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IN THE HIGH COURT OF SOUTH AFRICA
Gauteng Division, Pretoria

CASE NO: **2026-082603**

In the matter between:

DIGNITY SA NPC	Plaintiff / Applicant / Appellant
and	
MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT,NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS,MINISTER OF HEALTH,HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA	Defendant / Respondent

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Notice of Motion (Long Form)

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ELECTRONICALLY SIGNED BY:

Registrar of Pretoria , Gauteng Division,Pretoria

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

Case No.

In the matter between:

DIGNITY SA NPC	Applicant
and	
MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT	First Respondent
NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS	Second Respondent
MINISTER OF HEALTH	Third Respondent
HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA	Fourth Respondent

NOTICE OF APPLICATION

PLEASE TAKE NOTICE

1 The applicant intends to apply to this court for the following orders:

1.1 In these orders, "*medical assistance in dying*" means medical assistance in dying from a health practitioner to and at the informed and voluntary request of a competent patient with a terminal or irremediable condition whose suffering is unbearable or intolerable, and includes practitioner-

administered medical assistance in dying and self-administered medical assistance in dying.

1.2 It is declared that the common law prohibition of medical assistance in dying is unconstitutional, unlawful and invalid.

1.3 This declaration of invalidity is suspended for 24 months to allow Parliament to bring the law on medical assistance in dying in line with the Constitution.

2 The applicant will use the accompanying affidavit of Willem Landman and its attachments in support of its application.

3 The applicant has appointed the address of its attorneys indicated below at which it will accept notice and service of all documents in these proceedings.

4 If you wish to oppose this application you must:

4.1 notify the applicant's attorneys in writing within 10 days of service of this notice;

4.2 in that notice, appoint an address, within 25 kilometres of the office of the Registrar of this court, at which you will accept service of all documents in these proceedings; and

4.3 within 15 days after your notice of intention to oppose, deliver your answering affidavit, if any.

5 If you fail to give notice of your intention to oppose as required, the applicant will set down the application for hearing on a date to be allocated by the Registrar of this court.

DATED at PRETORIA on this 9th day of APRIL 2026.

Adams & Adams
Applicant's attorneys
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PRETORIA
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REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA GAUTENG DIVISION, PRETORIA
Private Bag X67, Pretoria 0001
REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA GAUTENG DIVISION, PRETORIA

TO: **THE REGISTRAR OF THE HIGH COURT**
PRETORIA

AND TO: **MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT**
17th Floor, Momentum Centre
329 Pretorius Street
PRETORIA

AND TO: **NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS**
VGM Building
123 Westlake Avenue
Weavind Park
Silverton
PRETORIA

AND TO: **MINISTER OF HEALTH**
Dr AB Xuma Building
1112 Voortrekker Road
Pretoria Townlands 351-JR
PRETORIA

AND TO: **HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA**
553 Madiba Street
Arcadia
PRETORIA

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

Case:

In the matter between:

DIGNITY SA NPC	Applicant
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MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT	First Respondent
NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS	Second Respondent
MINISTER OF HEALTH	Third Respondent
HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA	Fourth Respondent

FOUNDING AFFIDAVIT

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I, the undersigned,

WILLEM LANDMAN

state under oath as follows:

INTRODUCTION

1 I am a director of the applicant, Dignity SA NPC (DignitySA). I am duly authorised to bring this application and depose to this affidavit on behalf of DignitySA.

2 I hold degrees from the universities of Stellenbosch, Oxford, and South Africa (now, UNISA) in philosophy, political philosophy, theology, and law. From 2000 to 2024, I was a professor extraordinaire of Philosophy at the University of Stellenbosch. Prior to this, I was a professor and chair of the Department of Philosophy at the University of the Western Cape, from 1986 to 1994, and a professor of Medical Humanities (medical ethics) at the Brody School of Medicine, University of North Carolina, USA, from 1994 to 2000. Whilst in North Carolina, I was the bioethical member of a medical team that made treatment decisions in conjunction with terminally-ill patients in intensive care, and their family members. I therefore also have practical experience in end-of-life decision-making. Although I do not depose to this affidavit in the capacity of an expert, I attach as "**WL1**" a copy of my curriculum vitae, which sets out the positions I have held during my career and details of the books, chapters, and

WL1

articles that I have written relating to medical ethics and philosophy. I do so to assure the Court that I am well placed to depose to this affidavit.

3 The facts to which I depose are, save where otherwise stated or the context indicates the contrary, within my personal knowledge and are, to the best of my knowledge, true and correct.

4 I depose to an array of factual accounts in the section on the experiences of people who have been affected by the laws challenged in this application. In that section, most of the facts to which I depose are confirmed by individuals with personal knowledge. The story of a deceased individual is told by someone else, such as a family member or friend. In those cases, the best available evidence is hearsay in nature. DignitySA asks the Court to admit the evidence in the interests of justice.

5 Where I make legal submissions, I do so on the advice of DignitySA's lawyers.

THE PARTIES

6 The applicant is DignitySA, a non-profit company duly registered and incorporated in terms of the company laws of the Republic of South Africa with registration number 2025/680716/08. Its registered address is at 79 Longlands Country Estate, Polkadraai Road (M12), Vlottenburg, Stellenbosch, 7604.

6.1 DignitySA was originally established in 2011 as a not-for-profit organisation in terms of the Nonprofit Organisations Act, 1997, focusing

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on end-of-life decisions. One of its core objectives is decriminalising medical assistance in dying in South Africa.

6.2 Central to its work is informing the public about medical assistance in dying and advocating for a change of the law on the ability of persons to choose the time and nature of their death.

6.3 Annexure "**WL2**" sets out the history and activity of DignitySA and its consistent advocacy for the rights of individuals to make end-of-life medical decisions, including choosing medical assistance and dignity in dying.

7 DignitySA brings this application in the following capacities:

7.1 in its own interest, in terms of section 38(a) of the Constitution;

7.2 on behalf of all people with terminal or irremediable conditions who are suffering intolerably and wish to exercise the choice of medically assisted death in terms of sections 38(b) and (c) of the Constitution;

7.3 on behalf of health practitioners who consider that they ought to be able to alleviate a patient's suffering in accordance with the latter's choice, free from the risk of criminal or professional sanctions, including those who have signed the statement "**WL3**", as published in the South African

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Medical Journal in February 2024,[1] in terms of sections 38(b), 38(c) and 38(e) of the Constitution; and

7.4 in the public interest, in terms of section 38(d) of the Constitution.

8 The first respondent is the Minister of Justice and Constitutional Development, care of the State Attorney, Pretoria situated at Momentum Centre, 17th Floor, 329 Pretorius Street, Pretoria.

9 The second respondent is the National Director of Public Prosecutions, of VGM Building, 123 Westlake Avenue Weavind Park, Silverton Pretoria, 0184.

10 The third respondent is the Minister of Health, care of the State Attorney, Dr AB Xuma Building, 1112 Voortrekker Rd, Pretoria Townlands 351-JR, Pretoria, 0187.

11 The fourth respondent is the Health Professions Council of South Africa (HPCSA), a statutory body established in terms of the Health Professions Act, 1974. The HPCSA has its offices at 553 Madiba St, Arcadia, Pretoria, 0002.

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[1] *SAMJ* 2024, Vol. 114, No. 2.

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OVERVIEW

Medical assistance in dying

12 It is currently illegal, in terms of the criminal branch of the common law, for a health practitioner to provide medical assistance in dying to a patient. The HPCSA Guidelines also classify the provision of medical assistance in dying by health practitioners as unethical and unprofessional conduct.

13 DignitySA submits that individuals with a terminal or irremediable condition have a constitutional right, in appropriate circumstances, to ask for and be afforded medical assistance in dying. It accepts that the exercise of the right must be properly controlled. It is not the purpose of this application to design the controls. That is to be left to Parliament. I merely describe some of the proposed controls to clarify what DignitySA means when it speaks of medical assistance in dying.

14 Medical assistance in dying should only be afforded to qualified patients,

14.1 who suffer a terminal or irremediable condition;

14.2 whose suffering is unbearable or intolerable;

14.3 who are capable of making an informed request for medical assistance in dying; and

14.4 who make an informed, voluntary and considered request for medical assistance in dying.

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15 Only registered health professionals should be allowed to render medical assistance in dying.

16 Medical assistance in dying may, in a *wide sense*, refer to a number of end-of-life interventions, including assistance with terminal pain management (including palliative sedation), withholding or withdrawal of potentially life-sustaining treatment (including artificial nutrition and hydration), issuing Do-Not-Resuscitate orders, and respecting living wills or other advance directives. However, "*medical assistance in dying*" as referred to in this application, comprises the following *specific* practices:

16.1 *self-administered* medical assistance in dying, which is the process in which a health practitioner[2] intentionally provides the means for a patient to end their suffering by terminating their own life. In this regard, the patient is able to perform the act themselves, but obtains lethal drugs, or a prescription for such drugs, or other such means, from a health practitioner, who therefore assists such patient; and

16.2 *practitioner-administered* medical assistance in dying, which allows the health practitioner to administer the life-terminating act at the patient's request.

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[2] This is a person who is registered as such in terms of the Health Professions Act.

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The current prohibition

17 I am advised that the current position pertaining to medical assistance in dying under the common law is that:

17.1 Practitioner-administered medical assistance in dying constitutes the crime of murder on the part of the health practitioner. There is no allowance in the criminal law for a person to request or to consent to being actively killed by another.

17.2 Insofar as self-administered medical assistance in dying is concerned, criminal liability of the health practitioner depends on the facts of the particular case and the ordinary criminal law principles of intention, unlawfulness and causation.

18 In terms of the HPCSA Guidelines:

18.1 **Guideline 2.2 in the "*Guidelines for the Withholding and Withdrawing of Treatment*" (Booklet 7)**[3] states that the HPCSA's Guidelines are based on the premise that "*any medical intervention where the health practitioner's primary intention is to end the patient's life is both contrary to the ethics of healthcare and unlawful*"; and

[3] Dated 2023.

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18.2 **Guideline 9 in the "*Ethical Guidelines on Palliative Care*" (Booklet 17)**[4] states that:

> *"9.4 Euthanasia is the employment of any medical intervention primarily aimed at ending a patient's life (e.g. giving a patient lethal drug or injection).*
>
> *9.5 Doctor-assisted suicide occurs when the health practitioner provides the means necessary to enable the patient to end their own life (e.g. handing a patient a lethal drug or prescribing a lethal drug for a patient).*
>
> *9.5 At present, South African courts have acknowledged that both euthanasia and doctor-assisted suicide are fundamentally incompatible with a practitioner's role as a healer, and a practitioner guilty of either is regarded as having acted unethically and unlawfully."*

19 The Health Professions Act empowers the HPCSA and/or professional boards established under the Health Professions Act to take disciplinary steps against health practitioners who are said to have participated in "*unprofessional conduct*"[5] or "*improper or disgraceful conduct*".[6] The approach of the HPCSA in the HPCSA Guidelines, namely that medical assistance in dying is unethical

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4 Dated 2019.

5 Section 1 of the Health Professions Act defines unprofessional conduct as "*improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy*".

6 See section 42(1) of the Health Professions Act.

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and unlawful, places medical assistance in dying in the realm of unprofessional and improper conduct, with the result that health practitioners who provide medical assistance in dying face the consequences set out in the Health Professions Act for those who have engaged in improper or unprofessional conduct.[7]

20 Consequently, any patient who chooses medical assistance in dying places the health practitioner who assists them at risk of being found guilty of unethical practices and/or murder, with the possibility of imprisonment and the likelihood of having their medical licence revoked. There is no lawful justification for a health practitioner who provides medical assistance in dying; whether the assistance was provided on the basis of the patient's informed request, or that the assistance was driven by care and compassion, or the motive was to ease suffering.

21 Notwithstanding the position regarding medical assistance in dying, I am advised that the law *does allow* a competent patient to **refuse medical treatment**, even if such refusal would lead to their death, or to **request the withdrawal of treatment or life support**, even where such cessation of treatment would lead to their death. A patient's decision to voluntarily stop

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[7] The consequences for unprofessional conduct are set out predominantly in Chapter IV of the Health Professions Act, and include an inquiry into the health practitioner, suspension and/or removal from the register, and the imposition of a penalty under section 42. The relevant sections include sections 19, 19A, 41, 41A, 42 and 49 of the Health Professions Act.

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eating and drinking must also be respected. In addition, the law *allows* health practitioners to prescribe and administer pain-relieving medication, notwithstanding that such medication is known to have the so-called "**double effect**" of *both* relieving pain and hastening the patient's death.

22 In other words, whilst the law recognises that there are instances where a patient is entitled to choose death over suffering and where a health practitioner is duty-bound to respect the patient's wishes, this does not apply to circumstances where the patient requires medical assistance in dying in either of the forms set out above. To the contrary, in the context of medical assistance in dying, the law currently prohibits a health practitioner from acting in accordance with a patient's chosen treatment, with no consideration of whether the patient's request is carefully considered or well-informed, whether the patient's suffering is intolerable to them, constituting an unbearable and unrelenting violation of their person, whether the patient will be forced to continue to suffer, with no hope of recovery, in a state of existence that is intolerable to them, or *any other factor*. The prohibition on medical assistance in dying, imposed by the criminal law and the HPCSA Guidelines, is absolute.

23 The decriminalisation of medical assistance in dying sought in this application thus refers to a change to the current position in the law which denies a competent, informed person, who has a diagnosed terminal or irremediable condition (in that there are no acceptable treatment options available to the patient) causing such patient intractable and unbearable suffering, which cannot

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be alleviated by an acceptable treatment option, to voluntarily request medical assistance in dying.

24 DignitySA submits that the current prohibition of medical assistance in dying unjustifiably infringes upon:

24.1 the right to bodily and psychological integrity, including the right to security in and control over their body, and the right to freedom and security of the person, and therefore infringes the rights in section 12(1) and (2) of the Constitution;

24.2 the right to dignity, in breach of section 10 of the Constitution;

24.3 the right to equality, in breach of section 9 of the Constitution; and

24.4 the right to life, in violation of section 11 of the Constitution.

25 At the outset, I acknowledge that the topic of medical assistance in dying is a controversial one, about which many will have strong and differing opinions and beliefs. It is, however, a matter of utmost importance to those who face suffering that others cannot even imagine, and who wish to exercise their rights to self-determination at the time that they are most in need of being respected as autonomous beings with control over their bodies.

26 In our constitutional dispensation, I am advised that Courts cannot shy away from difficult topics, or abdicate their duty to pronounce on matters affecting fundamental rights. To the contrary, since the introduction of fundamental rights three decades ago, our Courts have grappled with topics such as the death

penalty, termination of pregnancy, same-sex marriages, prisoner rights, surrogacy, wrongful birth, corporal punishment, male primogeniture, intestate succession, customary marriages, access to antiretroviral drugs and access to housing, to name but a few.

27 The right to put an end to intolerable suffering, to regain control over one's body, and to die with dignity is a matter which the Courts can no longer avoid. This is particularly so when the rights affected go to the very core of the values and freedoms that form the foundation of our constitutional dispensation and, in fact, the very essence of human existence: bodily and psychological integrity, security and freedom of the person, dignity, equality, and life.

28 In what follows, I deal first with the following topics:

28.1 First, I summarise the current legal position pertaining to medical assistance in dying in South Africa.

28.2 Second, I set out the effect of the prohibition of medical assistance in dying in practice, including a series of case studies of South Africans who have been affected by the criminal prohibition of medical assistance in dying, and the expert opinions of medical doctors that there are no legal alternatives that fulfil the same needs as medical assistance in dying.

28.3 Third, I contend on behalf of DignitySA that the current law pertaining to medical assistance in dying unjustifiably infringes upon a number of constitutional rights.

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28.4 Fourth, I set out, with the assistance of expert witnesses, the successful legalisation of medical assistance in dying in comparative jurisdictions, to which the legislature can have regard when establishing a legal framework that is appropriate in the South African medical setting. The evidence from these jurisdictions shows that the common fears raised by opponents of medical assistance in dying have no support in the factual experiences and data that emerge from jurisdictions where medical assistance in dying is permitted.

28.5 Fifth, I explain that the South African healthcare system is already equipped to deal with decisions of this kind and would be able to implement an appropriate and safe medical assistance in dying regime.

28.6 Sixth, I set out the relief sought by DignitySA.

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Medical assistance in dying in South Africa

29 The prohibition of medical assistance in dying is located in the criminal law leg of the common law. There is no specific legislated prohibition of medical assistance in dying although the effect of the HPCSA's classification of medical assistance in dying as "*unethical*" and "*unlawful*" in its Guidelines, read with the consequences under the Health Professions Act for a health practitioner who has acted unethically or improperly, means that the common law prohibition on medical assistance in dying is reaffirmed in statute.

30 Under the common law, the usual principles pertaining to causing another's death apply in this context without discrimination. Assuming all the elements have been met, a health practitioner (or any other person) who administers a lethal injection to cause the death of a patient, even where this is done on the patient's request and after the patient has carefully considered and chosen this path for themselves, may be found to have committed the same crime (murder) as a criminal who shoots another in cold blood.

31 As set out above, *self-administered* medical assistance in dying and *practitioner-administered* medical assistance in dying can have different legal consequences for the health practitioner depending on the particular circumstances of each case. In both instances, however, the health practitioner who assists the patient with their end-of-life request is at risk of being charged with, and being found guilty of, murder.

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32 I am advised that the crime of murder is defined as the "*unlawful and intentional causing of the death of another human being*". The elements that must be proven by the state are that the accused has (a) unlawfully and (b) intentionally (c) caused the death (d) of another person.

33 For most crimes, an accused can raise one of the legally recognised justifications to exclude the element of unlawfulness. One such justification for other crimes (that will make otherwise unlawful conduct lawful) is *consent*. For example, where a person intentionally cuts another with a knife, it may be unlawful assault, or lawful surgery. The (main) distinguishing feature is that in the latter instance, the patient has consented to the medical doctor cutting them.

34 The justification of consent arises from the significance given in our law to self-determination and, where it concerns decisions around one's body, bodily integrity. I am advised that consent by a patient to medical treatment falls under the defence of *volenti non fit injuria*, which would justify an otherwise wrongful delictual or criminal act. In this context, invasive medical treatment, which would otherwise have constituted a violation of a patient's right to personal integrity, is justified and lawful only because it is performed with the patient's informed consent. Consent must be properly informed and given voluntarily by a competent patient.

35 I am advised that the principle of informed consent and giving effect to a competent patient's wishes in relation to medical decisions is in accordance with the fundamental rights of individual autonomy, bodily integrity and self-determination that underpin South African law. It is also consistent with the shift

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from medical paternalism to patient autonomy in modern times. So important are these principles that children from as young as 12 years old can consent to, and lawfully make decisions regarding, their medical treatment, provided they are competent to do so, and any decisionally-competent pregnant woman or girl regardless of age may request a termination of pregnancy on any basis during the first trimester of her pregnancy, and thereafter on the grounds set out by the relevant legislation.

36 Consent is not, however, recognised in our common law as a defence available to a person who brings about the death of another, including in the context of medical assistance in dying. I am advised that it is not currently available to a health practitioner, who administers or provides the means with which a patient's life is ended, to raise the defence of *volenti non fit injuria* in circumstances where the patient requested or gave their voluntary and informed consent to their death.

37 The current position in our law is that, provided the elements are proven, *practitioner-administered* medical assistance in dying constitutes the crime of murder.

38 Insofar as *self-administered* medical assistance in dying is concerned, whilst a person who kills themselves or attempts to do so does not commit a crime, a person who *assists* another to kill themselves may, depending on the circumstances of the particular case, be guilty of murder if the requisite elements are present: i.e. the unlawful and intentional causing of another's death. Whilst a Court faced with self-administered medical assistance in dying

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may find in a particular case that the patient's own independent and voluntary action breaks the chain of causation, I am advised that the jurisprudence in this regard is contradictory, creating uncertainty in the law. There is thus a risk for *any person* seeking to assist another to end the latter's life peacefully and on their own terms that such assistance, whether in the form of assistance or administration, could be found to be murder.

39 Even if particular circumstances are such that a health practitioner who has provided medical assistance in dying is not charged or found guilty of murder, the position adopted by the HPCSA, as set out in the HPCSA Guidelines, means that the health practitioner will likely be accused of and have to face the consequences for unprofessional and/or unethical conduct, including losing their licence to practise as a health practitioner.

40 Until the law is changed, health practitioners who wish to assist or give effect to a patient's decision for medical assistance in dying cannot do so without facing the risk of being charged with murder, and/or losing their ability to practise their profession, notwithstanding that they are acting on the request of the patient when doing so. There is, in effect, a blanket prohibition on medical assistance in dying in our law.

41 The blanket prohibition on medical assistance in dying is not consistent with how our law approaches other end-of-life decisions. I am advised that there are a number of <u>other</u> instances where the law *allows* a competent patient or a health practitioner to *choose death*. Moreover, in these circumstances, the

patient's request *must* be respected, and such choice or conduct is not considered to be unlawful or unethical. These instances include the following:

41.1 First, a competent patient may refuse lifesaving or life-prolonging treatment, even if such refusal will lead to their death, because their rights of bodily integrity and autonomous moral agency entitle them to refuse medical treatment. I am advised that this applies even where such refusal is considered unreasonable by others, including a health practitioner. In this regard, the law gives preference to a person's rights to bodily integrity, autonomy and dignity over other considerations, such as the State's interest in preserving life or safeguarding the integrity of the medical profession.

41.2 Second, a competent patient may ask that life-sustaining treatment or artificial nutrition or hydration be withdrawn or discontinued. Again, a health practitioner must accept the patient's decision, even if it would lead to their death.

41.3 Third, a health practitioner may give a terminally ill patient drugs with the primary object of relieving their pain, despite it being foreseen by the health practitioner that the drugs will almost certainly hasten the patient's death (the so-called, "*double effect*" doctrine).

41.4 Fourth, a health practitioner does not commit a criminal offence by ceasing, on their own accord, treatment or medical intervention that is fruitless and does not serve a purpose. Thus:

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41.4.1 The uncoupling of a respirator, although it may be a factual cause of death, will not be the legal cause of a patient's death where the underlying injury or illness would, but for the respirator, cause the patient's death. In these circumstances, the cessation of the artificial measures is not murder but merely the termination of a fruitless attempt to save the patient's life.

41.4.2 There is no legal duty to continue life-sustaining measures or artificial nutrition or hydration, even if cessation of such would hasten or accelerate death, where these interventions have proved to be unsuccessful. Moreover, such interventions are not successful simply because they maintain life in the form of certain biological functions.

42 In sum, a patient may choose death over life by refusing medical treatment or asking for treatment to be discontinued. In addition, a health practitioner is not under a duty to give or continue treatment where it would be futile to do so, and may decline or cease to give such treatment, notwithstanding the quickening of death as a result. A health practitioner may, moreover, prescribe and administer medication to a patient for the purpose of pain-relief, even if the medication will hasten death.

43 There are, therefore, certain socially and legally accepted options available to *some* patients who wish to choose for themselves death over continued suffering.

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44 There are, however, also many instances where (a) a patient does not fall within any of the categories above, (b) the refusal of treatment or artificial feeding does not immediately lead to death, but continues to cause suffering, or (c) suffering cannot be relieved by other means. Without access to medical assistance in dying, many people who wish to end their lives on account of intractable and unbearable suffering are unable to do so. This is because the very nature of a number of irremediable illnesses or disabilities is such that patients are unable to end their own lives unassisted, as can be seen from some of the case studies set out below. In those circumstances, the patient is forced to continue to suffer, against their will and their freely and competently-formed decision regarding their body and their life, or to face the danger of placing another at risk of criminal charges and conviction.

45 DignitySA contends, in light of the above, considered alongside the practical experiences that follow, that the prohibition on medical assistance in dying is inconsistent with the Constitution and invalid.

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THE EFFECT OF THE PROHIBITION

Case studies

46 In this section, I set out some true accounts of patients who have sought medical assistance in dying, notwithstanding the current prohibition, who have taken their lives in other ways, or who would still wish to seek medical assistance in dying and hope that it may be decriminalised for them to do so lawfully.

47 Given the criminal sanctions that may await any person who provides medical assistance in dying, accounts of medical assistance in dying are often not publicised. I know, through my interactions with many in the medical profession and from the requests and accounts to which I have been privy through DignitySA, that requests for medical assistance in dying are not uncommon in South Africa. Over the 15 years of DignitySA's existence, the organisation has received more than 150 requests for information about, or advice regarding, medical assistance in dying.

48 The accounts of each person set out below have been provided to me either by the patient themselves, or, where the patient has died, by the person who assisted them in dying, or by a family member of the patient who was privy to the decision. In each case, I include a supporting or confirmatory affidavit by such person with this application.

49 The purpose of these personal accounts is not to analyse whether the decision made in each instance was, objectively, the "*correct*" decision, whether the medical condition was "*dire enough*", the suffering "*intense*" or "*unendurable*"

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enough, or the loss of dignity "*severe enough*" to "*justify*" the patient's choice of death in the circumstances. It is certainly not to ask the respondents or this Court to publicly assess, judge or criticise the decisions of these individuals who have been brave enough to share their stories.

50 Rather, it is to show the true stories of real people who are impacted by the current state of the law. These personal accounts bring to the fore the people behind the suffering that is central to the medical assistance in dying decision, and illustrate, through real-life experiences, the effect that the prohibition on medical assistance in dying has on the rights of people seeking it, their loved ones, and those who assist them. Moreover, the range of the medical conditions of the patients who seek medical assistance in dying shows the subjective and intensely personal nature of suffering and of making a decision to seek medical assistance in dying. No two persons experience terminal or irremediable conditions, or tolerate suffering in the same way. Suffering that is endurable for one patient may be intolerable to another.

51 The accounts set out below are of ordinary people. These are brave people, people who had (or still have) full and meaningful lives, were loved, who knew their own minds, and made a decision in accordance with their own wishes and beliefs, and the way that they wished to live and to end their lives. For a number of them, however, the prohibition on medical assistance in dying meant that they were not able to be assisted by a health practitioner to ensure a safe and peaceful death; for others, it meant that they had to hide their death from their family and friends, being alone in their final moments; and for some it meant

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that they died knowing that, in acting out their wishes, there may well be criminal consequences for the person who assisted them.

52 In seeking to make a choice that was already so hard, one literally of life and death, the criminalisation of medical assistance in dying made the decision taken by each of these patients even harder, tarnishing the peace that they sought through a chosen peaceful death.

53 The accounts below also show what is well-known about human nature: that legal prohibition does not stop people from exercising their free will. Where there is a strong wish, a way will be found to give effect to it. And, like a "backstreet" abortion, the covert option, unregulated and intentionally hidden from all scrutiny on account of its prohibition and stigma, leaves people in a more vulnerable and unprotected position than they would have been in had they been able to legally access assistance, in a safe medical space, with proper procedures and safeguards in place.

Diethelm Gunter Harck

54 The following account is given by Diethelm Gunter Harck, as set out in further detail in his affidavit included with this application.

55 Mr Harck suffers from Motor Neurone Disease (MND), in the form of primary lateral sclerosis, a neurological condition that progressively causes the deterioration of nerve cells leading to a loss of ability to control and use his muscles.

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56 Before the onset of his disease, Mr Harck lived an active life and loved many different types of sport. He recalls that "*physical activity . . . was freedom . . . [and r]ecreating body, mind and soul was a way that [he] could counterbalance the challenges of everyday life*".

57 However, in 2010, at age 61, Mr Harck's health began to decline:

57.1 In 2010, Mr Harck had a laminectomy (an operation on his spine), on account of an old injury. This gave rise to jerking and weakness of his right leg and foot, an issue which became more prominent over time.

57.2 During 2011, Mr Harck was diagnosed with Chronic Inflammatory Demyelinating Polyneuropathy, a slow developing autoimmune disorder. Although the recommended treatment initially relieved the symptoms of lameness experienced by Mr Harck, the effectiveness of the treatment plateaued, and the treatment was aborted.

57.3 The prognosis given to Mr Harck was non-reversible atrophy of the myelin sheath around the nerves, with resultant loss of muscle control and mass. He was told that he had a life expectancy of between two and five years at that point.

57.4 Mr Harck recounts that he experienced a deep depression in 2012 as a result of his diagnosis, both because of the irremediable nature of his condition and the impact it would have on his ability to participate in physical activities, which had been such a significant part of his life. He

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managed, however, to successfully treat his depression with anti-depressant medication and the support of loved ones.

57.5 His physical deterioration continued, with a feeling of weakness and lameness first in his lower limbs and then his arms. Walking and fine motor activities became a challenge, as did breathing, chewing and speaking. Mr Harck recounts constant exhaustion setting in and the daily difficulties he experiences.

57.6 In 2013, Mr Harck sought a second medical opinion, this time from a neurologist in Durban, which confirmed that he had a sub-form of MND: Primary Lateral Sclerosis. The diagnosis was confirmed by another neurologist in 2017, and yet another in 2021.

58 Mr Harck was given no treatment options. MND is generally considered to be an irremediable condition. He was advised to remain as active as possible for as long as possible and to focus on good nutrition. He has done so and takes great pride in his efforts to remain active despite his diagnosis and symptoms.

59 Mr Harck's independence is sacred to him, and he knows that there will come a time when the deterioration of his body will lead to a loss of control, first of his extremities, then his diaphragm and his breathing. He fears total dependency, exhaustion, pain of falling uncontrolled, and the deterioration that awaits his body. He has a "*living will*", in which he has recorded that he does not want to be connected to a ventilator or respirator, nor does he want artificial hydration or feeding.

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60 The importance Mr Harck places on independence does not come from an absence of support. To the contrary, Mr Harck has a strong support base, including his current partner, his three adult children, his former spouse, and a MND support group. He has also been receiving palliative care support since 2014.

61 Nonetheless, Mr Harck is of the view that what he is offered in palliative care will not be a solution to his fears of bodily deterioration, loss of independence and the suffering that he has seen others face, and that he fears he will experience, in his final days. He does not want palliative sedation to "ease" his final weeks or days. He does not want to be reduced to a sedated state, rendering him – in his view – to little more than a shell of himself.

62 Mr Harck's understanding of the progression of his disease is that, leading up to his death, he will struggle with basic bodily functions, like breathing and swallowing. He knows that everyone fears dying in some way, but his fear – on account of his condition – is the total loss of independence and suffering that he knows will accompany his dying days, and not being able to choose a voluntary and peaceful death before he is in a state of utter helplessness and dependency. This is a thought which is unbearable to him.

63 He knows that he has (theoretically or practically) the option of ending his life now, whilst he is physically able to do so, but he has *no desire* whatsoever to end his life at this stage or before he has to. He is not a man who wishes to die. He wishes to live, and to live knowing that he will be able to die peacefully when the time comes. All he wants is to know that he will be able to ask for medical

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assistance in dying when his body has deteriorated to a state that is no longer bearable for him so that he does not have to live out his fear of being trapped in a bodily state that he cannot tolerate.

64 Mr Harck states that not having this comfort, not knowing that he will have the choice when he wants to exercise it, is creating an emotional and psychological strain on him and his family, and affecting his current quality of life.

65 For more than a decade, Mr Harck has known that there will be a time in the future when he wishes to choose a peaceful death over continued suffering or palliative sedation. He has discussed this with others and this is not an impulsive decision.

66 He also knows, however, that there will come a time where, because of the nature of his disease, he will be unable to end his own life unassisted, but he cannot tell when he will lose his ability to do so. He also cannot tell, now, when the suffering will be too much for him to bear.

67 He therefore sets out an impossible choice. With the law as it currently stands, he must decide between ending his life too soon, whilst he knows he can still do so, but before he would like to and perhaps many years before he needs to, or risk being too late and face being forced to bear suffering and conditions that are intolerable to him, to die slowly and painfully, when at that stage there is nothing he can do to speed up death or to die peacefully.

68 Unless medical assistance in dying, and for Mr Harck's case, medically assisted *practitioner-administered* dying, is decriminalised, Mr Harck has said that he

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may take his own life, much too soon, but whilst he is still able to do so unassisted. This would be a great tragedy.

Craig Schonegevel

69 Craig Schonegevel was born with Neurofibromatosis type 1 (NF1), a genetic condition that affects the nervous system, causing lumps to grow on nerves. At age 28, he decided to end his suffering by ending his life. He did so alone so as not to implicate his loved ones, and he needed more than one attempt to be successful – a lonely and heart wrenching end, both for him and those left behind, for a brave soul who had always been loved and supported.

70 The story of Mr Schonegevel is told by Marianne Thamm in the biography she wrote called "*The Last Right*". I provide a high-level summary of that biography here, with Ms Thamm's permission.

71 This book has not been included with this application so as not to overburden the Court, but a copy can be made available to this Court if requested. As per her affidavit filed with this application, Ms Thamm's account of Mr Schonegevel's story was informed by interviews with Mr Schonegevel's family and loved ones after his death, and by studying the letters, emails and diary entries that Mr Schonegevel wrote in his final years.[8]

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[8] She records that the original letters, emails and diary entries were since stolen from her, and she therefore no longer has these in her possession. Ms Thamm's transcription of these are the best available evidence of their content.

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72 Mr Schonegevel's story is best told in his own words, captured by Ms Thamm, and I therefore quote extensively from his writings at the time. I also attach transcriptions of extracts that are too extensive to quote.

73 Mr Schonegevel was born with NF1 and his life with NF1 was not easy. During his 28 years, Mr Schonegevel underwent countless surgeries, starting with surgery to remove a brain tumour at the age of seven.

74 Mr Schonegevel spent many years trying to overcome and reduce the effects of NF1 by means of diet and exercise, and his supportive family and faith gave him a positive outlook on his life and his disease.

75 In early 2009, however, at the age of 28, Mr Schonegevel told his parents that he had "*found [his] peace*". He had discovered Dignitas, a non-profit organisation in Switzerland that provides medical assistance in dying. He wished to go there to die with dignity.

76 At that time (2009), the cost of medical assistance in dying at Dignitas (excluding other expenses such as flights) comprised:

76.1 a registration fee of 200 Swiss Francs (then, approximately R1,750);

76.2 a membership contribution of 80 Swiss Francs (approximately R700); and

76.3 a special membership contribution, which covers the tasks carried out by Dignitas, but would not guarantee that the applicant will be granted

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access. This contribution was 3,000 Swiss Francs (then, approximately, R27,000).

77 Once he had made the decision to go to Dignitas, in April 2009, Mr Schonegevel composed a letter to his parents. A copy of a transcription of this letter is attached as "**WL4.1**".

78 In this letter, Mr Schonegevel told his parents, amongst other things:

78.1 "*When I think back on my life and my ongoing physical suffering and pain and all the other non-related health ups and down, I know with 110 percent surety that I would do it all again with all the NF1 issues, if it meant having both of you as my parents. You are both beautiful and wonderful in your ways.*"

78.2 *"Even the strongest soldiers grow weak, and as a very wise and great man who happens to be my uncle and my godfather recently said, 'Nobody knows more than Craig himself how much he has suffered'."*

78.3 *"This disease has raped me emotionally and physically, violently and brutally, and repeatedly throughout my life."*

78.4 *"I truly feel that Craig, the true Craig, has been slowly but surely eroded over the years of my illness, which has been my whole life from birth to now and has been drastically accelerated over the last number of years. Now the true Craig (Craig beyond his body) is so tired he is barely there and I want to leave peacefully before he has vanished."*

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78.5 *"I am fully aware of the pain and the suffering as well as the poverty in the world. There is so much suffering and everyone on earth has their problems. Physical pain and the level of its severity is a self-perceived thing, we all experience physical pain differently, what one person can take is not what the other can stand."*

78.6 *"Craig is hardly Craig anymore and I want to go in peace before the little bit of me that is left has gone*".

78.7 *"I have tried my best to change the things I am able to do. And have fully accepted those I cannot and, yes, I know the difference. It has got to a point where I have been forcefully put in a corner and bricked in and to top it off, the bricks are falling and caving in on me, bruising and destroying me."*

78.8 *"I feel no anger towards NF. It has just got to a point where enough is enough and I no longer want to be abused."*

78.9 "*If I could leave a thought or lesson behind, it would be that it is okay to sometimes say, 'I have had enough', particularly when a person has had a long period of fighting.*"

78.10 "*Please tell people not to judge a man until you have walked in his shoes, as George [Irvine] put it. I feel that my challenges have not made me stronger, they have made me weaker and I want to sleep before more of who I am is taken.*"

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78.11 "*Please tell those who said you have to stop me and who questioned how you could allow this, to ask themselves who it would have been better for . . . Tell people that even if you said to me that you were not going to allow this, I would have gone without your blessing. . . I would like them to think deeply about the regret you will feel if I went with someone else to Dignitas and not my parents. The regret you would feel if you were not there as I breathed my last breath. They must think how I have suffered and be at peace that I, for the first time, am at peace, something I have searched for my entire life.*"

78.12 "*Dad, . . . you probably raise your problems with me not being terminal. All I ask of you is that in these discussions you mention that I do in fact have an incurable disease, that I am badly affected.*"

78.13 "*Dad, I know this is extremely difficult for you because naturally you are a fighter. I thank you so much for your support. I want to thank you so, it is beyond words. It is more a tidal wave of love and gratitude pouring from my heart for supporting me in your own way this far and for what is to come. Just always remember my dream of finally being at peace in all senses of the word.*"

78.14 "*I love you both for the parents you are and have been. All of our hearts are breaking and I just want to sleep, be at peaceful sleep.*"

79 Mr Schonegevel had a profound faith in God. He told Reverend George Irvine, a confidant and a former Methodist Church Bishop, that he believed that God

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would agree with his decision as he did not want to get to the stage of lying in a bed no longer his real self, but a body that would only be a shell because of the necessary surgical procedures.

80 In May 2009, Mr Schonegevel and his parents wrote a collection of emails to his close friends and family about Mr Schonegevel's Dignitas decision. The letters and emails in response to Mr Schonegevel's decision show the extensive love and support from his family and close friends. A copy of some of the extracts included by Ms Thamm in the biography is attached hereto as "**WL4.2**".

81 In one of the emails included in this collection, Mr Schonegevel set out the following to his music teacher, Dr Howard Nock:

> *"All I can ask is that you keep this to yourself and respect that this is a very personal decision that I have made entirely on my own and that this decision has given me true peace.*
>
> *For a while now I have had discussions with George Irvine and he is of the opinion that it is the true Craig that is thinking and not a depressed or disillusioned Craig.*
>
> *My health just does not give up and I should have already been to Cape Town to have the operation in my arm. (I feel it has grown in size since I've had the MRI and it is causing more pain as well as well as giving me pins and needles in my fingers all the time.) I have been unable to have the op because my colon is playing up again. I was in hospital again for an obstruction 10 days ago, which thankfully passed this time. I am basically still on liquids. Adhesions have formed again and it is just a waiting game until it leads to surgery again. The scar down my entire abdomen has been cut six times now and the irony is that each time more adhesions form that again lead to surgery. There is no cure for this*

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problem, like there is no cure for Neurofibromatosis, the disease that I have.

I have decided and this is the part that will shock you . . . to go to Dignitas Clinic in Switzerland, which is an assisted-suicide clinic. I have been in contact with them and am submitting medical history and other forms.

If they accept me (subject to certain conditions), I get a "green light" to travel to them and be assisted. This is legal in Switzerland. The thing is that my parents will be travelling with me and may face legal issues when they return. They respect my decision. They have been advised to approach senior legal counsel. There have been a few cases in the UK before, Daniel James went there and his parents were charged but the case was dropped.

After 12 operations and the pain I have experienced and the imminent surgeries that await me, as well as all that goes with my disease, all I dream of is peace. And to not have the true Craig further and further "raped" to the point that what is left of him will be gone."

82 Mr Schonegevel did not view his decision to die as one made in desperation or depression. He recorded the following in an email to Sandy Coffey, a photographer who had been photographing Mr Schonegevel's journey for a book that he wanted published about his life and his death:

"I believe that what I have decided to do is in a way different [to other instances of suicide]. . . Often with suicide, the person is looking through a "frosted window" and acts out of desperation or a depressed mind. I am of sound mind and fully believe this is the way to go.

. . .

The last thing I want to do is end my life in a violent way, e.g. shooting myself, because if there is a botch-up then I will be worse off. Also the anxiety that goes with this is great. I have had enough of anxiety with my

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condition to add more in my passing. So too has enough violent hurt been done to both my body and spirit. I don't want my body to be violently hurt, whether it kills me or not, as my body and my spirit has [sic] been repeatedly subjected to great violence."

83 The next day, he wrote that "*[a] perfect day for me would be lying on the bed at Dignitas and know[ing] that peace, to know I was loved by those in my life who matter to me*".

84 Of his fears, Mr Schonegevel recorded that all merged into one: Neurofibromatosis. He feared its unpredictability, its constant growth and more fibromas on his body, his stomach condition and the adhesions that led to colon operations, and pain, suffering and imminent surgeries. He recorded that he feared "*more of the current suffering [he] experience[s] and will experience. [He] fear[ed] dying in pain, from whatever form of death [and] living with Neurofibromatosis and the colon condition that [he has], [what it] has meant for [his] life and will mean in the future*".

85 Mr Schonegevel further stated that if he did not get the "green light", and if he could not personally persuade Dignitas to take him, then he would "*have to find a doctor who has a heart for my suffering and wishes to help me privately. He must act out of free will, it will be a great risk to his career and his family, but all I will be able to say from my heart to him is that my soul will be eternally grateful as I hug him with thanks. I will sob in my heart with thanks. For the first time in my entire life I can now be in the driver's seat. That brings me peace, comfort, certainty and bliss. The "green light" has not yet appeared and that brings*

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uncertainty but once it has shone, I will follow it to this state of inconceivable bliss."

86 A transcription of a selection of emails exchanged with Ms Coffey, including the above, are attached as "**WL4.3**".

87 Mr Schonegevel, however, then experienced various delays with Dignitas, which did not want to give him the "green light" until he had had further surgery.

88 The delay was intolerable to Mr Schonegevel. He wrote to his cousin in London in August 2009 that he had "*created my own "green light" as the manner in which Dignitas is dealing with me is appalling*". A transcription of this email is attached as "**WL4.4**".

89 Mr Schonegevel decided to take matters into his own hands, although he wanted to die in a way that was not violent.

90 His first attempt, on 14 August 2009, was unsuccessful. He had accumulated sleeping tablets, but it was not enough.

91 Ms Coffey was with him when he came round in the hospital. She told Ms Thamm that Mr Schonegevel had been furious, and could not believe that he was still alive. Mr Schonegevel recorded that: "*My attempt failed over the weekend. Just when I find a way to cope it is taken from me or fails me. I will persevere though, until the deed is done*." This recordal is included in an email included in the bundle of correspondence attached above as "**WL4.3**".

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92 Just over a week before this attempt, Mr Schonegevel had written the following about his state (in an email to Ms Coffey, also included as part of "**WL4.3**"):

> *"Emotionally, I have never in my life been more stable than I am at present.*
>
> *Spiritually, I have never in my life been so connected and at peace with my God as I have been for the last while.*
>
> *Psychologically, I am of sound mind (which many will confirm) as well as completely rational.*
>
> *It is sick to expect anybody to carry on accepting, adapting to being operated on and for there still to be no cure. We live in an age where we do all sorts of things but science cannot benefit me."*

93 Between his first attempt and when he then ended his life, Mr Schonegevel wrote a number of frustrated emails and daily thoughts to Ms Coffey (some of which are included in the bundle of correspondence attached as "**WL4.3**"). He recorded that Dignitas was his "Plan A", his unsuccessful attempt at overdosing had been "Plan B" and he had developed a "Plan C". He expressed his frustration at this in, *inter alia*, the following manner:

93.1 "*In some cases this condition should be seen as terminal by the medical fraternity in which case the sufferers should have access to morphine in order to terminate their lives.*"

93.2 *"My dad also said this morning that society has it all wrong. How astute! I cannot even be granted my peace when I am in a terminal state for the rest of my life."*

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93.3 *"For F*^*^g hell, where is the grace for this little abused boy who wants to just go to sleep, that is his only wish?"*

93.4 *"Society has it all wrong. To have to take my own life in this horrid way is disgusting after all the suffering."*

93.5 *"I hope that in 100 years people may take a grain of consideration towards this topic that needs attention. I wish this end on no man who has suffered his entire life, but this end, even though terrible in nature, is a zillion times softer than all the brutality of NF to my body!"*

94 Finally, on the night of 31 August 2009, Mr Schonegevel took his own life. He did so by tying plastic bags over his head, alone in his bedroom, and without telling his family or friends. It was certainly not the death he had told his grandmother that he "*so badly wanted*", which was "*to die in a dignified manner… lying in [his mother's] arms with his father's arms around the two of them*".

95 Ms Thamm reflects:

> *"What would it have been like for Craig, his parents, his family, his friends and those who loved him had he been allowed to die as he wished: legally, without any additional trauma, in his own country and with his mother's and father's arms wrapped around him?"*

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Carol de Swardt

96 Carol de Swardt received medical assistance in dying in a Swiss clinic called Pegasos in January 2024. She died by self-administering a lethal injection of sodium pentobarbital. The following is a summary of her journey to this end.

97 The story of Ms de Swardt is as told by Professor Sean Davison, who was involved in her journey to medical assistance in dying. An affidavit by Professor Davison in which he confirms the accuracy of this account, and the others below, is filed with this application.

98 Ms de Swardt contacted Professor Davison in May 2023 through Exit International – a not-for-profit organisation which supports dignity in dying. She sought advice on how she could access medical assistance in dying in Switzerland. They exchanged more than a hundred emails, WhatsApp messages and telephone discussions, and a friendship soon developed.

99 The unfortunate medical history that led Ms de Swardt to seek medical assistance in dying was as follows:

99.1 She was diagnosed with squamous carcinoma on both legs, a common form of skin cancer.

99.2 In 2010, she started radiotherapy, but was negligently given excessive doses of radiation, resulting in irreversible damage to her lower limbs. She developed multiple ulcers and gross sepsis.

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99.3 Following ten surgeries, the only treatment available was an above-knee amputation of her right leg.

99.4 After the amputation, Ms de Swardt was confined to a wheelchair. She described that she was in so much pain that she seldom went outside.

100 Ms de Swardt decided that her suffering was intolerable. In her application to Pegasos, she described her decision to seek medical assistance in dying as follows:

> *"I am 63 years old and disabled. I have a very short stump for my right leg due to a high above knee amputation. My left leg is ulcerous and needs constant wound care. My knee is packing in, and I am getting more disabled every day. I am very limited and have no quality of life. It is all gone. I live alone and every day I wake up into this battle to try and get through another day. I do not wish to do it any longer. I have simply had enough. I have reached the end of the road and just do not want to carry on."*

101 Unlike many other South Africans, Ms de Swardt could afford to pay the 10,000 euros for assisted dying in Switzerland because she had received medical malpractice compensation.

102 The road to Switzerland to ease her suffering was, however, still not an easy one. As summarised by Professor Davison:

102.1 First, as a requirement of Swiss law, Ms de Swardt needed to be accompanied by someone who knew her well: an "*identification witness*". Although Ms de Swardt was close to her son and daughter,

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she feared that they may be prosecuted upon their return to South Africa if they assisted her. She was ultimately assisted by Professor Davison.

102.2 Second, she faced resistance from the travel agent who was booking her air ticket and who insisted on knowing why she was booking a one-way ticket, then refusing to assist her when she was told the reason.

102.3 Third, she faced similar resistance in seeking to obtain a visa, having ultimately to pretend that she was travelling to Switzerland as a tourist.

102.4 Finally, the trip itself caused difficulty: travelling to Switzerland as a paraplegic was difficult and painful. This was the first time that she had left Africa, and she had to travel to another continent to end her life, at an enormous expense and far away from loved ones.

103 Ms de Swardt nevertheless received the "*green light*" for medical assistance in dying at Pegasos. Exit International appointed Prof Davison to act as her witness.

104 Ms de Swardt died peacefully on the morning of 30 January 2024, after self-administering a lethal injection in Switzerland. Professor Davison states that, in her last moments, she came across as grateful, serene and completely at ease with what she was doing.

Anrich Burger

105 The account of Anrich Burger is also provided by Professor Davison, as set out in his affidavit provided with this application.

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106 Dr Burger was a medical doctor. In 2004, at age 34, he was involved in a motor vehicle accident whilst on holiday with a friend. At the time, he was training in acute and emergency medicine.

107 The accident rendered Dr Burger a quadriplegic, unable to ever regain the use of his arms and legs. He was almost totally paralysed from his neck downwards. This rendered him dependent on others.

108 There was no prospect of recovery and Dr Burger knew that his condition would only worsen with time.

109 Professor Davison describes that, for Dr Burger, life as a quadriplegic was intolerable:

109.1 He had severe, insistent and uncontrollable neuropathic pain. Dr Burger said this pain was like experiencing constant torture. He tried all available pain medication, but nothing worked. Whilst morphine drops provided some relief, Dr Burger hated the effect they had on his mind.

109.2 Dr Burger felt humiliated by the way things had to be done on account of his condition, for example using the bathroom. He complained that his condition meant that he had to bear daily hardships which were contrary to the way that he wished to live his life.

109.3 Moreover, Dr Burger constantly feared the future. He found a life in which he was unable to do outdoor activities or practise medicine an

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unbearable one. He did not want to be forced to continue living merely for the sake of existing.

110 Dr Burger's initial contact with Professor Davison appeared to be driven by his interest in supporting DignitySA's efforts to change the law. This progressed to him asking Professor Davison to assist him with ending his life.

111 Dr Burger was resolved to die, and had attempted to do so years before meeting Professor Davison.

111.1 This started shortly after his accident, and in or about January 2005, Dr Burger attempted to end his life with an overdose of medication. His attempt was unsuccessful, but he kept his resolve.

111.2 Thereafter, Dr Burger approached friends in the healthcare profession to assist him. Each refused, some for fear of legal repercussions.

111.3 Dr Burger thereafter applied for medical assistance in dying at Dignitas in Switzerland. He went public with his decision to go to Dignitas. A copy of the article which featured in YOU magazine in September 2013 is attached hereto as "**WL5**".

111.4 The logistics of going to Dignitas were too much for Dr Burger, and he changed his mind, telling Professor Davison that he sought to rather die in South Africa.

112 Dr Burger's resolution to die was not an impulsive one. He told Professor Davison that he had not wavered from this decision for the almost ten years

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following his accident. Rather, his choice was the outcome of careful reasoning, informed by his feelings of indignity, neuropathic pain and fear of what the future would hold.

113 In November 2013, Dr Burger obtained 100 phenobarbital tablets from a pharmacy, using a prescription he had written for himself, and made a reservation at a hotel in Cape Town.

114 Dr Burger required assistance in administrating the medication, and he asked Professor Davison to crush the phenobarbital tablets, dissolve them in water, and hold the mixture for Dr Burger to consume through a straw.

115 Dr Burger lost consciousness soon after consuming the mixture and, according to Professor Davison, he passed away peacefully approximately 20 minutes later.

116 Professor Davison was later arrested and charged with the murder of Dr Burger.

Richard Holland

117 The following account is also provided by Professor Davison. It concerns Richard Holland, whose mother approached Professor Davison in 2015 for assistance with Mr Holland's death following a cycling accident in 2012. Professor Davison's account of Mr Holland's death, as summarised below, is set out in his affidavit filed with this application.

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118 Mr Holland was a South African cyclist who was involved in a tragic accident in which he sustained multiple life-threatening injuries, including severe brain injury.

119 Mr Holland had complete paralysis of nearly all voluntary muscles in his body. This is called Locked-In Syndrome. He could not move or use verbal communication. At most, he was able to make vertical eye movements. He had to be fed through a percutaneous endoscopic gastrostomy tube directly to his stomach.

120 Mr Holland still had full cognitive function and awareness. He developed a blinking technique to communicate with his family. He had incredible support – including psychological counselling, tutoring, medical insurance, physical therapy, and every other type of support imaginable.

121 There was, however, no hope of recovery, and Mr Holland began to express his wish to die. His mother reached out to Professor Davison and together they devised a plan for Mr Holland's peaceful death. Mr Holland could not contemplate spending the rest of his life trapped in a lifeless body, having been a physical and active man. Professor Davison sets out some of the conversations he had with Mr Holland to ensure that dying was truly his wish. In their conversations, Professor Davison also posed control questions to ensure that Mr Holland was mentally capable and aware of what he was expressing – he was.

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122 On 18 November 2015, Professor Davison assisted Mr Holland with a peaceful death. Since Mr Holland was unable to swallow, Professor Davison administered a lethal dose of Nembutal into his feeding tube, which went directly to his stomach.

123 Mr Holland died shortly thereafter, with his mother and sister next to him.

124 Professor Davison was later arrested and charged with his murder.

Justin Varian

125 The story of Justin Varian is also told by Professor Davison, as per the affidavit filed herewith.

126 Mr Varian had Motor Neurone Disease (MND) and was in the final stages of the disease at age 52 when he sought out Professor Davison for medical assistance in dying in 2015. In the manner feared by Mr Harck (summarised above), in this final stage of MND:

126.1 Mr Varian had lost most of his independence, and relied on 24-hour assistance from caregivers;

126.2 He spent his days in an armchair, to which he was carried each morning;

126.3 He could not speak, other than grunts and moans;

126.4 He was bathed and taken to the toilet, and spoon-fed liquidised food in small mouthfuls by his caregivers;

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126.5 He felt the aches and pains of his shrinking and unsupportive muscles and joints, despite patches and tablets for pain relief; and

126.6 He was unable to keep his mouth from hanging open.

127 Mr Varian communicated with the aid of an alphabet board to spell out words and sentences, grunts and moving his head. He repeatedly expressed his wish to die to Professor Davison.

128 Mr Varian was unable to terminate his own life unassisted due to his disease. He was also unable to drink more than a little liquid at a time, and would not be able to ingest Nembutal fast enough for it to work. This was hard for Mr Varian to hear.

129 He needed the lethal drug to be administered safely by a healthcare professional by means of an injection. But, despite attempts to find a doctor who would be willing to administer this for him, none of the doctors he approached was prepared to assist him, given the potential consequences.

130 Professor Davison thus assisted Mr Varian with a gas death, a technique occasionally used at Dignitas where people are unable to swallow. This restricts oxygen to the brain, resulting in the person quickly losing consciousness and dying peacefully.

131 Mr Varian had such a death, dying voluntarily and painlessly, in the company of a few of his loving friends.

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132 Before his death, Mr Varian had an interview with the Sunday Times. He explained his wish to end his life, which is captured in the article. A copy of the published article is attached as "**WL6**".

133 Professor Davison was later arrested and charged with Mr Varian's murder.

Mario Oriani-Ambrosini

134 The account of Dr Mario Oriani-Ambrosini is recounted by his wife of ten years, Carin Oriani-Ambrosini, as per the affidavit filed with this application.

135 Dr Oriani-Ambrosini was a loving husband and doting father. He was also a constitutional lawyer and member of Parliament, and an avid supporter of constitutional rights. He had strong moral convictions and contributed in many significant ways to our constitutional democracy. The media statement following his death in which this was expressed by the Office of the Chief Justice is attached as "**WL7**".

136 Dr Oriani-Ambrosini was diagnosed with terminal lung cancer in 2013. He tried every treatment that was suggested to him – from experimental treatments in Rome, Italy, to Chinese medicine from the Dalai Lama's personal doctor, to different diets, therapies, ultraviolet light and radiation. One possible palliative but non-curative treatment option was that of cannabis oil, the medical use of which Dr Oriani-Ambrosini then sought to legalise through Parliament.

137 Although Dr Oriani-Ambrosini was able to extend his life by nine months longer than the initial prognosis, none of the treatments worked. By mid-2014, the

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cancer had spread everywhere and Dr Oriani-Ambrosini sought to end his pain and suffering by ending his life. He felt that he was losing a battle that he had fought so hard and courageously, and he wanted a dignified end to his struggle.

138 In the early morning of 16 August 2014, after being with his wife, sister and nurse all night, Dr Oriani-Ambrosini asked to be left alone. With his family downstairs, including his young son, Dr Oriani-Ambrosini shot himself.

139 His wife reflects on how different the position could have been if he had been medically assisted in his death:

> *"[Mario] tried everything. He could do no more. The cancer was everywhere – his lungs, his stomach, his legs, everywhere! Everything in him stopped working. It robbed him of his dignity, especially for his child [the couple's seven-year-old son Luke] to see him like this. He was in emotional conflict, in unbearable pain … on the brink of death that would not come gently and quickly.*
>
> *It could have been so different. Imagine if we who loved him could hold his hand, hug him for a last time, while a doctor injected him and released him peacefully from all this suffering?"*

Lucy Bradley

140 The story of Ms Lucy Bradley is told by her son-in-law, Roelof Steenkamp. His affidavit is filed with this application.

141 Ms Bradley was diagnosed with colon cancer in November 2014. Despite numerous medical interventions that she was willing to (and did) undertake, she was given just two years to live from the date of her diagnosis.

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142 Ultimately, Ms Bradley was left with no option but to remove her cancerous colon. The removal of her colon, however, left her unable to process food. She and her family were informed that there was nothing further to be done. She was discharged from the hospital to spend her remaining days at home.

143 The inability to process food resulted in her losing weight rapidly. In turn, this caused the protection around the nerve cells of her nervous system to grow ever-thinner and she was in immense pain.

144 During her last weeks, the issue of medical assistance in dying was discussed between Ms Bradley and Mr Steenkamp. Ms Bradley knew that it was illegal, and although she was suffering greatly, she told Mr Steenkamp that she did not want anyone to get in trouble for assisting her in dying, and that he could not take any steps to do so.

145 Ms Bradley ultimately died from dehydration and starvation. Mr Steenkamp records that the effects of this were awful to witness:

145.1 The dehydration caused her to suffer headaches, confusion, and a dry mouth.

145.2 Her skin became dry and inelastic, and her eyes sunk inwards.

145.3 She later became delirious, and her kidneys began to fail.

145.4 She dropped to 26 kilograms, a mere skeleton of her former self.

146 Her death from dehydration and starvation took 21 days (three weeks) after her release from hospital. Whilst it finally freed her from suffering, Mr Steenkamp

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contends that it ought not to have been necessary for her to endure those three weeks of unbearable suffering.

Willi van Aarde

147 Dr Willi van Aarde was a general practitioner. His story is told by his wife, Ria van Aarde. Mrs van Aarde's affidavit is filed with this application.

148 Dr van Aarde was diagnosed with prostate cancer at 73. He underwent treatment, went into remission, and continued working until the age of 79. At the age of 83, he began experiencing pain in his back. Blood tests subsequently revealed that the cancer had returned and had metastasised throughout his skeletal system, including his scapulae, spine and legs.

149 To manage his pain, Dr van Aarde was prescribed morphine patches, which initially provided some relief. Thereafter, the cancer progressed further, causing significant spinal degeneration, and he was prescribed substantially more invasive treatment.

150 Dr van Aarde's condition deteriorated rapidly. He endured persistent pain and significant physical decline and ultimately passed away at the age of 83 on 18 July 2023, after approximately two months of ongoing pain and struggle following the recurrence of his cancer.

151 Dr van Aarde accepted that the end was near. He wanted to depart with peace and dignity, but this was not an option presented to him and, being a medical doctor himself, he knew it was not legally available. Instead, he was just

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prescribed more medication, reducing his kidney function and limiting his heart valve function.

152 He had a "*choice*" to request cessation of treatment and dying slowly from the cancer, or to continue with futile treatment, prolonging both life and suffering. With both options, his suffering would continue.

153 Mrs van Aarde reflects that:

> *"The futility of his suffering in his final days was heart-breaking. The morphine stickers relieved his pain, but only to an extent. I cannot truly describe the pain and suffering I watched him go through. Our family experienced his pain right into our souls. We would rather have mourned his departure than have him struggle so much. I know he would never have treated his patients so heartlessly."*

Neil Savage

154 Mr Neil Savage's story is told by his widow, Ms Mary-Anne Savage. An affidavit by Ms Savage is filed with this application.

155 Mr Savage was a father of three who loved music and chess. He graduated from the University of Glasgow with a Master's degree in music and mathematics. He thereafter worked as an actuary, setting up his own consultancy and retirement fund administration business in 2000.

156 Mr Savage was diagnosed with rectal cancer in 2020, which had already spread to his colon and liver by the time of his diagnosis. He received radiation and chemotherapy and then underwent extensive surgery in December 2020 during which his anus, his rectum, his bowel, part of his colon and half of his liver were

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removed. After the operation, he had a stoma bag and continued with further chemotherapy.

157 Despite having access to the best medical care possible, Mr Savage's condition continued to deteriorate, and he sustained a number of urinary and kidney problems. A suprapubic catheter (a catheter placed through the skin directly into the bladder) had to be inserted and, at the end of 2023, he had to have a blockage in his small intestine surgically removed.

158 Mr Savage never fully recovered. The cancer continued to spread throughout his body despite ongoing chemotherapy. By the end of 2024, he was almost totally bed-bound, but his mind remained as sharp as ever.

159 In February 2025, he was admitted to hospital again. The tests revealed that the cancer had spread and that his kidneys were failing. Nephrostomy tubes were inserted in his kidneys to drain the urine from his body directly, bypassing his damaged urinary system. But the cancer had torn holes through his colon and bladder, causing faecal matter to leak uncontrollably throughout his abdominal cavity. The leakage was uncontainable. Despite the previous surgical attempts to seal his rectum, waste poured from his anus, penis, the catheter site, and around the drainage tube sites. The only solution was double adult diapers, which left his skin from waist to knees chemically burned from the contact with waste. He lived in relentless, unbearable pain.

160 Nothing further could be done for him and he was discharged to spend his final six weeks at home. He was in control of his mind, but not his body. Ms Savage

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states that "*[h]e was tortured by his own body and forced to witness his own decline*".

161 During his last weeks, Mr Savage was so ashamed of his condition that he did not want to see anyone, including his children. He told Ms Savage that he wished that he could end his suffering.

162 He died on 11 April 2025.

163 Ms Savage reflects:

> *"I am not completely certain whether, if he had been given a choice, Neil would have chosen an assisted death at some point in those final weeks to end his suffering. But I do know that he suffered unbearably and died shorn of all dignity. Almost worst of all was that he was completely in control of his brain and cognisant of, and humiliated by, his appalling condition. I do know that he was mentally capable until a few hours before his death and should have had the choice to choose to die a more dignified death, if that was what he wanted."*

Yvonne Downs

164 Ms Yvonne Downs's story is told by her daughter, Dr Jennifer Downs, whose affidavit is filed with this application.

165 Ms Downs was an artist, a mother, a grandmother and a loving spouse for 42 years before she died aged 67 from ovarian cancer.

166 Ms Downs was diagnosed with ovarian cancer in January 2012. When she did not respond to her initial cancer treatment, she commenced chemotherapy. At the time, she was living in the Eastern Cape and flew up to Johannesburg once

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a month for the treatment. By late 2012, however, she was too sick to travel. The doctors informed her family that there was nothing further they could do.

167 Ms Downs was bed-bound and required full-time assistance, and so she moved into her daughter's home in Johannesburg. Her daughters looked after her, and she received home visits from a specialist palliative care provider. As Dr Downs was medically trained, she was able to administer the medication to her mother, even when difficulty swallowing meant that Ms Downs had to receive medication and fluids intravenously.

168 Despite having access to the best care possible, some of Ms Downs's symptoms could not be alleviated. She remained in unbearable pain. This was particularly caused by severe heartburn as a result of bowel obstruction from the deposits of ovarian cancer. Not even strong pain medication like morphine would do anything to relieve her pain.

169 Dr Downs recalls a particularly vivid memory from one morning at 04h00, when her mother pleaded: "*when this will all be over?*". But Dr Downs could do nothing to help her.

170 Eventually, Ms Downs's suffering ended when she passed away in January 2013.

171 Dr Downs remarks as follows about her mother's final days:

> *"It should not have been necessary for my mother to be forced to bear such unbearable pain during her last few weeks. It should have been*

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possible for her to make an informed decision to end her pain and suffering and to die with dignity."

Application to admit hearsay evidence

172 DignitySA asks this Court, to the extent necessary, to admit any hearsay evidence set out in these case studies in the interests of justice in terms of section 3(1)(c) of the Law of Evidence Amendment Act, 1998.

172.1 The evidence concerns the tragic accounts of persons who have passed away, with the exception of Mr Harck who tells his own story. Such evidence can only be given by family members, loved ones, or others who had a close and personal connection to their story and who have been brave enough to share those stories in these proceedings. They have nothing to gain personally by sharing these stories. To the contrary, they have had to relive painful moments in doing so. Nonetheless, they have each participated in this application in the hope that some good may follow their loved ones' suffering.

172.2 The evidence is tendered to demonstrate to the Court the lived experiences of those who have been impacted by the blanket prohibition on medical assistance with dying, namely persons who were terminally ill or had irremediable conditions and faced unbearable suffering. The purpose is to illustrate, with real examples, the impact of the current state of the law on the fundamental rights of such people.

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172.3 These case studies, shared by family members or loved ones, serve this purpose. They were with them at or near the end, and lived their experience alongside them. Where possible, the memory shared by a family member or loved one is supported by the contemporaneous words written or spoken by the person themselves at the time. The evidence provided is corroborated where possible, is the best available evidence, and is not rendered unreliable by the fact that the person is dead and cannot personally tell their story.

172.4 There is no prejudice whatsoever to the respondents if the Court admits this evidence. The evidence concerns individual experiences, which cannot be contradicted or denied, and which are not placed before the Court to be assessed or challenged. They are simply here to be told and to be heard. As I set out above, there is no need for the Court or respondents to assess objectively whether a particular person *ought not to have* chosen medical assistance in dying. By its very nature, it is a choice that only they could make.

172.5 Save for Mr Harck, the case studies concern persons who have already died. It is a reality that not many persons suffering from irremediable conditions, and who may wish to seek medical assistance in dying, have the luxury of time to participate in a court process such as this. Mr Harck's form of MND progresses slowly, but that is exceptional. Moreover, those still wishing to access medical assistance in dying may be wary of making that known. If the law does not change, they do not

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want to have placed others at risk by casting doubt on their subsequent death.

173 I therefore submit that it is in the interests of justice to admit the hearsay evidence relied upon in presenting these case studies. Further legal argument in this regard will be made at the hearing of the matter, if necessary.

Conclusion on the case studies

174 The above experiences reflect that the criminalisation of medical assistance in dying:

174.1 forces a terminally ill person, or someone with an irremediable medical condition, to continue to endure physical and mental suffering;

174.2 denies a mentally competent patient the ability to choose a (legal) humane, efficient, and pain-free treatment for their suffering;

174.3 can turn loving relatives, friends and caring health practitioners, operating with compassion and the aim of stopping suffering and giving effect to a patient's request, into "criminals" in the eyes of the law;

174.4 leaves patients feeling isolated and fearful, uncared for and abandoned, and disrespected in their final hours;

174.5 has an arbitrary effect on patients with terminal or irremediable conditions, as it leaves to chance and the nature of the patient's irremediable condition whether their autonomous requests to end their life are respected (for example, if they are reliant on treatment that they can

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request to be withdrawn, leading to their death, or if they are able to end their own suffering unassisted), or whether these requests are ignored (because none of the legal routes to dying is available to them); and

174.6 places assisted dying out of reach of an indigent patient, whilst wealthier patients may be able to travel to Dignitas or Pegasos in Switzerland, albeit at great expense to them and their families, and often forcing them to end their lives sooner than would otherwise be necessary.

175 The effect on patients of the prohibition on medical assistance in dying is also set out in the medical experts' reports filed with this application.

Expert opinions

176 Professor Schuklenk states in the "*Schuklenk Report*" (at para 7.1) that:

> *"Keeping [medical assistance in dying] illegal (maintaining status quo) is not cost neutral. When people are unable to access a physician's assistance in ending their life, there are some who continue to experience suffering that is intolerable to them, and where the suffering is such that they have decided they do not wish to experience it any longer, that continued living is not worth it in their best considered judgment, and where they have no way out".* (My emphasis)

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177 The manner in which maintaining the prohibition of medical assistance in dying is not cost neutral is highlighted in a number of the reports filed by medical experts in support of this application.[9]

178 Allowing a disease to progress naturally, in circumstances where there are no acceptable treatment options, may cause significant suffering for a patient. This can be so even where a patient is undergoing pain management through palliative care. In these circumstances, a person who wishes to end their lives must resort to other means. These could include some of the alternatives adopted by persons in the case studies above, including refusing or withdrawing treatment, voluntarily stopping eating and drinking (VSED), using measures that could lead to botched, traumatic or lonely suicides, travelling to Switzerland if wealthy enough to do so, or illegally involving family members or others to assist them.

179 I summarise the experts' views on these "*alternatives*" to medical assistance in dying below, but, first, I set out the "natural" progression of the most common illnesses or conditions that lead to medical assistance in dying requests in permissive jurisdictions, and then the role of palliative care near the end of life, as set out in the expert reports that have been filed in support of this application.

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9 See, in this regard, the reports of Prof Schuklenk (Canda), Dr Trouton (Canada), Prof Wiebe and Dr Green (Canada), and Prof Downar (Canada).

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Diseases most commonly associated with medical assistance in dying

180 In permissive regimes, some of the common underlying diseases of persons requesting medical assistance in dying include (a) cancer,[10] (b) neurodegenerative diseases, like Amyotrophic Lateral Sclerosis (ALS) or Motor Neurone Disease (MND),[11] and (c) end-stage Chronic Obstructive Pulmonary Disease (COPD) or a cardiovascular disease.

181 The purpose of this section is not to contend that living with these, or other, conditions is, as a rule, intolerable or undignified. It is further not to analyse these illnesses or their progression to set a benchmark for "suffering". Rather, I set out, at a very high level, the progression of these diseases, as summarised by the medical experts, for the Court's understanding of why, for some people,

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[10] In **Canda**, cancer is the identified incurable disease for between 60-65% of requests for medical assistance in dying. In the **USA**, cancer is the terminal illness for approximately 70% of requesting patients. In **Belgium**, cancer has been reported as the illness on the registration form for 65% of reported cases. In the **Netherlands**, the most common illness among recipients of physician-assistance in dying is cancer (2005: 84%; 2021: 62%). In **Australia**, cancer was recorded as the qualifying condition in 77% of cases. In **Colombia**, cancer accounted for the underlying condition in 76-89% of cases.

[11] See, Wiebe and Green Report and Downar Report for the position in **Canada**. The Pope Report sets out that, in the **USA**, 10% of qualifying patients have a neurodegenerative disease. Neurological conditions accounted for 11% of cases in **Australia**. In **Colombia**, ALS has accounted for 75% of non-oncological conditions. Diseases of the nervous system make up 8% of cases in **Belgium**.

the experience of a terminal or irremediable condition in their final days may be unbearable to *them* and thus violate *their* fundamental human rights, especially in the absence of any true alternative, as set out below.

182 The inevitable outcome for patients with incurable cancer is natural death. By the time a patient has stage 4 cancer, symptoms can include pain, nausea, weight loss and weakness. Pain and nausea can be controlled by medication, but not always. The Trouton Report summarises the usual progression of lung, colorectal and hematologic cancers, as the main types of cancers leading to medical assistance in dying. These can include struggling to breathe, the inability to do ordinary simple tasks, being bedridden and relying on oxygen (in the case of lung cancer); bowel obstruction, which is intensely painful and can be accompanied by intractable nausea and vomiting (in the case of colorectal cancers); and dependency on blood transfusions, weakness or fever, and organ failure (for hematologic cancers).

183 Insofar as neurodegenerative diseases are concerned, the patient loses motor function until they can no longer care for themselves, including no longer being able to walk, talk or eat. It can be accompanied by painful muscle spasms, but these can be treated, just as feeding can be obtained through feeding tubes, and breathing can be supported by machines. Prof Wiebe and Dr Green contend that death usually occurs from sepsis once a patient is too weak to fight off infections.

184 For end-stage Chronic Obstructive Pulmonary Disease (COPD), a patient will suffer from severe lung damage, causing painful coughing and extreme

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shortness of breath. Whilst this can be alleviated by medication and oxygen, it can have an adverse effect on cognitive function.

The role of palliative care

185 Professor Downar, a critical care and palliative care physician, and head of the division of palliative care at the University of Ottawa, has set out in the "*Downar Report*" the important role to be played by palliative care for patients near the end of life. Dr Trouton similarly notes the benefits of palliative care as a management approach to the end of life, which reduces suffering and improves the quality of life. Palliative care is employed where there is no known or acceptable alternative curative treatment available.

186 Prof Downar notes that palliative care can significantly improve symptoms and quality of life in people with serious and advanced illnesses, but whilst palliative care can reduce suffering, it is sometimes not enough to ease suffering in the final days of life. In addition, palliative treatment may include increases in sedation, resulting in confusion and other side-effects.

187 Palliative sedation, for example, is an approach used in palliative care to manage suffering by lowering a person's consciousness in order to reduce suffering. It is distinct from medical assistance in dying, and whilst the two can be used alongside each other, Prof Downar opines that palliative care, including palliative sedation, does not address the suffering that prompts requests for medical assistance in dying. In addition, Dr Trouton notes that people who choose medical assistance in dying after or during palliative care make this

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choice because some of the medications increase sedation, and they do not want to be sedated, but would rather appreciate alertness in their final moments.

188 Professor Deliens' view is that palliative care and medical assistance in dying are "*not antagonistic, and on the contrary can and should reinforce each other*". They are not mutually exclusive, but rather medical assistance in dying is an option that is usually taken at the end of a palliative care pathway. In the Belgian model of integral end-of-life care, which Prof Deliens describes in his report, patients are assured continuity of care by the seamless transition between the two, which are seen as harmonious; both focusing on the centrality of the patient.

189 In sum, the shared opinion of the experts who have addressed the question of palliative care in their reports,[12] is that palliative care and medical assistance in dying are, or should be, complementary to each other, each forming part of a multidisciplinary approach to the end of life that values and supports a patient's choice.[13] Both palliative care and medical assistance in dying share the goal of

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12 See, in this regard, the Trouton Report, the Downar Report, the van der Heide Report, the Deliens Report, and the Wiebe and Green Report.

13 For example, in **Canada**, more than 95% of persons receiving medical assistance in dying have access to palliative care, and between 75% and 78% of persons who obtain medical assistance in dying have received palliative care. In **Australia**, palliative care was accessed by 84% of patients requesting medical assistance in dying.

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providing care to patients that is consistent with the patient's values and preferences, and should not be seen at odds with each other.

190 The reality is that palliative care may not be enough to eliminate pain and suffering. Moreover, whilst there is "*no universal rationale for [medical assistance in dying] requests in the terminally ill*" (Downar Report, para 21.1), the common suffering reported by those seeking medical assistance in dying (in Canada) includes "*loss of ability to engage in meaningful activities*", followed by "*loss of ability to perform activities of daily living*", "*loss of dignity*", "*inadequate pain control or concern about controlling pain*" and "*loss of independence*" (Downie Report, para 50).

191 Suffering thus goes beyond pain, and so even if pain could be controlled by good palliative care, that would not result in the end of unbearable suffering (Schuklenk Report, para 7.6.3). As stated by Dr van der Heide, "*[l]oss of dignity, loss of meaning, loss of independence and loss of purpose are important challenges at the end of life, that cannot be addressed with even the highest quality palliative care in all cases*" (van der Heide Report, para 21).

The "alternatives" to medical assistance in dying

192 Whilst patients may be able to ease suffering and improve their quality of life to some extent with palliative care, in many instances there comes a time, often in the last few weeks or days, where the palliative care measures no longer successfully ease suffering or provide sufficient improvement to the patient's quality of life.

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193 Medical assistance in dying offers something to patients which other (legal) alternatives do not – a chosen, peaceful and pain-free death in their own time. Dr Trouton, for example, observes that:

> *"Being able to access [medical assistance in dying] gives people back some dignity and some control. Without the overwhelming preoccupying fear of dying with discomfort and in a coma, they can focus any remaining energy on their loved ones. They can determine who they want to see, and what they want to say to those they love. They are at peace because they do not need to fear the mechanism of death. They are at ease because they can control how much suffering, and for how long. They can direct their care and regain bodily autonomy, at a time when this autonomy may appear to be taken away from them by the unexpected and prolonged ravages of disease, illness and disability. . . rather than being an invalid, they are again the independent person they have known themselves to be."*

194 From a medical perspective, Dr Trouton then describes the experience of the IV method of medical assistance in dying in Canada (the most common method) as one of complete efficacy, with no suffering for the patient:

> *"The person experiences a deep and profound sleep within 2-3 minutes of the [sedative], and then feels nothing. The observers notice breathing become shallow and then usually stop during the propofol [coma inducing] administration. There is no choking, gasping or panic experienced or observed. While the end result is a respiratory arrest, there is no distress seen or felt. When the sequence is used on people who subsequently donate lungs for transplant, no effects of drowning are noted."*

195 The options available to the patient in the absence of medical assistance in dying, however, can cause greater suffering, or prolong suffering, before death.

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196 These proposed legal "*alternatives*" are said to be (a) suicide, (b) voluntary stopping of eating and drinking, and (c) the withholding or withdrawal of life-sustaining treatment. A further "*alternative*" is for (d) a patient to travel to Switzerland, to access a clinic there, but this is not available to most people, and poses its own problems. As set out below, in many instances, these lawful "*alternatives*" to medical assistance in dying are, in fact, not viable alternatives at all.

197 A number of the expert reports address these "*alternatives*", and set out their benefits and shortcomings, as well as their relationship with medical assistance in dying. I summarise the central points below.

198 Suicide is not considered a substitute for medical assistance in dying.

198.1 People who plan and attempt suicide are often depressed, with psychiatric troubles, and do so alone. Medical assistance in dying cannot be clouded by depression, and support is an integral part of medical assistance in dying.

198.2 Suicide is risky, uncertain, often violent and can be impulsive. It is frequently undignified and may be painful. This is compared to the certain, peaceful and planned nature of medical assistance in dying.

198.3 People who wish to end their lives but cannot access medical assistance in dying, have to contend with varying degrees of the likelihood as well as the consequential magnitude of risk accompanying a failed attempt,

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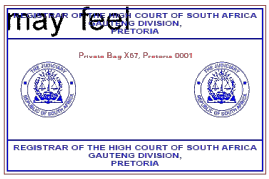
resulting in further suffering, induced by pain or distress, for them and their loved ones.

198.4 Suicide must be done alone to protect loved ones from the consequences. Medical assistance in dying, on the other hand, can include loved ones.

198.5 Suicide leads to suffering by the patient and complex bereavement by the family and loved ones left behind. Families left behind may feel shunned and troubled, and hurt by an unexpected loss.



198.6 In any event, people with end-stage cancer, or end-stage heart or respiratory disease, are too weak to attempt suicide. They are also mostly surrounded by caretakers or family at all times.

199 Voluntary stopping of eating and drinking (VSED) achieves the same end as medical assistance in dying: the death of the patient. However, it is prolonged and does not alleviate suffering as quickly as medical assistance in dying.

199.1 VSED is distinct from refusing artificial (or clinically assisted) nutrition and hydration. VSED is also distinct from the natural loss of appetite at the very end of life. VSED is purposeful and intentional conduct.

199.2 The early symptoms of VSED are hunger and thirst. Hunger can be managed with opioid medications, but thirst is harder to manage. Prof Pope therefore describes VSED as "*difficult and demanding*",

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noting that "*[i]t requires substantial willpower to refuse fluid when experiencing thirst and dehydration*".

199.3 A patient who follows through with VSED will experience dehydration and possible electrolyte imbalances that cause weakness, headaches and irritability. A patient would become increasingly weak and tired, unable to move without assistance. Dehydration affects the kidneys and the heart, which eventually stop working.

199.4 Patients will become less mentally alert. Eventually, VSED leads to delirium – a state of confusion and fluctuating levels of consciousness.

199.5 If a person continues with VSED, they will ultimately fall unconscious and die. Death usually occurs from kidney failure and/or multi-system organ failure.

199.6 This usually takes 10-14 days, although it may be quicker if a patient is suffering from infections (which can be common in patients with acute illnesses), or longer. Prof Pope therefore records that VSED is a "*long and drawn-out dying process*", which can impose significant psychological and other burdens on both the patient and their loved ones.

199.7 Prof Wiebe and Dr Green describe medical assistance in dying to be a faster option than VSED that involves much less suffering.

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199.8 Prof Downar highlights the inconsistency of the law permitting VSED and not medical assistance in dying, noting that the rationale and ethical underpinning of the decision to voluntarily stop eating and drinking is identical to the decision to seek medical assistance in dying. Moreover, VSED does not have the additional safeguards that regulated medical assistance in dying would have, and VSED may itself cause discomfort.

200 The withdrawal or withholding of life supporting measures can play a role in and co-exist with a plan for medical assistance in dying, but do not necessarily on their own lead to a predictable death. Rather, a patient may opt to refuse being kept alive by artificial means, but may also wish to access medical assistance in dying so that they die with dignity, surrounded by their loved ones. As Dr Trouton records "*[w]ith assistance, they believe they leave a positive memory of their last moments behind, where they were in control and able to attend their own celebration of a life well lived.*"

201 Finally, travelling to Switzerland to receive medical assistance in dying is not a true alternative for most South African patients. As Prof Schuklenk sets out, this option is replete with financial and logistical concerns, and limits access to a peaceful death only to those with money.

202 Given the consequences of a blanket prohibition of medical assistance in dying in practice, as seen in the above case studies and the medical expert reports, DignitySA submits that it unjustifiably violates a number of constitutional rights of a competent, informed patient, who has a diagnosed terminal or irremediable

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condition causing such patient intractable and unbearable suffering, which cannot be alleviated by an acceptable treatment option.

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THE CONSTITUTIONAL CHALLENGE

The right to freedom and security of the person

203 In terms of section 12 of the Constitution, every person has the right to freedom and security of the person and the right to bodily and psychological integrity. The latter includes the right to "*security in and control over*" one's body.

204 I am advised that:

204.1 The primary purpose of section 12(1) is to ensure that the physical integrity of every person is protected.

204.2 Section 12 provides procedural and substantive protection against the deprivation of physical liberty.

204.3 Section 12(2) extends this scope of the right to both *bodily and psychological integrity*, and specifically concerns the ability to make decisions about our bodies, grounded in the principles of respect, empathy and compassion. Everyone is entitled to *control over* (i.e. make decisions about) and security in their own bodies

204.4 Section 12 protects the right of people to make personal decisions about their bodies, free from state interference.

204.5 A concern for the protection of individual autonomy and dignity lies at the heart of the right to freedom and security of the person. This includes the right to make decisions that are consistent with one's own beliefs

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and values. It further demonstrates respect and attentiveness to the decisions of others.

204.6 An individual has the right to make fundamental medical decisions. Medical decisions are decisions and choices pertaining to bodily and psychological integrity and personal autonomy. These same principles underlie the requirement of informed consent for medical treatment.

204.7 A competent patient's response to a serious, irremediable medical condition and the treatment steps they wish to take, is a matter central to the bodily and psychological integrity of a person. Forcing any patient to endure unbearable suffering infringes their control over and security in their body.

205 As is apparent from the case studies, the current prohibition of medical assistance in dying has the effect that, a competent patient is often deprived of the right to make a decision about their body and their life, and is thereby deprived of control over their own body. Moreover, the prohibition forces a patient to endure intolerable suffering, causing psychological or bodily harm through continued suffering and the failure to respect their standing as an autonomous being and the right to self-determination.

206 The prohibition on medical assistance in dying thus infringes the right in section 12(1) of the Constitution to freedom and security of the person, and the right in section 12(2) to bodily and psychological integrity.

The right to dignity

207 Section 10 of the Constitution provides that everyone has the right to inherent dignity and the right to have their dignity respected and protected.

208 I am advised that:

208.1 Dignity is both a self-standing, justiciable and enforceable right and a foundational value that underlies the Bill of Rights and the interpretation of other rights and freedoms.

208.2 The protection of dignity in our Constitution recognises that each person has inherent and infinite worth. No person should be treated merely as a means to an end, but should be considered to be an end in themselves.

208.3 Intrinsic to the right to dignity is the right to be considered with respect, including respect for a person's autonomy, as a self-actualising being, and to be protected from unjustified intrusions into their capacity to make decisions.

208.4 Allowing competent adults to make difficult, complex and personal decisions about their lives is central to respecting a person's dignity.

208.5 The right to dignity includes a person's right not to be subject to treatment which undermines their worth, including that which is cruel or degrading.

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209 Where a competent person seeks to make a significant decision, one that goes to the core of their very existence, and is precluded from acting on it for reasons unrelated to their personal circumstances and their decision – because of, for example, the beliefs of others or fears that *other people* may be influenced to act in this manner – such a person is not being treated with equal worth. Instead, the law tells such a person that they are absolutely forbidden from receiving medical assistance in dying:

209.1 *notwithstanding* that they have passed all the usual requirements in medicine for making a competent decision;

209.2 *notwithstanding* that the law would allow them to make this life and death decision if they were able to do it unassisted;

209.3 *notwithstanding* that there is a medical practitioner who is willing to assist them;

209.4 *notwithstanding* that the law would allow them to make this decision if it was a question of withdrawing treatment and starving to death (ignoring for now that this may result in further unbearable suffering);

209.5 *notwithstanding* that they are suffering in a manner that is intolerable to them; and

209.6 *notwithstanding* that they have applied their mind to all available options and wish to choose to end their suffering in a peaceful and humane way.

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210 This paternalism has no place in a society centred on the rights to dignity, and bodily and psychological integrity.

211 Moreover, by this paternalistic approach, the law treats the patient as a means to an end. The patient is forced to continue to live in conditions unbearable to them, against their will, with no regard to their own subjective suffering and wishes, in order to fulfil *another's* wish for them to continue with palliative care, or on the basis that *other* potentially vulnerable people would otherwise be influenced to act against their will. This is not indicative of a law that has due regard for the intrinsic worth of each person.

212 As the case studies show, for those who have made the decision to put an end to their suffering through dying, this is because their disease or injury is such that it is unbearable to them. To force such a person to continue to suffer against their will and contrary to the values with which they have lived their lives, is an infringement of the patient's dignity.

213 For some, palliative care can be life affirming. It can reduce pain and suffering and give patients an opportunity to live the remainder of their days in peace, notwithstanding that death is imminent given their terminal illness. For others, the ability of palliative care to ease suffering to a significant degree is limited. For Mr Harck and others, palliative sedation is intolerable. As set out above, palliative sedation is described in the expert report of Professor Downar, as "*an approach generally used in palliative care to manage suffering . . . that is refractory to treatment. . . it is considered an acceptable option (with patient or surrogate consent) to relieve the suffering by giving medications* ***to reduce the***

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consciousness of the person in a deliberate way *to the point that they are no longer apparently suffering.*"

214 In these cases, the law as it stands forces such a patient to either continue to suffer unbearable pain or to agree to palliative sedation, living in a drug-induced state, waiting in uncertainty for their inevitable death. This strips a person of dignity, treating them as nothing more than an object forced to continue in an unwanted state of existence.

The right to equality

215 I am advised that section 9(1) of the Constitution requires the law to apply to persons in similar situations in a manner that is not arbitrary or manifests naked preferences.

216 The law pertaining to end-of-life decisions makes arbitrary distinctions between those who can and who cannot make decisions about their lives.

217 There is no rational basis for respecting a patient's wish to withdraw life-sustaining treatment or artificial feeding or undergo VSED, which could lead to a slow and painful death, as summarised above, but not allowing a willing health practitioner to respect a patient's wish to assist the patient with bringing an end to their suffering by means of a peaceful death.

218 The impact of the blanket prohibition on medical assistance in dying is subject to chance and means. A patient who is ill or injured in a manner that renders them reliant on life-sustaining treatment may decide that they no longer wish to

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suffer and ask for such treatment to be withdrawn, resulting in their death. Another patient, who is similarly suffering intolerably, but who maintains sufficient control over their body and has the means to end their suffering on their own, may similarly do so. So too, a person with means may decide to travel to Dignitas or Pegasos in Switzerland. In each case, it is a matter of chance what the degree of the illness or injury may be, and whether the patient has the resources and ability to give effect to their wish to end their suffering.

219 The application of end-of-life decisions in our law is therefore arbitrary and violates section 9(1) of the Constitution.

220 In addition, the blanket prohibition on medical assistance in dying imposes a disproportionate burden on people with disabilities in their end-of-life decision-making, as they are restricted to the option of, amongst others, self-imposed starvation and dehydration should they wish to end their lives on account of their unbearable suffering caused by the underlying condition. Put differently, certain disabled persons, such as Mr Varian, are unable to end their own lives unassisted, and if they wished to do so, in exercising their right to self-determination, their only lawful option would be voluntary cessation of eating and drinking, which itself can cause extensive suffering, as described by Mr Steenkamp in relation to his mother-in-law, Ms Bradley, and as set out by medical experts, summarised above.

221 I am advised that this amounts to indirect unfair discrimination on the basis of disability, in violation of section 9(3).

PICT

The right to life

222 Section 11 of the Constitution enshrines the right to life.

223 The prohibition on medical assistance in dying imposes an increased risk of premature death, as it can have the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable.

224 I am advised that this infringes such person's right to life.

225 I am further advised that the right to life is more than just a right of existence, and that it has been held that it "*is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity.*"[14] Thus, the right to life is a right to be treated as a human being with dignity.

226 For the reasons set out above, a patient forced to continue to endure unbearable suffering, against their will, is not being treated as a human being with dignity.

227 I am further advised that the right to life does not encompass a *duty to live*, and the position in our law pertaining to actions and social practices such as self-defence, termination of pregnancy, and refusal of medical treatment shows that

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[14] As per the judgment of O'Regan J in *S v Makwanyane* 1995 (3) SA 391 (CC) at para 326.

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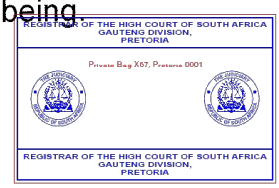
"*sanctity of life*" does not trump all. In our constitutional dispensation, there is no basis for imposing another's personal views on the "sanctity of life" on the person whose body and whose life are directly affected by the decision to end their life.

228 The prohibition on medical assistance in dying thereby infringes the right to life of those persons who are forced to continue their existence long after they are able to share in humanity or live as a respected autonomous human being.



The violations are not justified

229 I am advised that, once an applicant has established a violation of a fundamental right, the state bears the burden of justification, i.e. to justify why any such limitation of rights is reasonable and justifiable.

230 DignitySA submits that the limitation of the rights in sections 9 to 12 of the Constitution is not justifiable under section 36, as the blanket prohibition on medical assistance in dying is overbroad.

231 DignitySA reserves its rights to expand on this and to deal with the question of justification more fully in a replying affidavit, should any of the respondents allege that the limitations of the rights above are reasonable and justifiable.

232 Those who defend the prohibition of medical assistance in dying often say its purpose is to protect vulnerable people.

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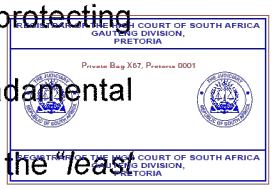
233 But the blanket prohibition also catches people who are not vulnerable. It catches fully autonomous and informed, competent adults who have made the decision to end their suffering on their own terms.

234 The experts' reports on end-of-life decision-making in other jurisdictions show that a permissive regime with properly designed and administered safeguards protects vulnerable people, respects, protects and upholds fundamental human rights, whilst ensuring that the State's legitimate objective of protecting vulnerable persons is met. The blanket prohibition, infringing the fundamental rights of the patients who seek medical assistance in dying, is thus not the "*least restrictive means*" of achieving the purpose of protecting vulnerable patients.



235 In sum, the blanket prohibition, which infringes on the rights to freedom and security of the person, bodily and psychological integrity, dignity and to live a life worth living, is overbroad and is not reasonable and justifiable in terms of section 36 of the Constitution.

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JURISDICTIONS THAT ALLOW MEDICAL ASSISTANCE IN DYING

236 I am advised that:

236.1 Foreign law is a useful aid, and advised, in approaching constitutional problems in South African jurisprudence.

236.2 International and foreign authorities on contentious issues are valuable as they show how courts and legislatures of other jurisdictions have dealt with, or are dealing with, the same or similar complex issue.

236.3 It is useful to consider the experience of those jurisdictions where medical assistance in dying has been permitted for a number of years to determine how these jurisdictions have implemented medical assistance in dying into their healthcare systems. In particular, it is useful to highlight that the common fears raised by opponents of medical assistance in dying have no support in the factual experiences and data that emerge from those jurisdictions where medical assistance in dying is permitted, and has been for a number of years.

236.4 It is also useful to consider the successes of, and any difficulties in, the implementation of medical assistance in dying in other countries to learn from the safeguards that have been successfully implemented and to have reliable information about various frameworks for medical assistance in dying, each already tried and tested by other jurisdictions, any one, or a combination, of which could be explored and weighed by

Parliament when it considers how best to implement it in a South African context.

237 I am further advised that:

237.1 Any limitation of fundamental rights in section 36 of the Constitution must be reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom;

237.2 It is therefore valuable to consider the jurisprudence of countries founded on a system of constitutional supremacy and with a bill of rights or constitutional document that is similar to ours and which protects the same or similar fundamental rights (for example, Canada). Jurisprudence from countries based on parliamentary sovereignty (for example, the United Kingdom), and **not** under a system of constitutional supremacy, or jurisdictions with very different constitutions to South Africa's, will not be as valuable;

237.3 In having regard to foreign law, courts must be cognisant of both the historical context into which our Constitution was born and our present social, political and economic context; and

237.4 Foreign jurisprudence must be viewed through the prism of the Bill of Rights and our constitutional values, and it is from the perspective of South Africa's legal culture, where all law must be grounded in constitutional values and where respect must be given to the fundamental rights in the Bill of Rights, that the assessment of the

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constitutional validity of the prohibition on medical assistance in dying must be determined.

238 To the best of my knowledge, there are a number of jurisdictions where medical assistance in dying is legal in some form. These jurisdictions include:

238.1 Canada;

238.2 Belgium;

238.3 The Netherlands;

238.4 Switzerland;

238.5 Spain;

238.6 Portugal;

238.7 Austria;

238.8 Germany;

238.9 Luxembourg;

238.10 Italy;

238.11 14 of 56 jurisdictions within the United States of America, namely:

238.11.1 Oregon;

238.11.2 Washington;

238.11.3 California;

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238.11.4 Colorado;

238.11.5 New Mexico;

238.11.6 Maine;

238.11.7 Montana;

238.11.8 Vermont;

238.11.9 New Jersey;

238.11.10 District of Columbia;

238.11.11 Hawaii;

238.11.12 Delaware;

238.11.13 Illinois;

238.11.14 New York;

238.12 Colombia;

238.13 Peru;

238.14 Ecuador;

238.15 Cuba;

238.16 States in Australia, including:

238.16.1 Victoria;

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238.16.2 Queensland;

238.16.3 New South Wales;

238.16.4 South Australia;

238.16.5 Western Australia;

238.16.6 Tasmania;

238.16.7 Australian Capital Territory; and

238.17 New Zealand.

239 Other jurisdictions are in the process of developments that will likely lead to the legalisation of medical assistance in dying. For example:

239.1 In the United Kingdom, a jurisdiction that has extensively considered medical assistance in dying in their jurisprudence and legislature over the years, a bill to legalise medical assistance in dying for terminally ill persons was passed by the House of Commons in June 2025, and is now undergoing scrutiny in the House of Lords.

239.2 In the British Crown Dependencies, which are self-governing jurisdictions under the sovereignty of the British Crown, significant progress has been made toward the legalisation of medical assistance in dying.

239.2.1 The Isle of Man's "*Assisted Dying Bill*" passed its final stage in Tynwald on 25 March 2025. The Bill awaits Royal Assent.

DICT

Implementation is projected for around 2027, contingent on Royal Assent being granted.

239.2.2 Jersey's Assisted Dying Law passed its final reading in February 2026, permitting medical assistance in dying for terminally ill adults meeting specified residency and capacity requirements. The law proceeds to the Privy Council for Royal Assent, with implementation expected approximately 18 months thereafter.

239.3 The Scottish Parliament, in May 2025, voted in favour of the principles set out in the Assisted Dying for Terminally Ill Adults (Scotland) Bill. The draft bill and its specific provisions and possible amendments are under consideration by the relevant Parliamentary committee.

239.4 In France, also in May 2025, the lower house of Parliament, the National Assembly, voted in favour of a bill to legalise medical assistance in dying, alongside a bill establishing a right to palliative care in specialist end-of-life institutions. The bills are still to be considered by the upper house, the Senate, and must then return to the National Assembly for a second reading.

240 A report published by the Health and Social Care Committee in the House of Commons in the United Kingdom on 20 February 2024 summarises a number of the above jurisdictions in its chapter on "International examples", and provides a map that shows the position in each of these jurisdictions, as at that

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date. Whilst there have been various developments since that report was published, it provides a useful overview of the international position and a copy of this map is attached as "**WL8**". A copy of the full chapter and/or the House of Commons report can be provided to the Court to the extent necessary.

241 I also attach, as "**WL9**", a table summarising the countries where medical assistance in dying is recognised in some form, the date on which medical assistance in dying was legalised, the extent of the legalisation (whether it permits self-administered medical assistance in dying only or also physician-administered medical assistance in dying), the eligibility criteria and safeguards adopted by that jurisdiction, the reporting obligations, and the number of reported incidents of abuse.

242 In this section, DignitySA's submissions are guided by the expert opinions of persons who have extensive experience in and knowledge about the medical assistance in dying regimes within the various jurisdictions, as set out in the expert reports attached to this affidavit. I summarise these reports below and highlight the key portions on which DignitySA intends to rely. But given the importance of what is set out in these reports, I ask that the Court consider the expert reports in full.

Canada

243 The position in Canada is set out in the following six expert reports:

243.1 the "*Downar Report*", by Professor James Downar, a practising critical care and palliative care physician, Professor and Head of the Palliative

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Care division at the Department of Medicine at the University of Ottawa, President of the Canadian Critical Care Society, and Clinical Research Chair in Palliative and End of Life Care at the University of Ottawa. Prof Downar's affidavit is filed with this application and the Downar Report is attached as "**WL10**";

243.2 the "*Downie Report*", by Professor Jocelyn Downie, a Professor Emeritus in the faculties of Law and Medicine at Dalhousie University in Halifax, Canada and acclaimed expert on end-of-life law and policy. Prof Downie's affidavit is filed with this application and the Downie Report is attached as "**WL11**";

243.3 the "*Sumner Report*", by Professor Wayne Sumner, Professor Emeritus, St George Campus, University of Toronto, Canada; Fellow of the Royal Society of Canada, and expert on medical law and ethics. Prof Sumner's affidavit is filed with this application and expert report is attached as "**WL12**";

243.4 the "*Trouton Report*", by Professor Konia Trouton, a family physician in Vancouver, Canada and Clinical Professor in the Department of Family Medicine, University of British Columbia, the University of Victoria and the University of Calgary, who has been involved in medical assistance in dying practice in Canada since it was legalised in 2016 and is the current President of the Canadian Association of MAiD Assessors and Providers. Prof Trouton's affidavit is filed with this application and the Trouton Report is attached as "**WL13**";

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243.5 the "*Schuklenk Report*", by Professor Udo Schuklenk, a Professor of Philosophy and the Ontario Research Chair in Bioethics and Public Policy at Queen's University at Kingston, Ontario, Canada and expert on medical assistance in dying. Prof Schuklenk's affidavit is filed with this application and the Schuklenk Report is attached as "**WL14**"; and

243.6 the "*Wiebe and Green Report*", by Professor Ellen Wiebe and Dr Stefanie Green. Prof Wiebe is a Clinical Professor in the Department of Family Practice at the University of British Columbia, and a licensed physician. She was a founding member of the Canadian Association of MAiD Assessors and Providers, and since 2016 has assessed over 860 people for medical assistance in dying and provided medical assistance in dying to over 480 people. Dr Green is also a licensed physician, the Founding President of CAMAP, and a medical advisor to the British Columbia Ministry of Health MAiD oversight committee. She has hosted several national conferences on medical assistance in dying and authored an internationally acclaimed book on the topic. Prof Wiebe and Dr Green's affidavits are filed with this application and their joint report is attached as "**WL15**".

244 The qualifications and applicable experience of each of these experts are set out in and/or attached to their respective reports.

245 The above experts address, *inter alia*, the following central topics regarding medical assistance in dying in Canada:

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245.1 First, the legal position pertaining to medical assistance in dying in Canada, including:

245.1.1 The process of the legalisation of medical assistance in dying in Canada;

245.1.2 The forms of medical assistance in dying permitted in Canada, and who may provide it;

245.1.3 The eligibility criteria for medical assistance in dying;

245.1.4 The procedural safeguards to be met;

245.1.5 The requirements for oversight, monitoring and reporting;

245.1.6 The mechanisms in place to prevent abuse and non-compliance with safeguards; and

245.1.7 The right of health practitioners to conscientiously object to providing medical assistance in dying.

245.2 Second, how medical assistance in dying operates in Canada in practice, including:

245.2.1 The requestors and/or recipients of medical assistance in dying;

245.2.2 Factors that lead to requests for medical assistance in dying;

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245.2.3 The practical process of medical assistance in dying;

245.2.4 The interaction between palliative care and medical assistance in dying.

245.3 Third, the experts' assessment of the current medical assistance in dying regime in Canada, including:

245.3.1 Common misrepresentations and misunderstandings;

245.3.2 Any experience of misuse or abuse of the regime;

245.3.3 Whether Canada is experiencing a slippery slope; and

245.3.4 Some of the successes, failures and lessons learnt thus far, as identified by the experts.

246 The expert reports contain a thorough exposition of medical assistance in dying in Canada.

247 In summary:

247.1 Medical assistance in dying in Canada was legalised in 2016 and includes both *self-administered* and *practitioner-administered* medical assistance in dying. The practitioner can be either a physician (medical doctor) or a nurse practitioner, although it is mostly a physician. Practitioner-administered medical assistance in dying is by far the more preferred method.

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247.2 Legislation establishing medical assistance in dying as a legal end-of-life option was precipitated by a decision of the Canadian Supreme Court in the *Carter* decision, which found certain provisions of the Criminal Code to be void – and contrary to section 7 of the Canadian Charter of Rights and Freedoms (the right to life, liberty and security of the person) – insofar as they prohibited medical assistance in dying for a competent adult person who clearly consented to the termination of life, and who had a grievous and irremediable medical condition that caused enduring suffering that was intolerable to the individual in the circumstances of their condition. "Irremediable" did not require the patient to undertake treatments that were not acceptable to them. The Court held that the limitations of these rights were not saved by section 1 of the Charter, which requires a limitation to be demonstrably justified in a free and democratic society.

247.3 The regulatory regime includes eligibility criteria, procedural safeguards, and oversight and monitoring requirements. There are also mechanisms in place to prevent non-compliance with the law.

247.4 Medical assistance in dying is initiated by the patient. The patient is then assessed by two independent and qualified health practitioners to assess capacity and eligibility.

247.5 To be eligible for medical assistance in dying, the patient must (a) be eligible for government-funded health services, (b) be at least 18 years old, (c) be capable of making health decisions, (d) have made a

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voluntary express request, (e) have given informed consent after being informed of other ways to ease suffering, including palliative care, and (f) have a grievous and irremediable medical condition, meaning: having a serious and incurable illness, disease or disability, being in an advanced state of irreversible decline in capability, and experiencing intolerable suffering that cannot be alleviated under conditions the person considers acceptable. There are two tracks for procedural safeguards, depending on whether natural death has become reasonably foreseeable or not. If it is not, there are additional procedural safeguards that must be undertaken. The procedural safeguards for both tracks include the opinion of two healthcare providers, a signed, dated and witnessed request, the giving of informed consent after being informed of all options, and being given an express opportunity to withdraw immediately before providing the assistance.

247.6 Express consent is required throughout the process, including immediately before the provision of the lethal medication (with the exception of final consent waiver and advance consent for failed self-administration).

247.7 All requests for medical assistance in dying must be reported to the federal government, where the Minister of Health is required to report annually on the data received.

247.8 Medical assistance in dying is provided predominantly in the home, hospital, or in palliative care facilities.

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247.9 Physicians may conscientiously object to providing or assisting in providing medical assistance in dying, although in most provinces there is a duty to then refer a patient or make an effective transfer of care.

247.10 Colleges of Physicians and Surgeons, and Colleges of Nurses have standards, policies and guidance documents to guide health practitioners' conduct, and the authority to discipline where there has been non-compliance.

248 The Canadian experience reflects the following in relation to some of the commonly-raised fears regarding the decriminalisation of assisted dying:

248.1 Palliative care: More than 95% of patients who had received medical assistance in dying had access to palliative care, and 75% to 80% of patients had been receiving palliative care when they accessed medical assistance in dying. 2.8% of MAiD recipients required but did not receive palliative care – of these in only six cases (out of 15,343) was palliative care needed but not accessible. Palliative care usage, as well as palliative care funding, has increased since the legalisation of medical assistance in dying in 2016, and the two work alongside each other.

248.2 Abuse: There have been no reported cases of any practitioner being charged by the police for non-compliance with medical assistance in dying laws or practice standards since the regulatory regime was introduced. In the almost ten years of medical assistance in dying being permitted in Canada, there has not been a single incident where a

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medical practitioner has been found to have exercised undue influence over a patient's decision to seek the procedure. There have, however, been some media reports, as well as some procedural compliance concerns, which are noted and explained by the experts in their reports.

248.3 "*Slippery slope*": The expert reports refute any allegation that Canada is on a slippery slope towards greater and uncontrolled inclusiveness or permissiveness, in any respect, with regards to medical assistance in dying.

248.4 Marginalised persons: People from marginalised or structurally vulnerable demographics are *less likely* to seek and receive medical assistance in dying. Persons who receive medical assistance in dying are more privileged in terms of income, education and other measures than those who are not.

249 In sum, the position in Canada developed in the courts based in a similar concern for fundamental rights, including the rights to freedom of the person and life. The implementation of the medical assistance in dying regime has largely been successful, and remains popular with the Canadian population.

Belgium

250 DignitySA relies on the expert report of Professor Luc Deliens *("Deliens Report")* attached hereto as "**WL16**".

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251 Professor Deliens is a medical sociologist and emeritus professor of palliative care research at Vrije Universiteit Brussel and Ghent University. He is the founding director of the End-of-Life Care Research Group in Belgium, President of Public Health Palliative Care International. He has published over 100 papers on medical assistance in dying and euthanasia, and over 50 books. His current curriculum vitae is attached to the Deliens Report. An affidavit by Prof Deliens is filed with this application.

252 Medical assistance in dying was legalised in Belgium in 2002, making Belgium one of the first countries to legalise it. At the same time, Belgium also passed laws on access to multidisciplinary palliative care and a patient's right to be fully informed, thus enacting the Belgium model of comprehensive end-of-life care.

253 The 2002 law legalises "euthanasia", which is defined as "*intentionally terminating life by someone other than the person concerned, at the latter's request*", i.e., practitioner-administered medical assistance in dying. Whilst self-administered medical assistance in dying does not explicitly form part of the 2002 law, Prof Deliens records that the Federal Commission for the Control and Evaluation of Euthanasia considers *self-administered* dying, or *physician-assisted* suicide to also be "euthanasia" for purposes of the 2002 law, as long as the health practitioner attended the death and all substantive and procedural criteria were met.

254 The stipulated substantive criteria for medical assistance in dying include that:

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254.1 the patient's request must be voluntary, not the result of external pressure, well-considered and repeated (there will be several conversations with the patient over a reasonable period);

254.2 the patient must be in a medically futile state of constant and unbearable physical or psychological suffering which cannot be alleviated, and is the result of a serious and incurable condition caused by illness or accident;

254.3 the physician must fully inform the patient about their condition and prognosis, and discuss the various options and their consequences with them; and

254.4 the patient and physician must together arrive at the conclusion that there is no reasonable alternative to the patient's situation.

255 Patients accessing medical assistance in dying in Belgium have serious illnesses, such as cancer or advanced Chronic Obstructive Pulmonary Disease or advanced neurological disease, and are suffering unbearably without any prospect of improvement. In the over 20 years since medical assistance in dying was legalised, most of the cases concern terminally ill patients in an advanced stage of their illness, and in most cases the patient dies within hours, days or weeks prior to what they would have had they had a natural death. Medical assistance in dying is almost always preceded by palliative care. Medical assistance in dying in Belgium takes place at home, in hospitals, and in care homes, palliative care units, or hospitals.

DKI

256 The procedural criteria consist of:

256.1 consulting another physician, who is competent to give an opinion about the disorder in question, and who is independent and impartial from both the patient and the attending physician. The consultant will assess whether the substantive criteria have been met, and must give a written report on their conclusions;

256.2 consulting a second consultant if the patient is not expected to die soon. This person must be a specialist in the disorder or a psychiatrist; and

256.3 mandatory notification of the medical assistance in dying to the official review committee (the Federal Commission for the Control and Evaluation of Euthanasia). The Federal Commission for the Control and Evaluation of Euthanasia reviews every case and checks whether the legal requirements have been met.

257 Since the implementation of medical assistance in dying laws in 2002:

257.1 The most significant reasons for requesting medical assistance in dying have been (a) suffering without prospects of improvement, (b) loss of independence in daily living, (c) loss of dignity, (d) general weakness, and (e) pain.

257.2 Professional palliative care is involved in the vast majority of cases where requests for medical assistance in dying are made, and more than 20 years of experience with the implementation of medical

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assistance in dying in Belgium has shown that medical assistance in dying practice and palliative care are mutually reinforcing. Both centre on patient autonomy, and advance care planning and joint decision-making by patient and physician have become hallmarks of contemporary health care. In Belgium, palliative care clinicians support the treating or assessing physician and team in all aspects of the patient's request for medical assistance in dying, occasionally also carrying out medical assistance in dying themselves. The majority of patients requesting medical assistance in dying in Belgium are integrated in a palliative care trajectory. Medical assistance in dying is an option in the continuity of palliative care and, for many patients who choose medical assistance in dying, the endpoint of a palliative care pathway.

257.3 The highest request rates are for people who have a higher education (university degree), and requests are evenly spread between men and women.

257.4 Only one case has been forwarded by the Federal Commission for the Control and Evaluation of Euthanasia to the Public Prosecutor. It involved a patient who ingested a supplied lethal substance without medical assistance. The Public Prosecutor decided not to prosecute.

257.5 There is no evidence whatsoever in Belgium that vulnerable people would more easily receive medical assistance in dying.

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257.6 Developments over time – about which there has been a considerable amount of empirical research – do not show any indication to support a "slippery slope" hypothesis.

257.7 The data did not support the concern that vulnerable people would more easily receive medical assistance in dying; to the contrary, requests from persons over 80 were granted less often and withdrawn more often.

258 In summary, Professor Deliens is of the expert view that legalisation of medical assistance in dying in Belgium:

258.1 has enhanced, as opposed to undermined, palliative care;

258.2 is an integral component of palliative care;

258.3 is being exercised in accordance with the Belgium Act and its criteria; and

258.4 is effectively protecting the vulnerable.

United States of America

259 DignitySA's submissions in this section are based on the expert report of Professor Thaddeus Mason Pope, as set out in the chapter and manuscript, authored by him, as confirmed in his declaration. I attach the chapter and manuscript as "**WL17**", and refer to them collectively as the "*Pope Report*". Prof Pope's declaration is filed with this application.

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260 Professor Pope is a professor at Mitchell Hamline School of Law in Saint Paul, Minnesota, USA. He has published over 300 publications focussing on end-of-life decisions in medicine, law, policy and ethics. Professor Pope has been a consultant to the Academy of Aid-in-Dying Medicine. He has recently acted as an expert witness in the case of *In re Natalie Duke, No. SBC-20-O-30803* (California State Bar Court 2021), which involved end-of-life healthcare decision-making under California law. A full curriculum vitae is included in the Pope Report.

261 Oregon was one of the first jurisdictions in the world to legalise medical assistance in dying, with its *Death with Dignity Act* of 1994. Since then, thirteen more jurisdictions within the USA have legalised assisted dying in some form: Washington (2008), Montana (2009), Vermont (2013), California (2015), Colorado (2016), Washington DC (2016), Hawaii (2018), New Jersey (2019), Maine (2019), New Mexico (2021), Delaware (2025), Illinois (2025), and New York (2026).

262 Medical assistance in dying in these states was done either through ballot (referendum) initiatives, the courts, or by enacting bills through the ordinary legislative process. Medical assistance in dying is regulated at state, and not federal, level.

263 The Pope Report sets out the legal framework of the Oregon *Death with Dignity Act*, which was the first of the regimes, and on which many of the regimes in the other USA jurisdictions are modelled.

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264 The *Death with Dignity Act* has the following core elements:

264.1 It permits only *self-administered* medical assistance in dying, and not clinician administration. The clinician (medical doctor) prescribes (and may assist with mixing) a lethal drug, which the patient ingests themselves. The drug most used is efficient: The patient becomes unconscious within five minutes and dies within the hour.

264.2 The eligibility criteria include the following. The patient must: (a) be over the age of 18, (b) have a terminal illness likely to end their life within six months, (c) possess the requisite decision-making capacity, and (d) be able to self-administer the medication. A terminal illness is defined as a disease that is "*incurable and irreversible*", has been medically confirmed, and "*will, within reasonable medical judgment, produce death in 6 months*".

264.3 In terms of procedural safeguards, the patient must be assessed by at least two clinicians, who must confirm that the eligibility requirements are met and that the patient is informed about and understands the request, as well as their underlying illness and the other options available to them. The request must come from the patient directly, and there must be at least two verbal requests made, separated by a period that varies from state to state, as well as a written request, signed by two independent witnesses. The attending clinician must also have one conversation with the patient with no-one else present to ensure that the request is made voluntarily.

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264.4 Clinicians and entities are allowed to "opt-out" of participating in medical assistance in dying. The only duty of an objecting clinician is to transfer the patient's medical records to the new attending clinician.

264.5 The patient's underlying disease must be listed as the cause of death, and using medical assistance in dying does not constitute "suicide". Consequently, medical assistance in dying would not affect a patient's life, health, accident insurance or annuity policies.

264.6 Participating clinicians are granted immunity from professional, criminal and civil liability in the appropriate circumstances.

264.7 There are various oversight, reporting and compliance requirements following medical assistance in dying.

265 In his consideration of medical assistance in dying in practice in the USA, Professor Pope notes that:

265.1 Less than 1% of deaths in the USA are from medical assistance in dying. This is considerably less than jurisdictions with more permissive regimes such as Canada and the Netherlands, where deaths from medical assistance in dying comprise more than 4% of all deaths.

265.2 More than one-third of patients who get prescriptions never use them (of 8,500 prescriptions written between 1998 and 2021, only 5,300 were used). This is because many people find that hospice or palliative care

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addresses their suffering, and they get comfort and peace knowing that medical assistance in dying is available, should they need it.

265.3 Of the terminal illnesses that give rise to requests for medical assistance in dying, 70% is accounted for by cancer, 10% by neurodegenerative diseases like Motor Neurone Disease (MND) or Amyotrophic Lateral Sclerosis (ALS), and 10% each for cardiovascular and respiratory conditions, like COPD.

265.4 In terms of race, 95% of patients who have received medical assistance in dying in the USA were non-Hispanic white people, and most patients are 65 years of age or older.

265.5 In terms of education and income, most people who seek medical assistance in dying in the United States are well-educated. More than 70% have at least one college degree, and over 90% have health insurance, although Medicare (a primary source of health insurance) may not be used for medical assistance in dying so even insured patients fund it by other means.

265.6 More than 90% of patients who received assistance in dying are on hospice care (that is, receiving palliative care), and more than 90% of patients ingest medical assistance in dying medications in their own homes.

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265.7 The top three reasons for seeking medical assistance in dying are: (a) loss of autonomy, (b) inability to engage in enjoyable activities and (c) loss of dignity.

265.8 There has been **no** evidence of abuse of the medical assistance in dying regime in the United States, notwithstanding that it was first introduced in Oregon more than 30 years ago.

266 In sum, the USA model of medical assistance in dying is a restricted one of *self-administered* medical assistance in dying only, which is used predominantly by educated patients, most of whom are receiving palliative care. There has been no experience of abuse in any of the jurisdictions, notwithstanding that there has been over 115 years of combined experience in the 14 USA jurisdictions.

Netherlands

267 DignitySA's submissions in this section rely on the report by Dr Agnes van der Heide, attached as "**WL18**" ("*van der Heide Report*"). An affidavit by Dr Van der Heide is filed with this application.

268 Dr van der Heide has been involved in research in end-of-life care and decision-making since 1995, and has been the principal investigator for the last four of the five-yearly nationwide research studies on end-of-life practices in the Netherlands that have been conducted since 1990. The latest results were published in 2023, and much of the evidence in the van der Heide Report is derived from that evaluation.

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269 The Netherlands has permitted medical assistance in dying for more than 20 years, following the coming into effect on the *Termination of Life at Request and Assisted Suicide Review Act* in 2002. The Act's objectives are to:

269.1 "*provide legal certainty to physicians who end a patient's life on the patient's request*";

269.2 "*guarantee the carefulness of that action*";

269.3 "*provide an accountability framework for physicians*"; and

269.4 "*promote social transparency*".

270 The medical assistance in dying regime is constantly evaluated, and every five years there is a comprehensive evaluation of the regime, including the assessment of legal and societal developments, the manner in which medical assistance in dying is being implemented in practice, trends or changes since the previous five-year period, and recommendations to improve the regime.

271 The *Termination of Life at Request and Assisted Suicide Review Act* permits medical assistance in dying in the form of both practitioner-administered medical assistance in dying, in which the physician administers the lethal medication, and practitioner-assisted, self-administered medical assistance in dying where the physician provides the patient with drugs to administer themselves.

272 "*Due care*" criteria comprising both eligibility criteria and safeguards, require that the physician must (a) be satisfied as to the voluntary and well-considered

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nature of the request; (b) be satisfied that the patient's suffering is unbearable, with no prospect of improvement; (c) have informed the patient of his situation and prognosis; (d) have reached the conclusion with the patient that there is no reasonable alternative; (e) have consulted with another, independent physician, who must give a written opinion on whether the criteria have been fulfilled; and (f) have exercised due medical care and attention. Patients from the age of 12 can access medical assistance in dying, if they meet all the specified criteria for their age group (including additional requirements such as parental consent or knowledge).

273 Physicians must report the provision of medical assistance in dying to the municipal coroner, and multidisciplinary review committees then assess whether legal due care criteria have been met.

274 Insofar as the exercise of medical assistance in dying in practice is concerned:

274.1 Termination of life requests largely concern people with cancer.

274.2 Palliative care and medical assistance in dying work hand in hand. Both are aimed at providing patients with an end-of-life trajectory that is consistent with their values and preferences, and have the objective of relieving suffering. There has been a consistent increase in the use of palliative sedation since the legalisation of medical assistance in dying, from deep palliative sedation being provided to 8% of dying patients in 2005, and 23% in 2021.

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274.3 The most common reasons for medical assistance in dying were that the patient lacked prospects that their situation would improve, experienced loss of dignity, suffered severe symptoms other than pain, anticipated suffering, or experienced severe pain.

274.4 During the period 2017 to 2022, the review committee ruled in 44 from a total of 42,396 reported cases (0.1%) that there was not proper adherence to due care criteria, mostly in relation to the requirement of a consultation with a second physician.

274.5 In 2023, there were five reported cases (from a total of 9,068) in which the physician was said not to have complied with the due care criteria: in one case, the "independent" physician consulted was not considered truly independent as he was registered as a patient of the GP practice of the physician who performed the act; in three cases, the physician did not exercise the *extra* precautions for persons with psychiatric illness; and in the fifth case, the physician left the lethal medication with the patient.

275 Dr van der Heide considers that the Dutch population is satisfied with the current system, and there is no development towards lower thresholds to access the practice. She therefore sees no evidence of a "slippery slope".

276 The recommendations that follow the latest assessment period concern increasing and sharing knowledge and practical advice about medical assistance in dying between physicians, educating citizens about medical

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assistance in dying and the options available to them during the end-of-life phase, amending the legal provisions to provide further clarity in the law, and encouraging public debate on the further regulation of end-of-life issues.

Australia

277 DignitySA's submissions on the position in Australia are based on the expert report of Professor Ben White and Professor Lindy Willmott, attached as "**WL19"** (the "*White and Willmott Report*").

277.1 Professors White and Willmott are both members of the Australian Centre for Health Law Research, and have been conducting research into the law, policy and practice of end-of-life decision-making for 20 years, having published over 150 publications on the topic.

277.2 Professors White and Willmott were engaged by the Victorian, Western Australian and Queensland governments to design and provide the legislatively mandated voluntary assisted dying training.

277.3 Their current work includes a four-year project into how best to safely regulate medical assistance in dying.

277.4 Their full curriculum vitae are attached to the White and Willmott Report and affidavits by them are filed with this application.

278 Seven Australian States have legalised voluntary assisted dying (VAD):

278.1 Victoria, through the *Voluntary Assisted Dying Act 2017 (Vic)*, which commenced on 19 June 2019.

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278.2 Western Australia, through the *Voluntary Assisted Dying Act 2019 (WA)*, which commenced on 1 July 2021.

278.3 South Australia, through the *Voluntary Assisted Dying Act 2021 (SA)*, which commenced 31 January 2023.

278.4 Queensland, through the *Voluntary Assisted Dying Act 2021 (Qld)*, which commenced on 1 January 2023.

278.5 Tasmania, through the *End-of-Life Choices (Voluntary Assisted Dying) Act 2021 (Tas)*, which commenced on 23 October 2022.

278.6 New South Wales (NSW), through the *Voluntary Assisted Dying Act 2022 (NSW)*, which commenced on 28 November 2023.

279 The Australian Capital Territory (ACT), through the *Voluntary Assisted Dying Act 2024 (ACT)*, which has been effective since late last year, on 3 November 2025.

280 The only jurisdiction in Australia which has not legalised VAD is the Northern Territory, although a final report by an Expert Advisory Panel published in July 2024 recommended that VAD legislation be passed in this jurisdiction, in line with the legislation in the other Australian jurisdictions.

281 All the jurisdictions above permit both self-administered and practitioner-administered medical assistance in dying.

282 The medical assistance in dying state laws are similar to one another, flowing from the Victorian framework, although they differ with respect to eligibility for

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accessing practitioner-administered VAD. Self-administration is the default option for administration in all jurisdictions except NSW and the ACT, which allow a patient to choose either.

283 The framework followed in Australia is regarded by many as the most conservative medical assistance in dying model internationally, with narrow eligibility criteria and many safeguards forming part of its framework. It is thus a highly regulated process.

284 Part of the detailed eligibility criteria include that:

284.1 the patient must be an adult, and in most jurisdictions, either an Australian citizen or permanent resident;

284.2 the patient suffers from a disease, illness or medical condition that is advanced, progressive and incurable (in some instances), and will cause their death, and is causing intolerable suffering;

284.3 the patient's death generally must be expected to occur within six or 12 months;

284.4 the patient must have decision-making capacity for VAD, assessed by medical practitioners multiple times in the process;

284.5 the request for VAD must be made voluntarily and without coercion, with several opportunities to withdraw from the process; and

284.6 in some jurisdictions, it must be an enduring request.

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285 The safeguards require, among others, at least three separate voluntary requests, and assessments of eligibility by at least two medical practitioners.

286 In most jurisdictions, the default method of medical assistance in dying in Australia is self-administration, and physician-administration is permitted only in specified circumstances, for example, in Victoria, physician-administration is only permitted where the patient is "*physically incapable . . . of self-administration or digestion*" of the substance.

287 Physicians can conscientiously object to participating in medical assistance in dying, but some jurisdictions impose requirements such as to provide information about the state voluntary assisted dying navigator service. A heavily reported barrier to access is an inability to locate a willing medical doctor.

288 All seven Australian jurisdictions have established VAD oversight bodies whose functions include monitoring the operation of the legislation and providing reports. The reports show that the majority of people accessing VAD were from major cities, with qualifying conditions comprising, in the main, cancer and neurological conditions. In 84% of cases patients received palliative care.

289 A five-year report of the Victorian VAD system, published in 2025, recorded that the regime was operating as intended, "*providing a safe and compassionate end of life choice to eligible Victorians.*"

290 Whilst certain reports of non-compliance have been recorded, "*none of the cases of non-compliance related to findings that ineligible individuals had been assessed as eligible and then accessed VAD.*" The Victorian VAD Review

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Board has recently observed that "*[t]he numerous safeguards in the Act and the integrity of those involved have ensured that those risks that were raised in debates about the Act have been safely avoided.*"

291 The White and Willmott Report highlights that (a) Australia's VAD systems are generally operating safely, but (b) there have been some challenges to accessing VAD, mainly attributable to the heavily safeguarded nature of the system.

Colombia

292 DignitySA's submissions in this section rely on the report compiled by the Center for Health and Human Rights at the O'Neill Institute for National Global Health Law at Georgetown University Law Centre, attached as "**WL20**" ("*the O'Neill Report*"). The authors of the O'Neill Report are:

292.1 Oscar Cabrera, the co-director of the Center for Health and Human Rights and the director of the Global Centre for Legal Innovation on Food Environments at the O'Neill Institute, as well as a visiting professor of law at Georgetown University. He obtained his Bachelor of Laws in Venezuela at the Universidad Católica Andrés Bello and his LL.M., focusing on health law and policy, at the University of Toronto. An affidavit by Mr Cabrera is filed with this application;

292.2 Silvia Serrano Guzman, the co-director of the Center for Health and Human Rights at the O'Neill Institute, and an adjunct professor of law at Georgetown University. She obtained her law degree in Colombia at the

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Universidad Autónoma de Bucaramanga. She also holds an LL.M. in international legal studies with a certificate in international human rights law from Georgetown University Law Centre, and an M.A. in legal argumentation from the University of Alicante. An affidavit by Ms Guzman is filed with this application; and

292.3 Natalia Acevedo Guerrero, a senior consultant with the Center for Health and Human Rights at the O'Neill Institute. She is a lawyer with a minor in History from Universidad de los Andes in Bogotá, Colombia. She holds an LL.M. from McGill University, and a M.A in Bioethics and a certificate in Latin American Studies from the University of Pittsburgh. An affidavit by Ms Guerrero is filed with this application.

293 The development of the legalisation of medical assistance in dying in Colombia has occurred predominantly through the court system:

293.1 In 1997, the Constitutional Court of Colombia determined, in an abstract constitutional challenge, that criminal penalties could not be applied to "*compassionate homicide*" where:

293.1.1 the patient provides consent;

293.1.2 the procedure is carried out by a physician; and

293.1.3 the patient has been certified as suffering from a terminal illness that causes unbearable pain incompatible with their concept of dignity.

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293.2 The ruling therefore permitted *practitioner-administered* medical assistance in dying only.

293.3 The ruling followed from the Court's reconciling the state's duty to protect life with respect for human dignity and the fundamental right of free development of personality.

293.4 The Constitutional Court thereafter ruled on several *tutela* cases, where patients were seeking to access medical assistance in dying and being denied. Through these rulings, the scope of the right to die with dignity has been clarified, and the requirements for informed consent in assisted dying procedures have been defined.

293.5 Following a further abstract constitutional challenge in 2021, the Constitutional Court altered the third of the above criteria to the patient experiencing intense physical or psychological suffering due to a bodily injury or a serious and incurable disease. The criterion of a terminal illness was thus removed.

293.6 In 2022, the law was further developed to allow for both *self-administered* and physician-administered medical assistance in dying.

293.7 Included in the right to die with dignity, as developed by the Constitutional Court over the years, is access to palliative care, modification of therapeutic effort, and specific dying procedures, such as terminal sedation, active euthanasia, and medical assistance in dying.

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294 There is currently no statutory law regulating medical assistance in dying in Colombia, despite at least 15 bills having been introduced in Congress since 1998.

295 In 2015, however, the Ministry of Health and Social Protection issued various administrative regulations to develop and implement the process for accessing medical assistance in dying, as well as to establish interdisciplinary scientific committees in hospitals and clinics, which are responsible for reviewing each medical assistance in dying request. Each committee is to consist of at least a physician with expertise in the patient's pathology or illness, a lawyer, and a psychologist or psychiatrist to assess the patient's mental capacity to make an informed decision.

296 Also in 2015, the Ministry of Health issued the *Protocol for the Application of the Euthanasia Procedure* which, *inter alia*, formally recognises practitioner-administered medical assistance in dying as a right and as a healthcare procedure covered by the national health plan.

297 Different data have been presented by the Ministry of Health and by a non-profit organisation regarding the number of medical assistance in dying cases since 2015 (the year in which it was regulated by the Ministry of Health), but they correlate in reflecting cancer as the most common primary diagnosis of the underlying illness.

298 Currently, the position is that patients in Colombia can access medical assistance in dying if they:

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298.1 provide free and informed consent, whether given directly, in an advance directive, or via substituted consent in certain circumstances;

298.2 obtain authorisation from the interdisciplinary committee within a designated clinic or hospital; and

298.3 demonstrate that they are experiencing intense physical or psychological suffering caused by a bodily injury or a serious and incurable disease.

299 The authors of the O'Neill Report note that the jurisprudence of the Constitutional Court has firmly established the right to die with dignity as a fundamental constitutional right, and the rulings, along with the regulations from the Ministry of Health, have established clear guidelines and safeguards that protect patients' autonomy. They note, however, that despite its almost 30-year lifespan, there remain significant barriers to access to medical assistance in dying in Colombia.

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SOUTH AFRICA IS EQUIPPED FOR MEDICAL ASSISTANCE IN DYING

300 DignitySA submits that the healthcare system in South Africa would be able to accommodate and successfully implement a permissive regime for medical assistance in dying, with properly designed and administered safeguards, capable of protecting vulnerable people from abuse and error. This view is supported by the expert reports of the foreign experts, set out above, which indicate that the risk of abuse can be drastically reduced or even eliminated through carefully considered safeguards.

301 This submission is further supported by the expert reports of Professor Graham Fieggen ("*the Fieggen Report*") and Professor Keymanthri Moodley ("*the Moodley Report*"), who attest to the fact that the South African medical profession would be capable of implementing medical assistance in dying, as summarised in this section. The Fieggen and Moodley Reports are attached as "**WL21**" and "**WL22**". I provide a summary of certain aspects of the reports, but ask that this Court consider what is set out in these expert reports in full.

302 In this regard:

302.1 Professor Fieggen, Head of Neurosurgery at the University of Cape Town and Director of the UCT Neuroscience Institute, confirms that South African medical practitioners are trained in and possess the core competencies necessary to implement medical assistance in dying safely in South Africa. His assessment demonstrates that South African medical doctors are already trained, and regulated by the HPCSA, to

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assess decision-making capacity, obtain informed and voluntary consent, detect coercion, and maintain rigorous documentation standards – the same foundational skills required in the foreign regimes, as set out in the foreign expert reports summarised above.

302.2 Professor Moodley, a leading bioethicist with 25 years experience and founding member of the Tygerberg Hospital Clinical Ethics Committee, provides a similar assessment based on her extensive involvement in end-of-life decision-making. Her report emphasises that South African healthcare professionals routinely make complex end-of-life decisions involving withdrawal of treatment, palliative sedation, and capacity assessments, particularly in intensive care and oncology settings.

302.3 Informed consent is required for healthcare services in South Africa, and all qualified South African healthcare professionals are already trained in assessing the capacity of patients to consent to a wide range of clinical scenarios, and do so daily, including scenarios that call for decisions about life and death. As Professor Downar highlights in the Downar Report, the key elements of a capacity assessment for medical assistance in dying are the same for any medical decision. Moreover, health practitioners involved in treating people with advanced or incurable illnesses—

> *"are often required to assess a person's capacity to consent to decisions or treatments that might result in death (either immediately or delayed), such as stopping chemotherapy; withdrawing life-sustaining measures such as mechanical*

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ventilation or haemodialysis; continuous palliative sedation; or voluntary stopping eating and drinking. The common concerns that are raised about assessing capacity to request [medical assistance in dying] (e.g. depression related to a poor diagnosis, impaired cognition due to medications, coercion by family members) are equally applicable to those requests. In my experience, [medical assistance in dying] assessors spend far more time and attention ensuring decisional capacity than clinicians spend on any other analogous decision, which is reassuring to me. The fact that each decision is performed in duplicate is even more reassuring."

302.4 Having considered the foreign expert reports, Prof Fieggen records that South African medical doctors are already required to, and do, practise the same core competencies required of healthcare professionals in the context of medical assistance in dying, as described by the foreign experts.

302.5 Both Prof Fieggen and Prof Moodley highlight that South Africa already operates sophisticated safeguard systems in analogous high-stakes and complex medical contexts, including organ transplantation, renal dialysis allocation, and termination of pregnancy services. These existing regimes demonstrate the healthcare system's capacity to implement eligibility criteria, multi-practitioner assessments, and robust oversight mechanisms that would be essential for the provision of medical assistance in dying in South Africa. According to Prof Fieggen, a regulated medical assistance in dying framework is thus feasible in

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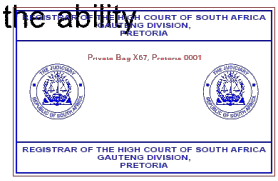
South Africa without a wholesale redesign of medical training or clinical governance.

302.6 The reports recommend a hospital-coordinated implementation model, initially operating through accredited secondary and tertiary hospitals with established multidisciplinary teams, palliative care services, and ethics committees. Such an approach would ensure appropriate specialist consultation, documented consent processes, and the ability to convene expertise promptly when complex cases arise.



302.7 The reports highlight the critical importance of integrating medical assistance in dying with enhanced palliative care services, so that medical assistance in dying is not a substitute for, but complementary to, palliative care, as is the case in Canada and Belgium. They recommend that any medical assistance in dying framework should ensure that palliative care is offered and is genuinely available, and hope that a medical assistance in dying regime will be accompanied by expanding palliative care capacity across the healthcare system.

302.8 The Fieggen and Moodley Reports identify South Africa's medical education standards as internationally comparable, noting that South African-trained physicians regularly practise in jurisdictions where medical assistance in dying is legal, including Canada, Australia, and the United States.

302.9 The Fieggen Report recommends an initial committee-based model adapted from the South African Law Reform Commission's proposals, involving multidisciplinary hospital committees with at least two independent medical practitioners, one with palliative care training, plus additional psychiatric and specialist input for complex cases. Prof Fieggen suggests that this model could evolve into a physician-decision pathway with two independent assessments as capacity and training mature over time.

302.10 Both experts conclude that, while South Africa's healthcare system faces resource constraints, a carefully phased implementation beginning at designated hospitals with appropriate safeguards, training programmes, and oversight mechanisms – drawing from the international experience – would be possible in South Africa and there is no reason to doubt the safe provision of medical assistance in dying to eligible South Africans. Should conscientious objection be permitted, any regime should ensure effective referral pathways to preserve patient access, in accordance with constitutional rights.

302.11 The shared opinion found in both reports confirms that South African healthcare education, training and practice already comprise the ethical frameworks, clinical competencies, and institutional capacity to implement a regulated medical assistance in dying regime that protects vulnerable populations while respecting patient autonomy and dignity in end-of-life care.

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303 It is furthermore evident from the statement by South African doctors, attached above as "**WL3**", that there are qualified and senior South African doctors who would find it ethical, in accordance with their view of the role of health practitioners, to assist medically a patient in dying if that act was not prohibited by law. This is a similar view of their ethical obligations to those of the medical practitioners who have provided expert reports in relation to foreign jurisdictions, all of whom do not see a conflict between their ethical duties as a health practitioner and the provision of medical assistance in dying.

304 There is therefore no reason why South Africa cannot introduce an appropriate regime for medical assistance in dying that gives effect to the fundamental rights of patients, whilst providing a safe and compassionate space for vulnerable patients at the end of their lives.

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REMEDY

Declaration of invalidity

305 Section 172(1) of the Constitution provides:

> *"When deciding a constitutional matter within its power, a court—*
>
> *(a) must declare that any law or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency; and*
>
> *(b) may make any order that is just and equitable, including-*
>
> *(i) an order limiting the retrospective effect of the declaration of invalidity; and*
>
> *(ii) an order suspending the declaration of invalidity for any period and on any conditions, to allow the competent authority to correct the defect."*

306 The blanket criminalisation of medical assistance in dying is unconstitutional on the bases set out above.

307 The criminal law should be declared unconstitutional and invalid to the extent that it does not allow for competent, informed patients suffering from an irremediable condition, causing such patient intractable and unbearable suffering, which cannot be alleviated by an acceptable treatment option, to voluntarily request medical assistance in dying.

308 The provisions of the HPCSA Guidelines that treat voluntary medical assistance in dying as unlawful, unprofessional, and unethical, are unconstitutional and should be declared invalid.

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309 The provisions of the Health Professions Act that refer to "*unprofessional conduct*" and/or "*disgraceful*" or "*improper*" conduct should be interpreted in a constitutionally compliant manner, namely that such conduct does not include medical assistance in dying.

310 The HPCSA Guidelines that declare that medical assistance in dying is unlawful and unethical should be amended to align with the order handed down by this Court.

Steps to remedy the defect

311 Parliament is directed to take steps to implement an appropriate legislative regime for medical assistance in dying.

312 The HPCSA is directed to amend and update the HPCSA Guidelines to reflect the position in the law following the order of this Court.

Suspension of the declaration of invalidity

313 The experience in foreign jurisdictions indicates that medical assistance in dying works best in a regulated framework, with guidelines for patients and health practitioners to follow.

314 It would not, in DignitySA's view, be appropriate to simply permit medical assistance in dying without any regulatory framework in place.

315 For this reason, DignitySA seeks that the declaration of constitutional invalidity be suspended for a period of 24 months to allow Parliament to implement an appropriate regime. This is a reasonable period:

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315.1 It allows sufficient time for Parliament to consider the matter and have regard to the position in other countries and the views of experts, many of which have been set out in these papers. Moreover:

315.1.1 In 1998, the South African Law Commission produced a comprehensive report on all end-of-life decision-making options, including medical assistance in dying, to which was attached a draft bill on end-of-life decision-making. This was a project more than a decade in the making.

315.1.2 More recently, a Draft National Health Amendment Bill 2018 was introduced to Parliament, which sought to amend the National Health Act to provide for the legal recognition for advance directives.

315.2 The topic of end-of-life decisions and medical assistance in dying is thus one that Parliament should be aware of. There is no reason to believe that it would take Parliament longer than 24 months to fulfil its responsibilities to remedy the constitutional defect.

315.3 Simultaneously, any longer period of suspension would amount to a continued infringement of fundamental rights of persons who are suffering. It is therefore of significant importance that the steps taken by Parliament are done expeditiously.

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COSTS

316 DignitySA has approached the court in the public interest to vindicate constitutional rights. As a non-profit organisation, DignitySA has limited means and relies on generous donations and pro bono assistance to pursue the decriminalisation of medical assistance in dying, which it does in its own and the public interest. Should DignitySA succeed in the application, it asks for its costs to be paid jointly and severally by all parties who oppose the application.

317 Should DignitySA be unsuccessful, DignitySA submits that it should not be mulcted with costs, in accordance with the principles applicable to constitutional litigation conducted in the public interest.

WILLEM LANDMAN

I hereby certify that the deponent knows and understands the contents of this affidavit and that it is to the best of his knowledge both true and correct. This affidavit was signed and sworn to before me at Stellenbosch on this the 31st day of March 2026, and that the Regulations contained in Government Notice R.1258 of 21 July 1972, as amended, have been complied with.

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COMMISSIONER OF OATHS

Full names:

Address:

Capacity:

DANELLE KAYLA ISAACS
KOMMISSARIS VAN EDE
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