for the reconciliation of competing rights claims involving the freedom of religion*, (Unpublished PhD thesis, University of the Witwatersrand).

2013. "Seeing through the secular illusion", *Nederduitse Gereformeerde Teologiese Tydskrif*, Vol. 54(4):12-29.

2013. "Religious interfaith work in Canada and South Africa with particular focus on the drafting of a South African Charter of Religious Rights and Freedoms", *HTS Teologiese Studies/Theological Studies*, Vol. 69(1): 1-13.

2008. "Physicians, patients, human rights, and referrals: A principled approach to respecting the rights of physicians and patients in Ontario", *Cardus*.

www.cardus.ca/organization/news/625/physicians-patients-human-rights-and-referrals-a-principled-approach-to-respecting-the-rights-of-physicians-and-patients-in-ontario/ (Accessed on 15 October 2017).

BERESFORD S

n.d. "Euthanasia, the right to die and the Bill of Rights Act", *Human Rights Research* (Online), Vol. 3(3): 1-24.

BERGER BL

2007. "Law's religion: Rendering culture", *Osgoode Hall Law Journal*, Vol. 45(2): 277-314.

BERNHEIM J, DESCHEPPER R & DISTELMAN W

2008. "Development of palliative care and legislation of euthanasia: Antagonism or synergy? ", *British Medical Journal*, Vol. 336(7649): 864-867.

BIJ DE VAATE I

2014. "Levensbeëindiging bij pasgeborenen: Een heroverweging", *Wetenschappelijk Bijdragen*: 57-82.

BORK RH

1990. *The Tempting of America: The Political Seduction of the Law*. New York: Touchstone, Simon & Schuster Inc.

BROCK DW

1992. "Voluntary active euthanasia", *Hastings Center Report*, Vol. 22(2): 10-22.

BROUDE AM

1987. "Pain control in terminal illness", *South African Medical Journal*, Vol. 72(8): 540-543.

BUDZISZEWSKI J

1999. *The Revenge of Conscience: Politics and the Fall of Man*. Dallas: Spence Publishing Company.

Brief of amicus curiae J. Budziszewski in support of plaintiff/appellant in the case of Sandra Cano v. Thurbert E. Baker, No. 05-11641-HH.

CHADWICK R

2007. *The bioethics reader: Editors' choice*. Malden: Blackwell Publishers.

CHAMBERLAIN K

2009. "Looking for a 'good death'", *The Elder Law Journal*, Vol. 17: 61-93.

CHAO DVK, CHAN NY & CHAN WY

2002. "Euthanasia revisited", *Family Practice*, Vol. 19(2): 128-134.

CHARO RA

2005. "The celestial fire of conscience - Refusing to deliver medical care", *The New England Journal of Medicine*, Vol. 352(24): 2471-2473.

CHASKALSON A

2000. "Human dignity as a foundational value of our constitutional order", *South African Journal of Human Rights*, Vol. 16(2): 193-205.

CHOCHINOV H

2006. "Dying, dignity, and new horizons in palliative end-of-life care", *CA: A Cancer Journal for Clinicians*, 56(2): 84-103.

CICA N

1996-1997. *Euthanasia – the Australian Law in an International Context. Part 2: Active Voluntary Euthanasia*. Research Paper, Parliament of Australia.

CLARKE D & EGAN A

2009. "Euthanasia - Is there a case? ", *South African Journal of Bioethics and Law*, Vol. 2(1): 23-27.

CLIFFORD M & HUFF T

2000. "Some thoughts on the meaning and scope of the Montana Constitution's 'Dignity' clause with possible applications", *Montana Law Review*, Vol. 61(2): 301-336.

COHEN A & WELLMAN C (eds.)

2005. *Contemporary Debates in Applied Ethics*. Malden: Blackwell Publishers.

COHEN-ALMAGOR R

2015. "First do no harm: Shortening lives of patients without their explicit request in Belgium", *Journal of Medical Ethics*, Vol. 41(8): 625-629.

CRAVEN JB

1976. "Personhood: The right to be let alone", *Duke Law Review*, Vol. 1976: 699-720.

CURRIE I & DE WAAL J

2005. *The Bill of Rights Handbook*, (5th Ed.). Claremont: Juta.

DAVIS DM

1999. "Equality: The majesty of Legoland jurisprudence", *South African Law Journal*, Vol. 116: 398.

DE BONDT W

2003. "The new Belgian legislation on euthanasia", *International Trade and Business Law Review*, Vol. 12(8): 301-310.

DE FREITAS S

2011. "Freedom of conscience, medical practitioners and abortion in South Africa", *International Journal for Religious Freedom (IJRF), Advocacy and the Law*, Vol. 4(1): 75-85.

2013. "Religious associational rights and sexual conduct in South Africa: Towards the furtherance of the accommodation of a diversity of beliefs", *Brigham Young University Law Review*, Vol. 2013(3): 421-456.

DE VILLIERS E

2002. "Euthanasia and assisted suicide: A Christian ethical perspective", *Acta Theologica Supplementum* 3, Vol. 22(2): 35-65.

DE VRIES U

2004. "A Dutch perspective: The limits of lawful euthanasia", *Annals of Health Law*, Vol. 13(2): 365-392.

DU PLESSIS JV & FOUICHE MA

2015. *A Practical Guide to Labour Law*. Durban: LexisNexis South Africa (Eighth Ed.).

DWORKIN R

1977. *Taking Rights Seriously*. Cambridge: Harvard University Press.

1993. *Life's Dominion: An Argument about Abortion and Euthanasia*. London: Harper Collins.

EGAN A

2008. "Should the state support the 'right to die'?", *South African Journal of Bioethics and Law*, Vol. 1(2): 47-52.

EMANUEL E

1997. "Whose right to die?", *The Atlantic*, March 1997. <https://www.theatlantic.com/magazine/archive/1997/03/whose-right-to-die/304641/> (Accessed on 24 March 2016).

FEINBERG J

1986. *Harm to Self*. New York: Oxford University Press.

FINNIS JM

1993. "The 'value of human life' and 'the right to death': Some reflections on Cruzan and Ronald Dworkin", Hiram H. Lesar Distinguished Lecture, 24 September 1992, *Southern Illinois University Law Journal*, Vol. 17: 559-571.

1998. "Euthanasia, Morality, and Law", (Fritz B. Burns Lecture, Loyola Law School, Los Angeles, 22 November 1996), *Loyola of Los Angeles Law Review*, Vol. 31: 1123-1145.

2011. *Human Rights and Common Good, Collected Essays: Vol. 3*. Oxford: Oxford University Press.

FISHER A

2012. *Catholic bioethics for a new millennium*, Cambridge: Cambridge University Press.

FISK S

1998. "The last place to die", *Montana Law Review*, Vol. 59(2): 301-341.

FOOT P

1977. "Euthanasia", *Philosophy and Public Affairs*, Vol. 6(2): 85-112.

FRANKOWSKI S

1987. "United States of America", in S. J. Frankowski & G. F. Cole (eds.), *Abortion and Protection of the Human Fetus*. Dordrecht: Martinus Nijhoff Publishers.

GARRARD E & WILKINSON S

2005. "Passive euthanasia", *Journal of Medical Ethics*, Vol. 31(2): 64-68.

GAVINSON R

1980. "Privacy and the limits of the law", *Yale Law Journal*, Vol. 89(3): 421-471.

GENUIS S & LIPP C

2013. "Ethical diversity and the role of conscience in clinical medicine", *International Journal of Family Medicine*, Vol. 2013: 1-18.

GEORGE RP

2001. *The Clash of Orthodoxies. Law, Religion, and Morality in Crisis*. Wilmington: ISI Books.

2006. "Terminal Logic", *Touchstone*, March 2006.

2013. *Conscience and its Enemies. Confronting the Dogmas of Liberal Secularism*. Wilmington: ISI Books.

GEORGE RP & PORTH, Jr W

1995. "Death, be not proud", *National Review*, 26 June 1995.

GIESEN D

1995. "Dilemmas at life's end: A comparative legal perspective" in J. Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, Cambridge: Cambridge University Press.

GRILLO R (ed.)

2009. *Legal Practice and cultural diversity*. Farnham: Ashgate.

HAIGH R & BOWAL P

2012. *Whistleblowing and Freedom of Conscience: Towards a New Legal Analysis*, Osgoode Centre for Professional Legal Education (CLPE). Research Paper.

HALEY JN

1974. "Haunting shadows from the rubble of *Roe's* right of privacy", *Suffolk University Law Review*, Vol. 9: 145-148.

HAWTHORN A

n. d. *Submission Against Legalisation of Physician-Assisted Suicide and Euthanasia*, Submission 787.

HERDERSCHEË G

2015. "Kinderartsen: 'Sta lijdend kind euthanasie toe'", *De Volkskrant*, 19 June 2015. www.volkskrant.nl/binnenland/kinderartsen-sta-lijdend-kind-euthanasie-toe~a4082152/ (Accessed on 10 November 2017).

HORAN DJ & BALCH TJ

1987. "Roe v. Wade: No justification in history, law or logic", in D. J. Horan, E. R. Grand & P. C. Cunningham (eds.), *Abortion and the Constitution: Reversing Roe v. Wade Through the Courts*. Washington D.C.: Georgetown University Press.

HURWITZ PJ, PICARD J & STEINBERG A (eds.)

2006. *Jewish Ethics and the Care of End-of-Life Patients*. Jersey City: KTAV Publishing House Inc.

JACKSON JA

2003. "The ethics and legality of euthanasia and physician assisted suicide", *University of Tennessee Honors Thesis Projects*, 5-2003.

JOCHEMSEN H & KEOWN J

1999. "Voluntary euthanasia under control? Further empirical evidence from the Netherlands", *Journal of Medical Ethics*, Vol. 25(1): 16-21.

JOHNSON V

1990. "The French Declaration of the Rights of Man and of Citizens of 1789, the Reign of Terror, and the Revolutionary Tribunal of Paris", *Boston College International & Comparative Law Review*, Vol. 13(1): 1-45.

KHAN A

2015. "The concept and psychological effects of sin in Islam", *Asian Journal of Social Sciences & Humanities*, Vol. 4(1):186-191.

KAMISAR Y

1995. "Physician assisted suicide: The last bridge to active voluntary euthanasia", in J. Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, Cambridge: Cambridge University Press.

KANT I

1997. *Lectures on Ethics*. Cambridge: Cambridge University Press.

KEOWN J

1998. "The legal revolution: From 'sanctity of life' to 'quality of life' and 'autonomy'", *Journal of Contemporary Health Law and Policy*, Vol. 14(2): 253-285.

2002. *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*. Cambridge: Cambridge University Press.

2004. *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*. Cambridge: Cambridge University Press.

KIRBY M

2009. "Law, human rights and religion: Of genocide, sexuality and apostasy", *Macquarie Law Review*, Vol. 9: 1-33.

KLEIN S

1994. "The right to die as an issue of privacy: A selective bibliography", *Journal Articles*, Paper 1150.

KOPPELMAN A

2009. "Conscience, volitional necessity, and religious exemptions", *Legal Theory*, Vol. 15(3): 215-244.

KREULEN E

2018. "Euthanasie bij wilsonbekwame dementiepatiënten is niet te verdedigen", *Trouw*, 13 January 2018. <https://www.trouw.nl/samenleving/-euthanasie-bij-wilsonbekwame-dementiepatiënten-is-niet-te-verdedigen-~a70bdd45/> (Accessed on 15 January 2018.)

LAMB C

2016. "Conscientious objection: Understanding the right of conscientious objection in health and healthcare practice", *The New Bioethics*, Vol. 22(1): 33-44.

LANDMAN WA

2012. *End-of-life Decision, Ethics and the Law: A Case for Statutory Legal Clarity and reform in South Africa*. Pretoria: Ethics Institute of South Africa.

LINDEMANN H & VERKERK M

2008. "Ending the life of a newborn: The Groningen Protocol", *Hastings Center Report*, Vol. 38(1): 42-51.

LITZ B, STEIN N & DELANEY E

2009. "Moral injury and moral repair in war veterans: A preliminary model and intervention strategy", *Clinical Psychology Review*, Vol. 29(8): 695-706.

MacKINNON B & FIALA A

2015. *Ethics: Theory and Contemporary Issues* (9th Ed.). Boston: Cengage Learning.

MALHERBE R

2002. "The constitutionality of government policy relating to the conduct of religious observances in public schools", *Journal of South African Law*, Vol. 3: 391-418.

MALHERBE R & VENTER R

2011. "Die reg op lewe, die waarde van menslike lewe en die eutanisie-vraagstuk (The right to life, the value of human life and the question related to euthanasia)", *Journal of South African Law*, Vol. 2011(3): 466-495.

MASON R

2015. "Assisted dying bill overwhelmingly rejected by MPs", *The Guardian*. 11 September 2015. <https://www.theguardian.com/society/2015/sep/11/mps-begin-debate-assisted-dying-bill> (Accessed on 30 September 2017).

McDOUGAL MS, LASWELL HD & GHEN L

1975. "The protection of respect and human rights: Freedom of choice and world public order", *The American University Law Review*, Vol. 24: 919-1086.

McCLAIN L

1995. "Inviolability and privacy: The castle, the sanctuary, and the body", *Yale Journal of Law and the Humanities*, Vol. 7(1): 195-241.

McCORMACK P

1998. "Quality of life and the right to die: An ethical dilemma", *Journal of Advanced Nursing*, Vol. 28(1): 63-69.

McCRUDDEN C

2008. "Human dignity and judicial interpretation of human rights", *The European Journal of International Law*, Vol. 19(4): 655-724.

McMINN M, RUIZ J & MARX D

2006. *Professional psychology and the doctrines of sin and grace: Christian leaders' perspective*. Graduate School of Clinical Psychology, Faculty Publications, Paper 170.

McQUOID-MASON DJ

2015. "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", *South African Journal of Bioethics and Law*, Vol. 8(2): 34-40.

MOSS Z

2013. Dignity in Dying, 10 April 2013. <http://www.dignityindying.org.uk/blog/assisted-dying-not-assisted-suicide/> (Accessed on 13 September 2016).

n.a.

1996. "The Kevorkian verdict: A chronology", *Frontline*, May 1996. <http://www.pbs.org/wgbh/pages/frontline/kevorkian/chronology.html> (Accessed on 16 September 2016).

n.a.

2016. "SA's shortage of medical doctors – A bleak picture", *Medical Brief*, 19 October 2016. <https://www.medicalbrief.co.za/archives/sas-shortage-medical-doctors-bleak-picture/> (Accessed on 17 October 2017).

n. a.

2017. "Nurse who refuses to administer euthanasia to her patients is forced to resign", *Généthique*, 7 July 2017. <http://www.genethique.org/en/nurse-who-refuses-administer-euthanasia-her-patients-forced-resign-67917.html#.WonLK6iWaUk> (Accessed on 10 February 2018).

n. a.

2018. "Medically assisted dying in Ontario: Limited conscientious objection for doctors", *Généthique*, 9 February 2018. <http://www.genethique.org/en/medically->

assisted-dying-ontario-limited-conscientious-objection-doctors-69162.html#.WonA56iWaUk (Accessed on 10 February 2018).

NICOL J & TIEDEMANN M

2015. *Euthanasia and Assisted Suicide: The Law in Selected Countries*. Ottawa: Library of Parliament.

NILES C

2015. “Colombian bishops threaten to shut down hospitals”, *Church Militant*. 29 April 2015. www.churchmilitant.com/news/article/Colombian-Bishops-Threaten-to-Shut-Down-Hospitals (Accessed on 19 July 2017).

NOVAK D

2007. *The Sanctity of Human Life*. Washington D.C.: Georgetown University Press.

NYST E

2018. “Een wilsverklaring kan een mondeling verzoek niet vervangen – Ethicus stapt uit de toetsingscommissie euthanasie”, *Medisch Contact*. 10 January 2018. <https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/een-wilsverklaring-kan-een-mondeling-verzoek-niet-vervangen.htm> (Accessed on 10 January 2018).

O'MEARA J

1974. “Abortion: The court decides a non-case”, *The Supreme Court Review*, Vol. 1974: 337-360.

PATERSON C

2008. *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach*. Burlington: Ashgate Publishing Company.

PAVLOVIC D, SPASSOV A & LEHMANN C

2011. “Euthanasia: In defence of a good, ancient word”, *Journal of Clinical Research and Bioethics*, Vol. 2(1): 1-5.

PELLEGRINO ED

2002. “The physician’s conscience, conscience clauses, and religious belief: A Catholic perspective”, *Fordham Urban Law Journal*, Vol. 30(1): 221-244.

POLANYI M

1958. *Personal Knowledge: Towards a Post-Critical Philosophy*. London: Routledge.

POPE JOHN PAUL II

1995. *Evangelium Vitae* (To the Bishops, Priests and Deacons, Men and Women, religious lay Faithful and all People of Good Will on the Value and Inviolability of Human Life), 25 March 1995.

PRETORIUS JL, KLINCK ME & NGWENA CG

2012. *Employment Equity Law*, Durban: LexisNexis South Africa Chapter 7 – “Reasonable Accommodation”, 1-58.

PROSSER W

1960. "Privacy", *California Law Review*, Vol. 48(3): 383-423.
- RAUTENBACH IM
 2014. "Proportionality and the limitation clauses of the South African Bill of Rights", *Potchefstroomse Elektroniese Regsblad*, Vol. 17(6): 2229-2267.
- ROSE M
 2008. *Abortion: A Documentary and Reference Guide*. Westport: Greenwood Press.
- ROSENFELD M
 2009. "Introduction: Can constitutionalism, secularism and religion be reconciled in an era of globalization and religious revival? ", *Cardozo Law Review*, Vol. 30(6): 2333-2368.
- RUBENFELD J
 1989. "The right of privacy", *Harvard Law Review*, Vol. 102(4): 737-807.
- RUSHE D
 2011. "Dr Death' Jack Kevorkian, advocate of assisted suicide, dies in hospital", *The Guardian*. 4 June 2011. www.theguardian.com/world/2011/jun/04/dr-death-jack-kevkorkian--suicide (Accessed on 25 May 2017).
- RUSSEL R
 1976. *Freedom to die: Moral and legal aspects of euthanasia*, New York: Dell.
- SACHS A
 1990. *Protecting Human Rights in a New South Africa (Contemporary South African Debates Series)*. Cape Town: Oxford University Press.
- SCHACHTER O
 1983. "Editorial comment", *The American Journal of International Law*, Vol. 77(4): 848-854.
- SHULTZINER D
 2003. "Human dignity: Functions and meanings", *Global Jurist Topics*, Vol. 3(3): 1-21.
- SINGER P
 1991. *A Companion to Ethics*. Oxford: Blackwell Publishers Ltd.
- SLABBERT M & VAN DER WESTHUIZEN C
 2007. "Death with dignity in lieu of euthanasia", *SA Public Law*, Vol. 22(2): 366-384.
- SLOANE A
 2016. *Vulnerability and Care: Christian Reflections on the Philosophy of Medicine*. London: Bloomsbury T&T Clark.
- SMITH S
 2010. *The Disenchantment of Secular Discourse*. Cambridge and London: Harvard University Press.

SMITH WJ

2015. "The coming of medical martyrdom", *First Things*. 20 February 2015. www.firstthings.com/web-exclusives/2015/02/the-coming-of-medical-martyrdom (Accessed on 25 July 2017).

SPRING B & LARSON E

1988. *Euthanasia: Spiritual, Medical & Legal Issues in Terminal Health Care*. Portland: Multnomah.

STONESTREET J

2017. "Second thoughts on assisted suicide: Canadian doctors balk", *Breakpoint*. 15 March 2017. www.breakpoint.org/2017/03/second-thoughts-on-assisted-suicide/ (Accessed on 30 March 2017).

SUPERIOR C

1991. "Ignoring an incompetent person's constitutional right to forgo life-sustaining treatment", *Florida State University Law Review*, Vol. 19(1): 209-241.

SWEET AS & MATHEWS J

2008. "Proportionality balancing and global constitutionalism", *Faculty Scholarship Series*, Vol. 47, Paper 14: 68-141.

TORRES JHR

2015. "The right to die with dignity and conscientious objection", *Colombia Médica*, Vol. 46(2): 52-53.

VAN WYK D, DUGARD J, DE VILLIERS B & DAVIS D

1994. *Rights and Constitutionalism*. Kenwyn: Juta & Co.

VERHAGEN E & SAUER P

2005. "End-of-life decisions in newborns: An approach from the Netherlands", *Pediatrics*, Vol. 116(3): 736-739.

VERSLUIS J

2015. "Genadedood: Regter gee rede vir bevel. 'Wetsontwerp moet nou ernstig oorweeg word'", *Volksblad*, 5 May 2015.

VISCHER R

2010. *Conscience and the Common Good. Reclaiming The Space Between Person and State*. Cambridge: Cambridge University Press.

WALDRON J

2013. "Is dignity the foundation of human rights? ", *New York University Public Law and Legal Theory Working Papers*, Paper 374.

WICCLAIR MR

2011. *Conscientious Objection in Health Care: An Ethical Analysis*. New York: Cambridge University Press.

WICKS E

2010. *The Right to Life and Conflicting Interests*. Oxford: Oxford University Press.

WILLIAMS RB

2001. *An Introduction to Swaminarayan Hinduism*. Cambridge: Cambridge University Press.

WILLIAMS J, LOWY F & SAWYER D

1993. "Canadian physicians and euthanasia: 3. Arguments and beliefs", *Canadian Medical Association Journal*, Vol. 148(10): 1699-1702.

WILSON KAC

2011. "Washington woman who witnessed Jack Kevorkian's first assisted suicide recalls her friend, Janet Adkins", *The Oregonian*, 3 June 2011. http://www.oregonlive.com/pacific-northwest-news/index.ssf/2011/06/washington_woman_who_witnessed_jack_kevorkians_first_assisted_suicide_recalls_her_friend_janet_adkin.html (Accessed on 16 September 2016).

WOLHANDLER SJ

1984. "Voluntary active euthanasia for the terminally ill and the constitutional right to privacy" *Cornell Law Review*, Vol. 69(2): 363-383.

WOOLMAN S & BOTHA H

2014. "Limitations", in S. Woolman and M. Bishop (eds.), *Constitutional Law of South Africa* (2nd Ed.). Cape Town: Juta (Revision service).

YOUNG R

2015. "Voluntary euthanasia" in E. N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy*. www.plato.stanford.edu/archives/fall2015/entries/euthanasia-voluntary/ (Accessed on 12 March 2016).

ESV (English Standard Version)

2001. Wheaton, Illinois: Crossway.

Various

Ramsey Colloquium of the Institute on Religion and Public Life in New York City, "Always to Care, Never to Kill", *First Things*, February 1992. <https://www.firstthings.com/article/1992/02/006-always-to-care-never-to-kill> (Accessed on 10 January 2017).

International Instruments

African Charter on Human and Peoples' Rights.

American Convention on Human Rights.

American Declaration on the Rights and Duties of Man.

Arab Charter of Human Rights.

Convention for Protection of Human Rights and Fundamental Freedoms.

Convention on the Rights of Persons with Disabilities.

Declaration of the Rights of Man and the Citizen.

European Commission for Democracy through Law, Venice Commission: 'The principle of respect for human dignity' (UniDem Seminar in Montpellier, France, 2-6 July 1998).

European Convention for the Protection of Human Rights and Fundamental Freedoms.

European Convention on Human Rights.

International Covenant on Civil and Political Rights.

United Nations Declaration on the Elimination of all Forms of Intolerance and of Discrimination Based on Religion or Belief.

Universal Declaration of Human Rights.

World Medical Association Declaration on Terminal Illness (as revised by the World Medical Association General Assembly at Pilanesberg, South Africa, 2006).
<https://www.wma.net/policies-post/wma-declaration-of-venice-on-terminal-illness/>
(Accessed on 15 October 2017).

Legislation – including Bills and Schedules

ABX2-12 End of Life Option Act.

Assisted Dying Bill HL Bill 24.

Assisted Dying for the Terminally Ill Bill HL Bill 17.

Belgian Act on Euthanasia of 28 May 2002 (Wet Betreffende de Euthanasie).

Bill C-14.

Bill C-407.

Bill C-384.

Canadian Charter of Rights and Freedoms (Being Schedule B to the *Canada Act* 1982 (UK), 1982.

Canadian Criminal Code R.S.C. 1985 c. C-46.

Constitution of the Republic of South Africa Act 108 of 1996.

D.C. Act 21-577.

Dutch Penal Code (*Wetboek van Strafrecht*).

Employment Equity Act 55 of 1998.

Human Rights Committee, General Comment 22, Article 18 (Forty-eighth session, 1993), U.N. Doc. HRI/GEN/1/Rev. 1 at 35 (1994).

Initiative Measure No. 1000, *The Washington Death with Dignity Act*.

Interim Constitution of the Republic of South Africa Act 200 of 1993.

Labour Relations Act 66 of 1995.

Mental Capacity Act of 2005.

National Health Act 61 of 2003.

No. 39, *An Act Relating to Patient Choice and control at end of Life*.

Oregon Death with Dignity Act (Ballot Measure 16).

Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.

Proposition 106: *End of Life Options Act*.

South African Law Commission Act 19 of 1973.

South African Law Reform Commission Act 19 of 1973 (as amended by the *Judicial Matters Amendment Act* 55 of 2002).

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

Institutional Documents

Canadian Medical Association *Code of Ethics*.

Cancer Association of South Africa Fact Sheet and Position Statement on Assisted Suicide.

End of Life Care – Advance decision (living will). www.nhs.uk/Planners/end-of-life-care/Pages/advance-decision-to-refuse-treatment.aspx (Accessed on 18 September 2016)

Health Professions Council of South Africa *Guidelines for the Withholding and Withdrawing of Treatment*, Booklet 7.

Health Professions Council of South Africa *Guidelines for the Withholding and Withdrawing of Treatment*, Booklet 12.

International Association for the study of Pain. <https://www.iasp-pain.org/> (Accessed 20 September 2016).

Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG): *Code of Conduct for Physicians*.

Law Commission Report on Euthanasia and the Artificial Preservation of Life, Project 86.

Pocket Guide to South Africa. South Africa's People, 2011/2012.
http://gcis.gov.za/sites/default/files/docs/resourcecentre/pocketguide/004_saspeople.pdf (Accessed on 17 September 2017).

Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.

South African Charter of Religious Rights and Freedoms.

South African Medical Association, *Living Wills and Advance Directive*, 2012.

Statistics South Africa (2016). Statistical Release P0318: General Household Survey, 2016.
<https://www.statssa.gov.za/publications/P0318/P03182016.pdf> (Accessed on 18 October 2017).

The Termination of Life on Request and Assisted Suicide (Review Procedures) Act in practice.

World Medical Association Statement on Physician-Assisted Suicide (As reaffirmed by the 200th WMA Council Session in Oslo, Norway, April 2015).
<https://www.wma.net/policies-post/wma-statement-on-physician-assisted-suicide/>
(Accessed on 15 October 2017).

Cases

Affordable Medicines Trust and Others v Minister of Health and Others 2006 (3) SA 247 (CC).

Airedale NHS Trust v Bland: HL 4 Feb 1993.

Bartling v. Superior Court (Glendale Adventist Medical Center) (1984) [Civ. No. B007907, Court of Appeals of California, Second Appellate District, Division Five. 27 December 1984].

Bernstein v Bester No 1996 (2) SA 751 (CC).

Blencoe v. British Columbia (Human Rights Commission) 2000 SCC 44, [2000] 2 S.C.R. 307.

Bouvia v. Superior Court (Glenchur) [No. B019134, Court of Appeals of California, Second Appellate District, Division Two. 16 April 1986].

Bowers v. Hardwick 478 U.S. 186 (1986).

Burwell v. Hobby Lobby Stores, Inc. 134 S. Ct. (2014).

Carter v Canada (Attorney General) SCC 5, [2015] 1 S.C.R. 331.

Chamberlain v Surrey School Board [2002] 4 S.C.R. 710.

Christian Education South Africa v Minister of Education 2000 (4) SA 757 (CC).

Cruzan v. Director, Missouri Department of Health 497 U.S. 261 (1990).

Cruzan v. Harmon 760 S.W.2d 408 (1988).

Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others 2000 (8) BCLR 837.

De Reuck v Director of Public Prosecutions (Witwatersrand Local Division) and Others 2002 (12) BCLR 1285 (W).

Du Preez v Minister of Justice and Constitutional Development and Others (368/04, ECJ24/2006) [2006] ZAECHC 17.

Employment Division, Department of Human Resources of Oregon v. Smith 494 U.S.

Eweida and Others v. The United Kingdom [2013] ECHR 37.

Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others (CCT5/95) [1995] ZACC 13; 1996 (1) SA 984 (CC).

Fourie v Minister of Home Affairs 2005 (3) BCLR 241 (SCA).

Griswold v. Connecticut 381 U.S. 479 (1965).

Gross v Switzerland (2014) 58 EHRR 7.

Haas v Switzerland (2011) 53 EHRR 33.

Hof Amsterdam 7 November 1995, TvGR 1996/1.

Hof Leeuwarden 4 April 1996, TvGR 1996/35.

In Re Quinlan 70 N.J. 10, 355 A.2d 647 (1976).

Koch v Germany (2014) 58 EHRR 6.

Kokkinakis v. Greece (25 May, §31, Series A no. 260-A).

MEC for Education: KwaZulu-Natal and Others v Pillay 2008 (1) SA 474 (CC).

Minister of Home Affairs and Another v Fourie and Another 2006 (3) BCLR 355 (CC).

Minister of Justice and Correctional Services and Others v Estate Late James Stransham-Ford and Others (531/2015) [2016] ZASCA 197 (2016).

Olmstead v. United States 277 U.S. 438, 478, Led 944 956, 48 S. Ct. 564, 66 ALR 376.

Planned Parenthood of Southeastern Pa. v. Casey 505 U.S. 833 (1992).

Pretty v. United Kingdom Application Number 2346/02.

Prince v President, Cape Law Society 2002 (2) SA 794 (CC).

Prince v. Massachusetts 321 US 158 (1944).

R (Williamson and Others) v Secretary of State for Education and Employment [2005] UKHL 15.

R. v. Big M Drug Mart Ltd. [1985] 1 S.C.R. 295, 1985 CanLII 69 (SCC) [Online].

R. v. Latimer [2001] 1 S.C.R. 3, 2001 SCC 1.

R. v. Morgentaler [1988] 1 S.C.R. 30, 1988 CanLII 90 (SCC).

Rb Alkmaar 26 April 1995, TvGR 1995/41.

Rodriguez v. British Columbia (Attorney General) [1993] 3 S.C.R. 519.

Roe v. Wade 410 U.S. 113 (1973).

SA Clothing and Textile Workers Union and Others v Berg River Textiles – A Division of Seardel Group Trading (Pty) Ltd. (2012) 33 ILJ 972 (LC).

S v Bhulwana; S v Gwadiso 1995 (2) SACR 748 (CC).

S v De Bellocq 1975 (3) SA 538 (T).

S v Lawrence 1997 (4) SA 1176 (CC).

S v Lawrence; S v Negal; S v Solberg 1997 (10) BCLR 1348 (CC).

S v Makwanyane and Another 1995 (2) SACR 1 (CC).

S v Mamabolo 2001 (5) BCLR 449 (CC).

S v Manamela and Another (Director-General of Justice Intervening) 2000 (5) BCLR 491 (CC).

S v Marengo 1991 (2) SACR 43 (W).

S v Steyn 2001 (1) BCLR 52 (CC).

Satz v Perlmutter 362 So.2d.

Schloendorff v Society of New York Hospital 211 N.Y. 125, 129-130, 150 N.E. 92, 93.

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

Stransham-Ford v Minister of Justice and Correctional Services and Others (27401/15) [2015] ZAGPPHC 230: 2015 (4) SA 50 (GP).

United States v. Lee 455 U.S. 252, 263 n.2 (1981).

United States v. Seeger 326 F.2d 846, 848 (2d Cir. 1964) *aff'd*, 380 U.S. 163 (1965).

Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk 1977 (4) SA 376 (T).

Vacco v. Quill 521 U.S. 793.

Washington v. Glucksberg 521 U.S.

Wittman v Deutscher Schulverein, Pretoria and Others 1999 (1) BCLR 92 (T) 1998.

Summary

In 2015 the South African judiciary was confronted with the so-called ‘right to die’, when Robin Stransham-Ford applied to the High Court of South Africa (the North Gauteng Division) for an order to have his life terminated. Although the Supreme Court of Appeal set aside the order (on procedural grounds), the High Court’s judgement serves as a catalyst towards jurisprudential debate in South Africa regarding the possible legalisation of euthanasia. Adding to the development of this debate is that some months prior to the *Stransham-Ford* case, the Canadian Supreme Court ordered the drafting of legislation which would offer Canadians the ‘right to die’ and which consequently included Canada among the ranks of States such as the Netherlands, Switzerland and Belgium. Arising from this is the question whether a medical practitioner may be compelled to comply with the wish of a person where such a person voluntarily and of sound mind requests that his or her life be terminated. Bearing the above in mind, this study argues for the protection of the rights of medical practitioners who conscientiously object against participating (whether directly or indirectly) in the administering of euthanasia. This necessitates an analysis of the rights applicable to all the relevant parties, the weighing-up against one another of the different meanings ascribed to such rights, as well as the postulation of a substantively competitive rationale against the background of the importance and sacredness of human life. This also overlaps with the importance of the endeavour towards higher levels of plurality pertaining to religious rights and freedoms in democratic societies around the world. By examining and comparing the nature and parameters of the various rights that come into play, it also becomes clear, through application of the proportionality test, that medical practitioners should indeed be entitled to, based on their religious convictions, refuse to participate in the intentional termination of innocent human life even in instances where a person voluntarily requests for his or her life to be terminated when such a request relies on the experiencing of substantive pain and suffering and where death is inevitable. This, together with the vacuum there is in sizeable human rights jurisprudence related to the protection of the medical practitioner’s religiously fed conscientious objection against the administering of euthanasia, anchors the importance of this study both for the South African context and beyond.

Key words: the right to freedom of religion; religious rights; religious freedom; conscientious objection; euthanasia; medical ethics; the right to life; the right to privacy; personal autonomy; human dignity and religion