Expert Report

Prof Graham Fieggen

1. Introduction and Expert Credentials

1.1 Purpose of the Report

1. This report is prepared on the instruction of Adams & Adams, on behalf of DignitySA.

2. Its purpose is to assist the Court in determining whether the South African healthcare system and its practitioners are equipped to implement a safe, regulated regime for medical assistance in dying ("MAiD").

3. The report addresses the practical, ethical, and professional capacity of South African medical practitioners to assess and implement MAiD, together with the operational feasibility of appropriate safeguards.

4. I have been provided with the following foreign expert reports provided to DignitySA for purposes of this litigation:

   a. Natalia Guerrero, with Oscar A. Cabrera and Silvia Serrano-Guzmán (Colombia)

   b. Luc Deliens (Belgium)
   c. Jocelyn Downie (Canada)
   d. James Downar (Canada)
   e. Ellen Wiebe and Stefanie Green (Canada)
   f. Thaddeus Mason Pope (United States)
   g. Udo Schuklenk (Canada)
   h. Wayne Sumner (Canada)
   i. Konia Trouton (Canada)
   j. Agnes van der Heide (Netherlands)
   k. Ben White and Lindy Willmott (Australia)

5. I understand that my primary duty is to the Court. I confirm that the opinions expressed fall within my areas of expertise and are based on my clinical experience, leadership roles in tertiary academic medicine, and engagement with national and international professional standards.

1.2 Expert's Qualifications and Experience

PKI

6. I hold the degrees BSc (Med) and MBChB from the University of Cape Town, an MSc in Neuroscience from the University of London, the Fellowship of the Colleges of Medicine of South Africa in Neurosurgery [FCS(SA)], and the Doctor of Medicine in Neurosurgery [MD] from the University of Cape Town. I am an International Fellow of the American Association of Neurological Surgeons.

7. I serve as the Helen and Morris Mauerberger Professor and Head of the Division of Neurosurgery at the University of Cape Town; Head of the Clinical Department of Neurosurgery at Groote Schuur Hospital; Paediatric Neurosurgeon at the Red Cross War Memorial Children's Hospital; and Director of the University of Cape Town Neuroscience Institute.

8. Prior appointments: Head, Department of Surgery, University of Cape Town, 2017 to 2022; Head, Paediatric Neurosurgery Unit, Red Cross War Memorial Children's Hospital, 1998 to 2007; Registrar in Neurosurgery, Groote Schuur Hospital, 1992 to 1997; Family Practitioner, Red River Valley Health District, Manitoba, Canada, 1990 to 1992; Senior House Officer, Groote Schuur Hospital, 1989; Intern, Groote Schuur Hospital, 1988.

9. Leadership in professional bodies: President, 18th World Congress of Neurosurgery, Cape Town, 2023; Member, Administrative Council, World Federation of Neurosurgical Societies, 2021 to 2023; President, Society of Neurosurgeons of South Africa, 2018 to 2021; President, International Society for Pediatric Neurosurgery, 2017 to 2018; Second Vice President for Africa, WFNS, 2017 to 2019; President, Continental Association of African Neurosurgical Societies, 2013 to 2016; Vice President for Africa, World Society for Stereotactic and Functional Neurosurgery, 2013 to 2017; Executive Committee, WFNS, 2013 to 2021; Scientific Chair, ISPN, 2015 to 2016.

10. Professional service and governance: Groote Schuur Hospital Facility Board, terms spanning 2016 to 2026; Co-Chair, MBChB Program Committee, UCT Faculty of Health Sciences, 2014 to 2016; Chair Health Sciences Faculty Animal Ethics Research Committee 2004 to 2006, International Liaison and Advisory Panel of Neurosurgery, 2009 to present; Member, World Academy of Neurological Surgeons; Corresponding Member, American Academy of Neurological Surgeons; inaugural honorary membership, Paediatric Neurology and Development Association of South Africa.

11. Honours and invited academic roles: Visiting professorships and named lectureships at leading international institutions, including Stanford University, New York University, University of Toronto, University of British Columbia, and others, with invitations between 2012 and 2024 that reflect standing in the field and capacity to influence clinical standards.

12. As Head of Division and Director of the Neuroscience Institute, I am responsible for postgraduate specialty training in neurosurgery, supervision of advanced clinical research, and the development of interdisciplinary postgraduate programs in neuroscience.

DK-I

13. My research covers paediatric and functional neurosurgery, neurocritical care, and global neurosurgery, with an ORCID identifier 0000-0001-6541-8377.

14. Several peer-reviewed publications are directly relevant to decision-making for patients with life-threatening neurological conditions that require intensive care, meticulous monitoring, and multidisciplinary judgments about treatment goals. These include work on severe traumatic brain injury and tuberculous meningitis, conditions in which capacity, best interests, and end-of-life deliberations arise in practice (Figaji et al., 2009, 2008; Figaji and Fieggen, 2010). These publications demonstrate longstanding involvement in neurocritical care systems that demand rigorous protocols for assessment, documentation, and review, all of which are pertinent to the safe implementation of MAiD in a tertiary setting.

15. As a neurosurgeon responsible for teams at Groote Schuur Hospital and Red Cross War Memorial Children's Hospital, I routinely participate in and oversee complex consent processes; capacity and voluntariness assessments; and multidisciplinary deliberations regarding withholding or withdrawal of life-sustaining therapies, including ventilation and invasive monitoring, for patients with catastrophic brain injury, advanced neurosurgical disease, or life-limiting congenital conditions. These activities are integral to neurocritical care and paediatric neurosurgery and align with the ethical and professional frameworks taught and practiced in tertiary academic medicine.

16. I have contributed to international discussions on professional standards, safety, and access in neurosurgical care through leadership in global neurosurgery forums and congresses.

17. I have also participated in academic fora on neuroethics and the ethics of emerging neurotechnologies, which address the interface between clinical decision-making, patient autonomy, and societal safeguards.

2. Assessment of South African Medical Practitioners' Ability to Implement MAiD

2.1 Competence in Assessing Patient Capacity and Consent

2.1.1 Training and oversight

18. South African medical education and early-career formation are nationally standardised and regulated by the Health Professions Council of South Africa (HPCSA), the statutory regulator of medical education, registration and professional practice. Undergraduate MBChB curricula are accredited by the HPCSA; after graduation, every doctor completes a two-year HPCSA-regulated internship across prescribed clinical domains, followed by a year of independent practice in public service known as community service. These stages are competency based, logbook driven, and supervised, and they explicitly prepare

DKI

doctors to assess patients, explain risks and alternatives, and obtain consent in high-stakes contexts (HPCSA, 2014).

19. As set out in my credentials in Section 1, my current leadership roles involve direct responsibility for training and supervising such practitioners and for governance of complex consent and capacity assessments in the tertiary setting.

2.1.2 Standards for informed consent and capacity evaluation

20. South African law requires patients to give informed consent for health services and places duties of disclosure on practitioners when obtaining such consent. Section 6 of the National Health Act, 2003 obliges clinicians to inform patients of their health status, options, risks, costs, and the right to refuse. Section 7 requires that consent be obtained from a person with legal capacity, with narrow exceptions for emergencies or lawful substitutes. The HPCSA's ethical guidelines on informed consent (Booklet 4) provide the professional standard: clinicians must ensure understanding, voluntariness, and a balanced presentation of options, and must not exert pressure. The guidelines also describe practical steps to evaluate a patient's decision-making capacity, emphasise the presumption of capacity, and advise serial assessments where doubt exists (HPCSA, 2021a).

21. Where a patient's capacity is uncertain or fluctuates, clinicians follow established pathways that include obtaining second opinions and/or specialist referrals. Psychiatrists provide formal decisional-capacity evaluations when indicated. For example, the existing curatorship process (South African High Court Uniform Rule 57) requires affidavits from two independent medical practitioners, one of whom should, where practicable, be a psychiatrist, that address the person's mental condition and decisional ability. These mechanisms illustrate that South African practice already incorporates escalation for complex capacity questions.

22. Although the nuances of capacity evaluation are not always taught as stand-alone components of undergraduate medical studies, they are developed and assessed during internship and community service through repeated supervised encounters in surgery, internal medicine, obstetrics and gynaecology, paediatrics, psychiatry, anaesthesia and family medicine. Since 2020, the internship model has strengthened rotations in family medicine and psychiatry, increasing exposure to consent discussions, acute decision-making and the assessment of insight and voluntariness (Ramoolla et al., 2023).

23. Surgeons in South Africa routinely obtain consent for procedures where outcomes are uncertain and serious complications, including death, are possible. The legal and ethical framework described above governs these encounters and demands the same core competencies that MAiD assessments require: explanation of consequences and alternatives, confirmation of comprehension, and documentation of a voluntary choice.

DKI

2.1.3 Voluntariness and detection of undue influence

24. The HPCSA guidance requires clinicians to be alert to coercion by relatives, employers, or others, to create space for private discussion, to disclose conflicts of interest, and to involve appropriate supports where vulnerability is identified. It records that clinicians must not put pressure on patients to accept their advice and should document concerns about external pressure and any steps taken. Robust record-keeping standards reinforce these safeguards as described in HPCSA Guideline Booklet 9 on patient records (HPCSA, 2021b).

25. South African doctors are trained, supervised, and professionally obliged to evaluate capacity, obtain informed consent, ensure voluntariness, detect coercion, document their reasoning, and escalate when needed. These are the same core competencies that MAiD regimes require for safe eligibility assessments and provision as described across the Canadian expert reports filed in this matter, which detail two independent clinical assessments, explicit findings on capacity and voluntariness, documentation of reasoning, and escalation to specialist opinion where appropriate (Downie, Downar, Trouton, Wiebe and Green, Schuklenk, Sumner), with parallel expectations set out in the Australian, Belgian, and Dutch reports (Willmott and White, Deliens, van der Heide).

2.2 Experience with End-of-Life Decisions

2.2.1 Respect for refusal of life-sustaining treatment

26. South African law and HPCSA guidance recognise a competent adult's right to refuse care, even if that refusal may hasten death. This principle is grounded in the National Health Act and HPCSA Guidelines Booklet 7: Guidelines for withdrawing and withholding treatment (HPCSA, 2023), and it is routine in clinical practice.

2.2.2 Withholding and withdrawing life-sustaining treatment in cases of severe neurological injury.

27. In tertiary centres, there are established protocols for end-of-life decisions following catastrophic brain injury. At Groote Schuur Hospital, a policy for the treatment of severe traumatic brain injury was developed after extensive consultation (Benatar, 2000). This set out clear pathways for admission, evaluation and management, with all patients receiving initial resuscitation, imaging and stabilisation, followed by a senior team review at about 24 hours to decide on continued active care. Decisions turn on the Glasgow Coma Score at 24 hours together with major adverse prognostic indicators on examination and CT scan. Where further intervention is not considered beneficial, the policy allows for non-escalation or withdrawal with best possible comfort care, supported by structured communication with families and documented senior oversight. Should there be disagreement, referral to hospital leadership may be required. This framework balances universal emergency care with timely, criteria-based decisions, family engagement and compassionate withdrawal where appropriate.

MK

DKL

2.2.3 Palliative care and palliative sedation

28. The HPCSA's guidelines as described in Booklet 17: Ethical guidelines on Palliative Care affirm that clinicians may treat suffering and pain even if a foreseen side-effect is to shorten life, provided the primary intention is symptom control and informed consent is respected. Practitioners are directed to apply bioethical principles, document goals of care, and work in teams (HPCSA, 2019).

2.2.4 Resource allocation decisions such as dialysis

29. The Constitutional Court in *Soobramoney v Minister of Health, KwaZulu-Natal* confirmed that prioritisation in a resource-constrained public system is lawful if based on reasonable and consistently applied criteria. Dialysis eligibility policies, applied transparently, are a long-standing example of high-stakes decisions made within procedural safeguards and notwithstanding limited available resources.

2.2.5 Late-stage feticide

30. Where severe fetal anomalies are detected after 20 weeks, many South African hospitals operate within written, multidisciplinary protocols to guide decisions, counselling, and procedures that offer the option of avoiding live birth. The South African Society of Obstetricians and Gynaecologists in conjunction with the South African Society for Ultrasound in Obstetrics and Gynaecology has published a position statement and guideline endorsing a transparent, team-based approach, with clear severity thresholds, ethics review where needed, and the use of feticide when indicated to ensure a non-surviving outcome before induction (SASUOG, 2025).

2.2.6 Organ donation

31. Organ and tissue donation is integrated into end-of-life care and governed by the National Health Act and the 2012 Regulations on the general control of human bodies, tissue, blood, blood products and gametes. Death must be certified by two independent doctors, one with more than five years of experience, and neither doctor may be part of the transplant team, consistent with the South African guidelines on the determination of death (Thomson et al., 2021). Consent follows HPCSA guidance on informed consent and, where no prior directive exists, the National Health Act specifies the surrogate order.

2.2.7 Summary

32. Across the domains described above, existing safeguards include: senior-clinician leadership and second opinions; multidisciplinary meetings; family engagement and structured communication; recourse to institutional ethics committees or dispute resolution; documentation standards; transfer pathways; and palliative care obligations. The HPCSA guidelines codify these elements to ensure they represent the standard of care within professional practice in the South African healthcare system.

33. The decisions described above occur daily across tertiary and regional hospitals in intensive care, emergency medicine and trauma, neurosurgery, oncology, nephrology, obstetrics, neonatology, and other services. Many of the core principles are issues that South African clinicians and hospitals already have to navigate so there is existing institutional knowledge. The ethical and legal frameworks are familiar to South African practitioners and function as a ready foundation for the additional, MAiD-specific processes and safeguards contemplated in this case.

2.3 Comparison with International Practice

34. South African medical training and ethical standards are materially aligned with those in jurisdictions where medical assistance in dying is lawful. The HPCSA sets rigorous standards for medical education and professional conduct, and South African-trained doctors regularly practice abroad in systems that include MAiD, such as Canada, the USA and Australia. The foreign expert reports filed in this matter confirm that MAiD regimes in Canada, Belgium, the Netherlands, and Australia rely on the same foundations of capacity assessment, voluntariness, documentation, and professional accountability that already govern South African practice.

35. In assisted dying jurisdictions, eligibility assessments require confirmation that the decision is **informed and voluntary**, that the patient has **decision-making capacity**, and that **further expertise (e.g., psychiatric consultation) is engaged when there is doubt** (e.g. see reports from Canadian experts Downie, Downar, Trouton, Wiebe, Green, Schuklenk, Sumner, or the Colombian experts Natalia, Acevedo and Guerrero, and Belgian and Dutch experts Deliens, and van der Heide). These safeguards to ensure eligibility criteria are met find similarities with South Africa's existing processes for capacity assessments, including in curatorship proceedings, where two independent doctors (one a psychiatrist) must certify capacity.

36. Across jurisdictions, MAiD involves structured assessments, independent confirmation, documentation, and clear communication with patients and families. South African clinicians already use comparable processes in ethically charged contexts such as withdrawal of life-sustaining care, palliative sedation, organ donation, and late-stage reproductive decision-making, all of which require multi-disciplinary consultation, second opinions, and documented consent in line with the National Health Act and HPCSA guidelines.

37. The portability of South African medical education provides external validation of competence. Thousands of South African-trained physicians practice in Canada, Australia, the UK, and the US, including in roles that involve assessing or providing MAiD. Studies on medical migration confirm the recognition of South African training as equivalent to international standards (Tankwanchi et al., 2019).

38. South African clinicians already operate within legal and ethical structures that require the very competencies MAiD demands: assessing capacity and voluntariness, detecting and

MM

DKI

documenting coercion concerns, obtaining and recording informed consent, consulting specialists when indicated, and practicing within written protocols that include second opinions, communication standards, and auditability. These existing capabilities would support the safe implementation of a regulated MAiD regime without requiring a wholesale redesign of medical training or clinical governance. Notwithstanding this general preparedness, it is important to provide additional training tailored to MAiD for those clinicians who serve as assessors and providers. Such focused training can readily be delivered, as has been successfully implemented in Canada through the Canadian MAiD Curriculum, developed by CAMAP and funded nationally (see reports from Canadian experts), and in Australia through state-mandated VAD training programmes for eligible practitioners (see report from Willmott and White).

3. Feasibility of Implementing a Regulated MAiD Framework in South Africa

3.1 Adoption of internationally-recognised safeguards and South Africa's capacity to apply them

39. The South African Law Reform Commission's Project 86 canvassed two main implementation models that mirror current international practice: physician decision with stringent procedural safeguards and decision by a hospital-based ethics committee, together with detailed documentation and confidential reporting to the Director-General of Health. Those options included repeated and witnessed requests, independent medical confirmation, and a record of reasons.

40. As I set out below, I am of the opinion that a hospital-based ethics committee model (similar to that described by the SALRC after extensive public consultation) can safely, albeit in a restricted fashion initially, implement MAiD services in South Africa.

3.1.1 Irremediable or terminal condition that causes intractable and unbearable suffering

41. Across jurisdictions where medical assistance in dying is lawful, eligibility depends on the presence of a serious illness or condition that is irremediable or terminal, and that causes, or will cause, intractable and unbearable suffering, coupled with decision-making capacity and a voluntary, informed request. The Canadian experts, Jocelyn Downie (Canada), Udo Schuklenk (Canada), Wayne Sumner (Canada), James Downar (Canada), Ellen Wiebe and Stefanie Green (Canada), and Konia Trouton (Canada), describe how Canada operationalises this threshold through two assessment tracks and layered safeguards. Belgian expert Luc Deliens (Belgium) explains the Belgian model which includes mandatory independent consultation and additional discipline-specific input where death is not reasonably foreseeable. Agnes van der Heide (Netherlands) sets out similar Dutch due-care criteria and consultation requirements. Willmott and White (Australia) detail

PFI

Australia's highly regulated model that uses narrow eligibility, three sequential requests and two independent clinical assessments. Thaddeus Mason Pope (United States) surveys U.S. practice standards and oversight mechanisms that anchor eligibility in a terminal condition causing intolerable suffering and require independent assessments and rigorous reporting. The Colombian report by Natalia, Acevedo and Guerrero (Colombia) confirms the same core threshold within a rights-based constitutional framework. These convergent models require multi-practitioner agreement and, where appropriate, assessment by a clinician with expertise in the condition that is causing suffering.

42. I am of the view that a South African model could effectively and safely ensure these same eligibility criteria are met. The two options suggested by the South African Law Reform Commission's Project 86 – either decisions by two independent medical practitioners or consideration by a hospital panel or committee, with clear procedural steps and written documentation – align with current practice norms in complex consent and end-of-life care in South Africa's public and private sectors, especially in regional and tertiary hospitals.

3.1.2 Patient competence and capacity

43. Determining decision-making capacity is core clinical work in South Africa.

44. As set out in Part 2 of this report, doctors routinely assess capacity for high-stakes decisions, and where uncertainty exists they refer for psychiatric or clinical psychology evaluation.

45. As stated above, in all of the jurisdictions where MAiD is legal, practitioners must assess patient's decision making capacity. Colombia's framework requires a psychiatrist or clinical psychologist on the hospital-based committee that evaluates each request.

46. I see no reason to suggest that South African clinicians could not perform similar capacity assessments in the MAiD context.

3.1.3 Voluntariness of the request

47. Voluntariness is safeguarded in the comparative frameworks by repeated, patient-initiated requests and a right to withdraw at any stage, together with either a self-administration pathway that keeps agency with the patient, or a requirement for contemporaneous confirmation immediately before any clinician-administered provision.

48. In Canada, patients must be informed that they may withdraw at any time and, immediately prior to provision, are given an express opportunity to do so while the provider confirms consent. Australia similarly builds in several opportunities to withdraw and defaults to self-administration, reserving practitioner administration to defined circumstances, which preserves voluntariness through the route of administration itself (Downie, Trouton, Wiebe and Green, Willmott and White). The Benelux reports emphasise the same voluntariness safeguards through the due-care criteria of a voluntary, well-considered and, in practice, repeated request, with techniques that can preserve patient control even in clinician-

DKI

administered cases (van der Heide, Deliens). This approach mirrors the South African Law Reform Commission's Project 86 model, which also contemplated written requests, independent review and the ability to rescind at any time.

49. Some jurisdictions, in an effort to ensure voluntariness, allow only patient self-administration by oral ingestion. This is the prevailing model in U.S. states (Pope). In my view that approach is unnecessarily restrictive because it excludes decisional patients who are experiencing intolerable suffering but cannot swallow or physically self-administer. Empirically, where both options are available, eligible patients overwhelmingly choose clinician-administered MAiD, with fewer than five self-administrations out of 15 343 Canadian MAiD deaths in 2023 (Downie). Voluntariness can also be reinforced in clinician-administered MAiD through simple technical measures that keep agency with the patient.

50. Australian practice illustrates a policy choice that, in my view, South Africa should avoid. Several state regimes, including Victoria's original law, prohibited practitioners from initiating VAD discussions, which hindered timely, informed requests. Victoria is now moving to remove the prohibition, recognising that autonomy must be matched by access to accurate information (Willmott and White). I support the Canadian approach, which permits clinicians to raise MAiD sensitively alongside other options during goals-of-care discussions while maintaining independent assessments, thorough documentation, and the patient's ability to withdraw at any time (Downie, Downar).

3.1.4 Enduring nature of the request

51. Endurance is tested through multiple requests separated in time. Waiting periods are particularly important where conditions have a protracted progression, such as neurodegenerative disorders like motor neuron disease. Canada's Track 2 requires a minimum 90-day assessment period, with explicit expectations for consultation with a specialist in the patient's condition.

52. I believe these features can be adopted in South Africa without difficulty.

3.1.5 Multi-practitioner assessment

53. Multi-practitioner assessment for MAiD is feasible in South Africa. The SALRC proposed either two-doctor decisions with documentation or a multidisciplinary hospital committee model. Colombia, the most similar jurisdiction to South Africa socio-economically, employs a model that requires each request to be evaluated by a three-member hospital-based committee that includes a medical specialist, a lawyer, and a psychiatrist or clinical psychologist (Natalia, Acevedo and Guerrero). South African regional and tertiary hospitals have established referral pathways, host multidisciplinary teams, many have ethics committees or have the ability to create them.

54. I have no reason to believe our hospitals do not have the expertise to make multi-practitioner assessments of the nature required to safely assess eligibility for MAiD.

DKI

3.2 Mandatory offering of alternatives, including palliative care

55. A regulated MAiD system in South Africa must ensure that the choice of MAiD is never driven by lack of palliative care. International consensus recognises that palliative care is not a substitute for curative treatment and assisted dying is not a substitute for palliative care. Equitable choice requires real access to comprehensive care (Sallnow et al., 2025). Access to palliative care in South Africa remains limited and uneven, with gaps in integration and availability across provinces and care levels. This reality demands that a South African MAiD system must include verification of both informed choice and the availability of real alternatives such as palliative care.

56. Evidence shows that even in jurisdictions where palliative care coverage is almost universal, MAiD remains a necessary option for a subset of patients with intolerable suffering (van der Heide). The Canadian foreign expert reports confirm that practitioners discuss means to relieve suffering, including palliative and disability supports, as part of assessment, and that most recipients have had palliative care involvement. The Belgian and Dutch experience reported by Deliens and van der Heide likewise shows palliative care and MAiD are complementary, not antagonistic.

57. To enable safe provision of a MAiD service in the near future despite the limited palliative care coverage in South Africa, I recommend that MAiD services be coordinated at tertiary or secondary public hospitals, or private hospitals with equivalent capacity. Before sites are granted permission to provide a MAiD service they must demonstrate access to multidisciplinary palliative care teams. This mirrors Colombia's requirement that hospital-based committees co-ordinate MAiD assessment and provision. It is also aligned with the SALRC proposal for hospital-based panels as one potential lawful model.

58. The assessment team must verify that the patient has interacted with palliative care- either receiving appropriate palliative care, or has had such care offered and declined. No one should be forced to undergo palliative care as a precondition, but the option must be real. In practical terms, a South African model could require that at least one of the two assessing practitioners should have some form of palliative care training, or if the hospital-based multidisciplinary committee model is used, this should include a clinician with such training, to ensure that alternatives have been properly explored and communicated.

59. To avoid the perverse outcome that a MAiD service appears easier or cheaper than building and expanding health equity and palliative care services in South Africa, Government must couple any MAiD regime with a defined, funded programme to expand palliative care, including staffing, medicines access, and home-based services.

60. Belgium's experience, as described by Luc Deliens, shows that palliative care and assisted dying can be advanced in parallel. The Canadian expert reports filed in this matter likewise emphasise integration rather than substitution, and Canada's official monitoring confirms that in 2023 three-quarters of MAiD recipients had accessed palliative care, with very few needing but unable to obtain it. Federally, Parliament enacted the Framework on

DKI

Palliative Care in Canada Act, followed by a national Framework and Action Plan and multi-year federal–provincial funding agreements that channelled substantial new money into home, community and palliative services. Australia has taken a similar path: Victoria introduced VAD together with a targeted palliative-care package and system reforms, and Western Australia paired its VAD law with record palliative-care investment, including expansions in beds, regional teams and community services. These patterns, reflected in the Canadian reports of Downie, Downar, Trouton, Wiebe and Green, Schuklenk and Sumner, and the Australian report of Willmott and White, demonstrate that legalising assisted dying has proceeded alongside substantial new investment in palliative care rather than at its expense. The same coupling is explicit in current European proposals: in France, an aide à mourir bill is accompanied by a 10-year palliative plan that adds about €1.1 billion and lifts annual spending to roughly €2.7 billion by 2034, and in the United Kingdom, the Terminally Ill Adults (End of Life) Bill has been debated alongside the largest hospice investment in a generation and continuing House of Lords bills to place a statutory duty on access to palliative care.

61. A South African statute should follow this model and, consistent with the South African Law Reform Commission's Project 86 options, should require verification that real palliative care has been offered and available at the point of assessment, backed by a national plan and earmarked funding to expand capacity.

3.3 Indications for MAiD

62. I will refrain from commenting on specific indications for MAiD as this should lie in the hands of experienced practitioners in the respective medical specialties.

3.4. Addressing the developing country context and a practical South African model

63. Given the strengths and weaknesses of the South African health system, I recommend that medical assistance in dying be coordinated from designated secondary and tertiary public hospitals, and from private hospitals with equivalent capacity, as the safest and most practical starting point. These institutions either already have, or can readily establish, palliative care teams and multidisciplinary ethics support, and they are the locus for comparable high-stakes decisions.

64. This approach is consistent with international practice, including Colombia's model of institutional committees in medium- and high-complexity hospitals. It also aligns most closely with the South African Law Reform Commission's Option 3 ("decision by panel or committee"), which was developed after broad public consultation and with reference to

PKI

international best practice. Those recommendations can be updated in light of current global experience and adapted to the realities of our health system today.

65. I believe a hospital should only be accredited to coordinate MAiD once it can demonstrate:
    - Access to a multidisciplinary palliative-care team and a process to ensure palliative options are discussed and, where accepted, delivered.
    - A MAiD governance pathway that supports either two-doctor decisions or a hospital-based committee decision, with defined documentation, timelines, and audit.
    - The ability to convene expertise promptly, including psychiatry or clinical psychology and condition-specific specialists when indicated.
    - Record-keeping and reporting capacity to support confidential notification to a national oversight unit.
    - Care navigation to help patients and clinicians move through the pathway efficiently and safely.

66. Although assessment and coordination occur at the accredited hospital, provision should be at the patient's chosen location if clinically appropriate: hospital, hospice, or home. Both practitioner administration and self-administration should be available, since each supports voluntariness for different patients and circumstances. Canadian experience shows all three settings are feasible and safe when properly supported, and Colombia permits provision outside the of the hospital environment subject to institutional coordination.

67. I am of the opinion that within this hospital-coordinated model, South Africa can safely implement adapted versions of the two SALRC options:
    - Adapted SALRC Option 2: physician decision with safeguards.
    - Adapted SALRC Option 3: decision by a hospital-based multidisciplinary committee.

68. I set out both below, and then explain why Option 3 should be the initial default.

3.4.2 Decision models for South Africa within a hospital-coordinated system

A. Adapted SALRC Option 3: decision by hospital-based multidisciplinary committee *(recommended as the initial default)*

69. The Adapted SALRC Option 3 process could operate as follows:
    - After repeated requests, a medical practitioner conducts the initial assessment. The patient submits a signed, witnessed written request. The assessment confirms the diagnosis and prognosis, records capacity, voluntariness, and nature of suffering, and confirms that palliative care has been discussed and offered.
    - The case is then referred to the hospital's MAiD ethics committee for an eligibility decision. Meetings may be convened virtually when clinically appropriate, particularly if the patient is too unwell to attend.

70. Hospital-based MAiD ethics committee composition:
    - Core membership (minimum three):
      • Two independent medical practitioners, ideally at least one with appropriate training and expertise in palliative care.
      • One other member from the multidisciplinary treatment team, for example a nurse, social worker, or the referring doctor.
      • For conditions with a protracted progression (e.g. neurodegenerative disorders such as motor neuron disease), or in any case where capacity may be limited by neurocognitive deficits or clouded by comorbid mood disorders such as depression, the committee must contain a medical practitioner with expertise in the underlying condition as well as a psychiatrist or clinical psychologist to provide a formal capacity evaluation. This psychiatric assessment must definitively confirm that the request for MAiD is a voluntary, competent decision and not a symptom of a treatable psychiatric condition. Further, in such cases, a minimum 90-day assessment period should be observed.

    - At least one member must be fluent in the patient's home language.
    - Patient-permitted attendees: one family member, healthcare proxy, or independent patient advocate.

71. Deliberation and timelines:
    - The committee issues a reasoned eligibility decision, ideally by consensus, but by majority vote if needed.
    - A decision should be reached within 10 days of receipt of the written request.
    - All documentation must reflect capacity, voluntariness, and that palliative care was offered.

72. I am of the opinion that safeguards should confirm eligibility and reduce risk, not simply create barriers. As Downar observes, a true safeguard improves safety, while an obstacle only makes access more difficult without benefit. Willmott and White caution against policy drift through many small, burdensome steps that cumulatively make systems unworkable. Evidence from Victoria shows that prohibiting clinicians from raising VAD and procedural over-complexity impeded access, while care-navigator support improved equity and safety (White et al., 2023). Further, some jurisdictions require a lawyer on the committee (Colombia) and as is proposed for the UK Assisted Dying Bill. I believe that this is not necessary for determining clinical eligibility and will likely only add administrative burden and serve as an obstacle to access for those that are eligible.

73. I am of the opinion that the adapted SALRC Option 3 described above should be used first. It builds in multidisciplinary review from the outset, which is prudent as practice is evaluated and training and services scale. It ensures consistent attention to palliative-care verification and specialist input where needed. It matches the institutional-committee approach used in a socio-economically similar jurisdiction, Colombia, and finally it allows

a national oversight unit to interact with a limited number of accredited committees during early implementation, which strengthens learning, training, and audit.

B. Adapted SALRC Option 2: physician decision with safeguards *(to be introduced as capacity grows)*

74. The Adapted SALRC Option 2 process could operate as follows:
    - Two independent clinical assessments conducted within the accredited hospital pathway. Each assessment confirms capacity, voluntariness, diagnosis, and intolerable suffering, and verifies that palliative care has been offered and either provided or declined. At least one assessor should have palliative-care training. For conditions with a protracted progression (e.g. neurodegenerative disorders), or where capacity may be limited by neurocognitive deficits or clouded by comorbid mood disorders (e.g. severe depression), assessors must obtain a condition-specific consultation from a medical specialist and refer the patient for a formal capacity evaluation by a psychiatrist or clinical psychologist. This evaluation must confirm that the decision is capacitated and distinct from the symptoms of a treatable mental illness. A minimum 90-day assessment period must be observed in these cases, as well as for any condition with a protracted progression..
    - The written request is signed and witnessed. A decision within 10 days of the request should be the norm once the assessments and required consultations are complete. If assessors disagree, or if red flags arise regarding capacity, coercion, or alternatives, the case should escalate to the hospital committee for a binding decision.
    - Immediately before provision, the provider must confirm contemporaneous consent, and the patient is reminded of the right to withdraw at any time. Provision may occur in hospital, hospice, or at home, with self-administration or practitioner administration available as clinically appropriate.

75. The physician-decision pathway mirrors SALRC Option 2 and international practice, and it should be adopted once accredited sites, training, and audit systems have matured. During the initial phase, routing cases through the hospital committee offers a conservative increase in safety without unnecessary obstacles.

3.4.3 Oversight, reporting, training, and conscientious objection

76. The foreign expert reports filed in this case explain how oversight and transparent reporting operate in practice across systems in jurisdictions where MAiD is legal, similar processes could be established in South Africa. Initially, oversight and reporting can use existing South African capabilities. Consistent with the South African Law Reform Commission's Project 86 draft bill, any hospital committee that authorises MAiD would report to the Director-General of Health, which mirrors existing notifiable-disease workflows where local authorities forward weekly notifications to the Director-General. A South African oversight body could begin with a small national unit supervising a limited number of hospital-based committees, publish anonymised annual reports and expand training for assessors and providers (see below). I believe this oversight unit should track

PKI

palliative-care offers and uptake in every case and report annually on palliative access expansion, aligning the scale-up of MAiD service points with concrete gains in palliative coverage.

77. Training can be delivered through accredited curricula and short courses, drawing on international examples and local palliative care expertise. Canada has implemented a federally funded, nationally accredited Canadian MAiD Curriculum for assessors and providers, which covers capacity assessment, assessment methods, provision, and complex cases. Australia's care navigator services provide a practical support model for patients, families, and clinicians. These approaches described in the foreign expert reports are readily adaptable to South Africa's tertiary and regional hospital networks.

78. Conscientious objection should be respected as a matter of professional ethics and constitutional rights, but it must be regulated to ensure patient access. In Canada, colleges and national practice standards limit conscientious objection to the individual practitioner and require continuity through effective referral or transfer of care, while prohibiting patient abandonment and maintaining duties to provide information and ongoing non-MAiD care. In Colombia, the Ministry of Health made clear when implementing the Constitutional Court's jurisprudence that conscientious objection is individual rather than institutional, and that where a practitioner objects, the institution must promptly designate a non-objecting professional so that the process continues. South Africa already balances conscientious objection in the context of termination of pregnancy, with duties of information, referral, and emergency care identified in the literature and guidance (Magwentshu et al., n.d.). The same approach can be adopted for MAiD. These conclusions are supported in the foreign expert reports of Natalia, Acevedo and Guerrero (Colombia) and the Canadian experts (Downie, Downar, Trouton, Stefanie Green and Ellen Wiebe, Schuklenk, Sumner) who describe how access is preserved while protecting individual conscience.

4. Conclusion

79. In my opinion, South African healthcare has the core competencies to implement medical assistance in dying safely and ethically. As set out in Parts 2 and 3 of this report, clinicians are already trained and regulated to assess decision-making capacity, obtain informed and voluntary consent, detect and document coercion concerns, consult when in doubt, and keep rigorous records. These are the same foundations on which MAiD regimes operate in comparator jurisdictions.

80. End-of-life decisions that are structurally analogous to MAiD are routine across tertiary and regional services, including withdrawal and withholding of life-sustaining treatment, palliative sedation, organ donation at end of life, and late-gestation termination in defined circumstances. These practices rely on senior oversight, second opinions, multidisciplinary deliberation, clear communication with families, and auditable

documentation, which together demonstrate a mature ethics and governance culture that can be extended to MAiD.

81. A regulated MAiD framework is feasible in South Africa without a wholesale redesign of medical training or clinical governance. South African doctors are already trained to, and practice the same core competencies that are required of healthcare professionals in the context of assisted dying, as described by the foreign experts. The safeguards used internationally can be adopted here, namely eligibility tied to a terminal or irremediable condition that causes intolerable suffering, confirmation of capacity and voluntariness through independent assessment, repeated and documented requests, mandatory offering of alternatives including palliative care, and post-event reporting with oversight.

82. I recommend an initial, hospital-coordinated model that adapts the South African Law Reform Commission's Option 3. Under this model, patient-initiated requests would be assessed within a defined hospital pathway, then decided by a small, multidisciplinary MAiD committee that includes at least two independent medical practitioners, one with palliative-care training, with additional psychiatry and condition-specific input for select cases. This approach is conservative, builds in layered review, and matches our institutional strengths.

83. As capacity, training, and audit mature, a physician-decision pathway adapted from the SALRC's Option 2 can be introduced, with two independent assessments inside the accredited hospital pathway and escalation to the committee if assessors disagree or red flags arise. Immediate pre-provision confirmation of consent would remain a constant safeguard, with provision in hospital, hospice, or at home, and with both practitioner administration and self-administration available when clinically appropriate.

84. The framework should be tied to explicit verification that palliative care has been offered and is available in practice, together with a national programme to expand palliative-care capacity. Accreditation of MAiD sites should require demonstrable access to multidisciplinary palliative services and the ability to convene specialist expertise promptly. This coupling avoids perverse incentives and ensures that MAiD is never a substitute for palliative care.

85. Oversight, reporting, and training can begin immediately using existing capabilities. An independent national unit should receive confidential notifications from accredited hospital committees, publish anonymised annual reports, and track the offer and uptake of palliative care in every case. Assessor and provider training can be delivered through accredited short courses that adapt established international curricula, and care-navigator functions can support patients, families, and clinicians. Conscientious objection should be respected at the individual level, paired with effective referral and continuity of non-MAiD care, so that patient access is preserved.

IOKI

86. There is a fundamental tension between the need for sufficient safeguards, and ensuring equity of access for deserving patients given the disparities that exist in our country. South Africa's readiness is not uniform across all facilities, and resource constraints are real. That is precisely why a phased, hospital-coordinated approach is prudent. By starting in designated secondary and tertiary public hospitals, and private hospitals with equivalent capacity, the system can deliver a safe service at modest scale, consolidate learning, and expand as training and audit systems grow. On balance, the country is capable of implementing a carefully regulated MAiD regime that meets constitutional imperatives for dignity and autonomy, while maintaining clinical safety and professional integrity.

Graham Fieggen

Professor Graham Fieggen

31st March 2026

OKI

References:

Benatar, S.R., Fleischer, T.E., Peter, J.C., Pope, A., Taylor, A., 2000. Treatment of head injuries in the public sector in South Africa. S Afr Med J 90, 790–793.

Figaji, A.A., Fieggen, A.G., 2010. The neurosurgical and acute care management of tuberculous meningitis: Evidence and current practice. Tuberculosis, Including a Special section: TB Meningitis Reviews 90, 393–400. https://doi.org/10.1016/j.tube.2010.09.005

Figaji, A.A., Fieggen, A.G., Argent, A.C., LeRoux, P.D., Peter, J.C., 2008. DOES ADHERENCE TO TREATMENT TARGETS IN CHILDREN WITH SEVERE TRAUMATIC BRAIN INJURY AVOID BRAIN HYPOXIA? A BRAIN TISSUE OXYGENATION STUDY. Neurosurgery 63, 83. https://doi.org/10.1227/01.NEU.0000313113.43447.0C

Figaji, A.A., Zwane, E., Fieggen, A.G., Argent, A.C., Roux, P.D.L., Siesjo, P., Peter, J.C., 2009. Pressure autoregulation, intracranial pressure, and brain tissue oxygenation in children with severe traumatic brain injury. https://doi.org/10.3171/2009.6.PEDS096

HPCSA, 2023. HPCSA GUIDELINES BOOKLET 7: GUIDELINES FOR THE WITHHOLDING AND WITHDRAWING OF TREATMENT.

HPCSA, 2021a. HPCSA GUIDELINES BOOLKLET 4: SEEKING PATIENTS' INFORMED CONSENT: THE ETHICAL CONSIDERATIONS.

HPCSA, 2021b. HPCSA GUIDELINES BOOKLET 9: GUIDELINES ON THE KEEPING OF PATIENT HEALTH RECORDS.

HPCSA, 2019. HPCSA GUIDELINES BOOKLET 17: ETHICAL GUIDELINES ON PALLIATIVE CARE.

HPCSA, 2014. Core competencies required by interns to qualify for registration at HPCSA as doctor.

Magwentshu, M., Chingwende, R., Jim, A., van Rooyen, J., Hajiyiannis, H., Naidoo, N., Orr, N., Menzel, J., Pearson, E., n.d. Definitions, perspectives, and reasons for conscientious objection among healthcare workers, facility managers, and staff in South Africa: a qualitative study. Sex Reprod Health Matters 31, 2184291. https://doi.org/10.1080/26410397.2023.2184291

Ramoolla, B., van, der H.G., Luke, A., King, R., Jacob, N., Luke, B., 2023. Medical internship training in South Africa: Reflections on the new training model 2020 - 2021. South African Medical Journal 113, 1195–1198. https://doi.org/10.7196/SAMJ.2023.v113i5.16784

Sallnow, L., Dorsey-Rivera, B.E., Ntizimira, C., Ahmad, N., Kumar, S., 2025. Assisted dying, complex systems, and global equity in palliative care. The Lancet 405, 103–105. https://doi.org/10.1016/S0140-6736(24)02717-X

SASUOG, 2025. SASUOG POSITION STATEMENT ON THE LATE TERMINATION OF PREGNANCY FOR FETAL ANOMALIES.

DKI

Tankwanchi, A.S., Hagopian, A., Vermund, S.H., 2019. International migration of health labour: monitoring the two-way flow of physicians in South Africa. BMJ Glob Health 4, e001566. https://doi.org/10.1136/bmjgh-2019-001566

Thomson, D., Joubert, I., De Vasconcellos, K., Paruk, F., Mokogong, S., Mathivha, R., McCulloch, M., Morrow, B., Baker, D., Rossouw, B., Mdladla, N., Richards, G.A., Welkovics, N., Levy, B., Coetzee, I., Spruyt, M., Ahmed, N., Gopalan, D., 2021. South African guidelines on the determination of death. South Afr J Crit Care 37, 10.7196/SAJCC.2021v37i1b.466. https://doi.org/10.7196/SAJCC.2021v37i1b.466

White, B.P., Jeanneret, R., Close, E., Willmott, L., 2023. Access to voluntary assisted dying in Victoria: a qualitative study of family caregivers' perceptions of barriers and facilitators. Medical Journal of Australia 219, 211–217. https://doi.org/10.5694/mja2.52004

DKI